

Scheduled Care – Queue Planning and Management

Achieving success through focus on the ‘Lucky Seven’ questions.

Objectives:

- ‘Enabling, Ensuring and Embedding’ sustainability of queue planning and management across NHS Boards; achieving the maximum efficiency gain from 10 years of improvement and delivery work.
- Queues will be effectively managed as one aspect of the three pronged ‘Queue/Pathway/Flow’ approach to clinically effective, resource efficient scheduled access management.

For specialities that are failing against elective queue based targets, NHS Boards should be able to provide evidence based answers to the following ‘**Lucky Seven**’ questions¹:

1. **Has available capacity been analysed, benchmarked and maximised at appropriate sub-speciality/queue level, with monthly/weekly targets set for utilisation?** All available capacity should be well utilised with sufficient activity available to meet queue targets without excessive use of waiting list initiatives or the independent sector.

2. **Are there an optimum number of queues in the specialty?** Reducing and optimising the number of queues in a speciality is a **cost neutral** efficiency and quality gain.

3. **Is there optimal scheduling of individual queues?** Achieving optimal scheduling and queue shape by admitting patients of similar clinical priority predominately in date order is a **cost neutral** efficiency and quality gain.

4. **As far as possible has artificial variation (in supply) been smoothed and variation in patient led demand projected for, resourced and managed.** Smoothing and managing variation is potentially a **cost neutral** efficiency and quality gain. Smoothing variation in supply is challenging but can provide significant gains through leave management and flexibility in annualised job plans. It is possible to project patient led demand based on previous seasonality and normal variation and then provide services to meet this demand on a monthly weekly basis. Managing variation in demand is more challenging but there are options in demand management; for example the AHP musculoskeletal pathway. The greater the variation, the greater the level of ‘waste’ that has to be built in to achieve a targets.

5. **Is the optimal size (range) for individual queues being maintained.** For any waiting list target there is a point beyond which the queue is too large to deliver the required target, e.g. there is a ‘backlog’ of patients waiting. A queue may be allowed to vary across a range between a low point and a high point as a means of managing variation in demand and supply. Treating this backlog is a **‘one-off’ cost** to improve efficiency and quality.

6. Is capacity balanced against demand for individual queues taking account of variation? There has to be sufficient capacity to meet demand, for example if there are 1000 additions to a queue over a year, there has to be the capacity to remove a 1000 from the queue over the year. Variation over the year in both demand and capacity will increase the capacity required, e.g. it may be necessary to provide a capacity of 1100 against an average annual demand of 1000 to manage weekly/monthly variation in additions and removals from the queue. Achieving balance is a **recurrent cost** to improve efficiency and quality.

7. Are there clear evidence based prospective trajectories against individual queues for planned capacity/activity and projected demand and queue size/shape; is the actual position against the planned/projected position managed on a monthly/weekly basis with corrective action taken as required? It is necessary to agree activity requirements that will delivery queue targets on an annual basis, based on competent plans/projections for demand/capacity and queue dynamics. It is then necessary to manage against competent trajectories on a monthly/weekly basis and take corrective action where required.

NOTE

¹ A queue is failing where the target is not being meet, or where the target is only being met with excessive use of waiting list initiatives and/or the independent sector. Queue based targets are: Treatment Time Guarantee; 12 weeks for new outpatients; appropriate time for review outpatients; 6 weeks for eight key diagnostic tests).