Waiting List Management - June 2022

Category:	Management of Waiting Lists
Speciality:	Cardiology
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Keywords	Waiting lists

Incident Summary

This incident involved two cohorts of patients:

Outpatient referrals within the electronic health record (in this case, a system called MAXIMS) for Non-Invasive Diagnostic Cardiology service which were not accepted (i.e., not actioned – either accepted or rejected), and not moved from the MAXIMS worklist and onto a Patient Administration System (PAS) waiting list. As a result, they did not show within the Royal Cornwall Hospital (RCH) waiting list reporting, however they did show on the MAXIMS Internal Referral monitoring report throughout. The service was established before 2021, but the team stopped moving patients over to PAS in June last year.

Paediatric patients were accepted and added to the new outpatient waiting list as non-referral to treatment (RTT) patients in 2020. These patients remained on the waiting list – they were not RTT reportable but were visible on the Cardiology new outpatient waiting list analysis report throughout.

Summary of findings

The main finding of the investigation was that the cardiology service did not have an effective

mechanism for monitoring outpatient referrals within the non-invasive diagnostic cardiology service which affected a total of 622 patients, a clinical review has confirmed no harm has been caused to these patients.

To help counter this the report finds that the cardiology senior management team will need to have a greater oversight of patient waiting lists utilising RADAR reporting for detailed analysis.

Single points of failure must be built out of the service. A rigorous system must be in place that holds up to staff leaving, is owned by the Care Group and overseen by the General Manager for the purposes of managing patients within the waiting lists. Patients must not be accepted onto waiting lists when their care cannot be provided without very clear documentation and regular reviews taking place, so it is always clear where their progress lies within the care pathway. This should all be reviewed as part of a Plan, Do, Study, Act (PDSA) cycle and the model for improvement and any necessary changes tested and incorporated into the service.

Recommendations

Recommendation 1: A rigorous system must be in place that holds up to staff leaving, owned by the Care Group and overseen by the General Manager for the purposes of managing patients within the waiting lists.

Recommendation 2: The management and responsibility of the waiting list should be jointly owned by the clinical lead and the service manager with regular meetings in place to discuss.

Recommendation 3: Given the activity within the Cardiology Department, consideration should be given regarding if the post for the above should be new or within the current Service Manager, Clinical Administration Lead and administration team scope of responsibility.

Recommendation 4: Consider the appropriateness of recruitment to a Band 2-3 administrative role rather than the Cardiographers that book now, to free up clinical patient facing time.

Recommendation 5: Patients should not be accepted onto waiting lists when their care cannot be provided without very clear documentation and regular reviews taking place.

Recommendation 6: Amalgamation of risks should only occur when the risks are identical or if the wider risk encompasses the former.

Recommendation 7: Risks should be regularly reviewed and updated as part of the governance process with documentation.

Recommendation 8: The waiting list should have had oversight from both a clinical lead and service manager level to reconcile information with RADAR reports.

Recommendation 9: The Trust should move towards having one concurrent electronic patient record (EPR). As it stands there are multiple systems in place that have to communicate with each other which can lead to error, delay or ambiguity.

Recommendation 10: There should be formalised training for all new members of staff that have direct interaction with waiting lists to ensure that they understand the principles of waiting lists and their management.

Recommendation 11: There should also be regular (yearly) training that is mandatory requirement for clinical and administrative staff that have interaction with waiting lists – this would provide opportunity for headlines to be communicated such as 'there should be no discrete waiting lists' ideally captured on the ESR platform.

Recommendation 12: A full review of the service management structure should take place, with no assumptions made that it is running optimally at present. This should include a review of governance processes within the cardiology department. This would bolster the work being undertaken following the Getting It Right First-Time visit (GIRFT) visit and subsequent work.

Specialist Medicine Learning summary completed January 2023

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