An Roinn Sláinte
Department of Health

The Better Letter Initiative: An Impact Evaluation of a Redesigned Waiting List Validation Letter

Research Services and Policy Unit, R&D and Health Analytics Division, Department of Health

IGEES
Irish Government Economic & Evaluation Service

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EXECUTIVE SUMMARY

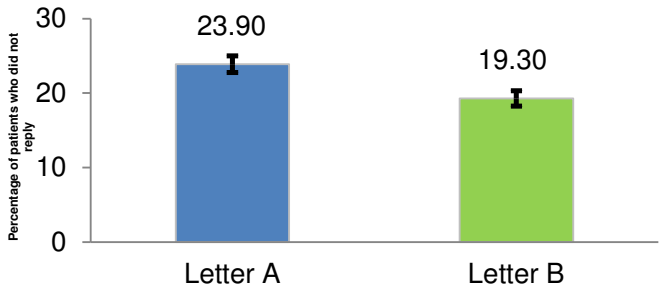
Background: It is good practice for hospitals to undertake administrative validation of waiting lists. This is a process where hospital administration contacts patients on waiting lists to check if patients still require a procedure or wish to be removed from a waiting list. The *National Inpatient, Day Case, Planned Procedure (IDPP) Waiting List Management Protocol (NTPF)* includes an administrative validation process for IDPP waiting lists and states that "it is compulsory that a formal bi-annual hospital validation is carried out on all inpatient and day case waiting lists over six months." It is estimated that approximately 25% or one in every four patients do not reply to a validation letter.

The Project: The National Treatment Purchase Fund (NTPF) is producing a communications pack for hospitals to manage waiting lists. This will include a template validation letter. Different validation letters are currently used throughout the health system. After looking at a sample of existing letters we wanted to explore if using behavioural insights would help more patients to engage with the validation process. This was measured by lower non-responses from patients. The Research Services and Policy Unit in the Department of Health worked collaboratively with the NTPF and the Health Service Executive (HSE) and an advisory group to design a behaviourally informed and tested letter for Inpatient and Day Case patients.

Results: The number of patients who did not reply was lower for the redesigned validation letter (Letter B) than for the control letter (Letter A).

Fig 1: Non responses by letter type (n = 2,861)

Patients who received Letter B had a statistically significant lower non-response rate of 19% compared to non-responses for patients who received Letter A of 24%, Z = 2.99, $p < .01$.



Letter B achieved a 19.3% better performance or resulted in one in five non-responders changing their behaviour.

Conclusion: Using the redesigned validation letter is likely to reduce non-responses. We suspect this is because it makes clearer the importance of the validation process and what the patient is asked to do. Based on bi-annual validation of 2017 waiting lists of three months plus for inpatient and day cases, it would result in at least 5,000 more patients responding. It would reduce follow-up for non-response, enable better use of resources and help hospitals to meet their requirement in the Protocol that "Postal validation cycles must be completed within a six week timeframe."

Impact: In early 2018 following the above results, the redesigned letter (Letter B) was adopted by the NTPF as the national template for waiting list validation correspondence.

1. INTRODUCTION

1.1 Administrative Validation of Waiting Lists

It is good practice for hospitals to undertake validation of waiting lists. The NTPF published a national protocol to support the management of waiting lists, *The National Inpatient, Day Case, Planned Procedure (IDDP) Waiting List Management Protocol* (2017). It states that

"the purpose of waiting list validation is to:

- maintain hospital-patient communication during the patient's waiting list journey
- update the patient record
- reduce DNA and patient cancellation rates
- provide clean, accurate, up to date waiting list data which reflects the true demand for hospital services."

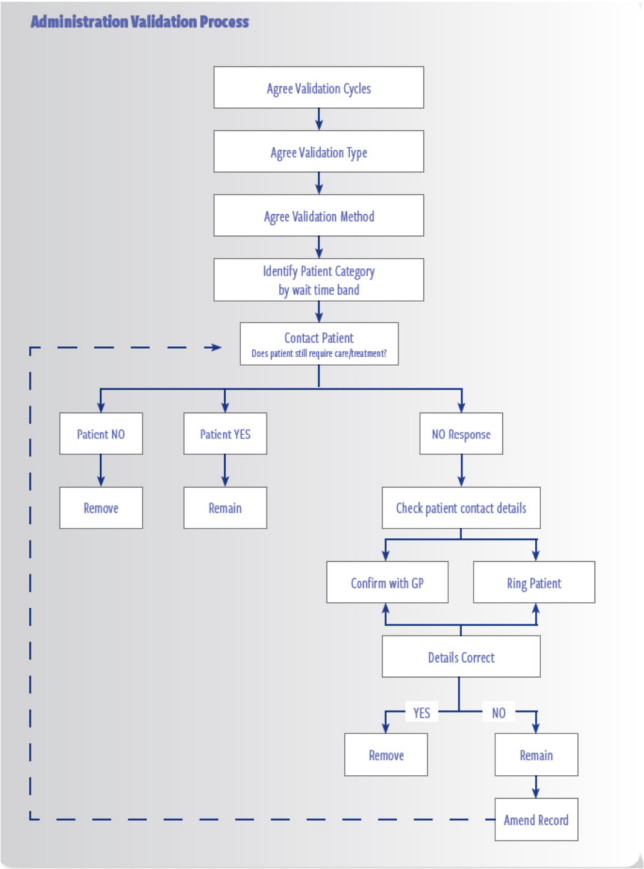
There are two types of validation process: administrative and clinical. Administrative validation is the process whereby hospital administration contacts patients on inpatient and day case waiting lists at pre-planned intervals during the year to ensure that patients are ready, willing, suitable and available to attend a hospital appointment or wish to be removed.

The Protocol notes that, in 2016, administrative validation methods vary across the hospital system: methods used were postal, telephone and email. This variation is largely due to the evolution of technology and the availability of resources.

The Protocol states that:

1. It is compulsory that a formal bi-annual hospital validation is carried out on all inpatient and day case waiting lists over six months.
2. A clear administrative validation process must consistently be followed (see Figure 1) and along with the following:
   - A clear audit trail must be maintained during every validation cycle and information/ outcomes should be communicated to stakeholders and available to the NTPF audit process.
   - Postal validation cycles must be completed within a six-week timeframe.
   - When a patient is removed from a waiting list due to non-response to a written validation cycle, notification must be sent to the GP, Source of Referral (SOR) and the patient. A copy is also to be placed in the patient's Health Care Record. If requested by the GP, patients can be reinstated on the waiting list.

Figure 1.1: Process for the administrative validation of inpatient and day cases



Source: *The National Inpatient, Day Case, Planned Procedure (IDDP) Waiting List Management Protocol* (2017).

Following publication of the protocol, the NTPF consulted across the HSE on requirements to help its implementation. One of the priority areas identified in this consultation was the need to develop a suite of consistent and effective patient correspondence for use with patients across the HSE when managing waiting lists.

1.2 Purpose

The Research Services and Policy Unit, Department of Health engaged with the Process Innovation Director Unit in the NTPF to discuss the possibility of taking a behaviourally-informed and tested approach to developing patient correspondence. It was decided the first project should focus on waiting validation.

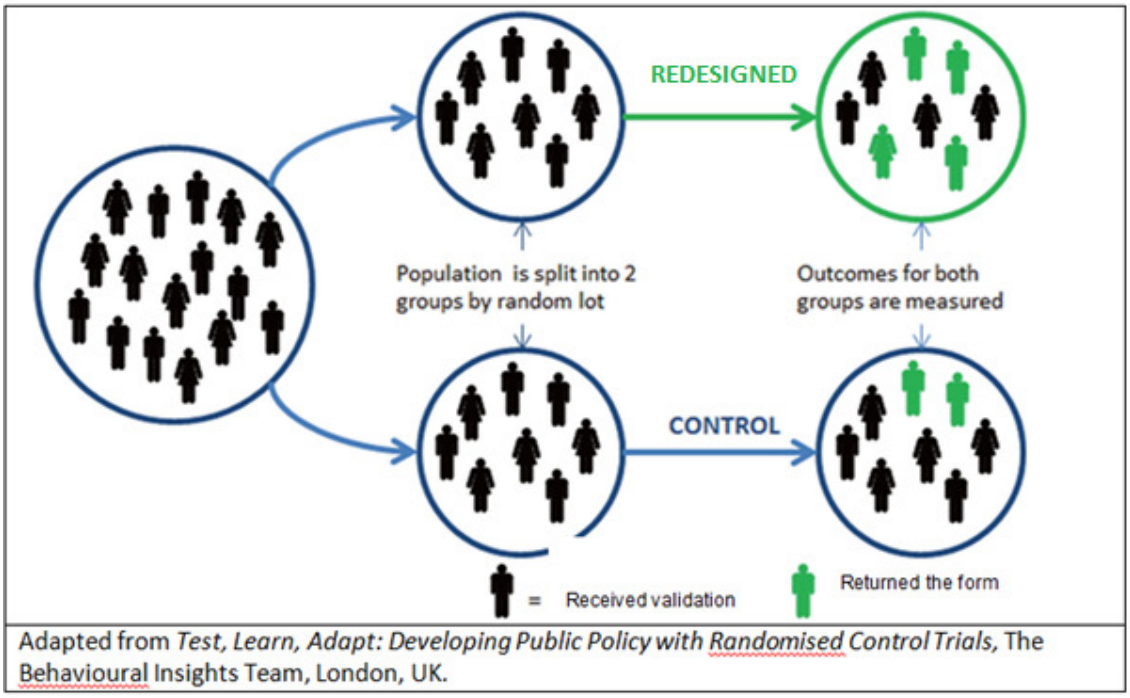
The purpose of this project was to explore whether using behavioural insights in the redesign of the validation letter would help more patients to engage with the validation process. This outcome was measured by lower non-responses from patients.

2. METHOD

2.1 Using an RCT to test the redesigned letter

We will only know with confidence if a letter variation is effective if we make the change, measure its impact, and compare it with a group and process identical in every way except for the new element we have introduced. To find out if a redesigned validation letter really makes a difference we used the scientific technique of a randomised control trial or RCT. The basic idea is illustrated in Figure 2: people are assigned to different groups on a random basis, and the impact for the group who received the redesigned letter is compared with a similar group who did not receive the redesigned letter. See Appendix A for a discussion of ethics and data protection issues.

Figure 2.1: How to determine the effectiveness of different validation options



Adapted from *Test, Learn, Adapt: Developing Public Policy with Randomised Control Trials*, The Behavioural Insights Team, London, UK.

This project's approach to doing this and recording the outcomes as part of the administrative process was relatively simple and fitted neatly into the intended process. It involved sending variations of the validation letter to different recipients and recording the type of validation letter sent. The "outcomes" of the process which need to be collected in any validation process (e.g. response, no response) were then compared according to the type of letter sent. In other words, the response rate for the existing letter used in a hospital (Letter A) was compared to the response rates for the redesigned letter (Letter B).

2.2 Redesign of the validation letter

The test letter was redesigned based on the following:

1. A review of literature on patient engagement/ non-engagement with health services (Miller-Matero et al, 2016; Verbov, 1992), approaches to increasing responses to surveys (Edwards, 2009), trials to gauge the impact of changing the wording and presentation of information in letters or SMS messages (Kennedy et al., 2017; Doyle and Purcell, 2017).

2. A review of existing validation letters from eight hospitals and of relevant requirements in the Protocol.

3. A review of guides on plain English (NALA, 2015; HSE, 2017) and guides on applying behavioural insights to public policy and services (Halpern et al., 2010; *Spotlight on Health Results: Behavioural Insights Short Report*).

4. An iterative process with the Advisory Group.

5. Review of draft redesigned letters by:

    - NTPF staff: Ms Alison Green, Process Innovation Director and Ms Helen Lenehan, Project Assistant;
    - members of the National IDPP Project Steering Group;
    - staff in the participating hospitals: Mr Gary Keenan and Ms Verona Walsh, RCSIHG; Mr John Doyle and Ms Aideen O'Callaghan, ULHG;
    - CEO, Patient Focus Ms Brigid Doherty.

The key design elements used are presented in Table 2.1. These are a call for action, simplified language, addressing the patient by their first name (personalisation), an apology, stressing the intention of checking the waiting list and the value of the service, highlighting important information for the patient (salience), listing of desired actions (readability), and highlighting consequences of non-response, including observation. It was decided not to use colour in the design as colour printing is not used in all HSE sites. **All letters – both test and control – were delivered with a Freepost envelope for return post.** The redesigned letter is shown on the page after Table 2.1.

Table 2.1: Design Elements Used

Font and size Font Arial was used; we aimed for 12 point as standard (but had to use 11 to fit to 1 page) Recommended in *How to use plain English when writing* (NALA, 2015).
Simplification The language within the letter is simplified to make the letter easier to read. Simplification is somewhat related to the fact that people have a limited attention span or limited "cognitive capacity". Research has shown that the easier it is for people to understand and process information, the more likely they are to enact a behaviour (Halpern et al., 2010).
Call for action The letter heading reads "Please reply to this letter" rather than the approach usually taken such as "Waiting List Validation".
Personalisation The client is addressed by their first name throughout the letter. Research has shown that people are more likely to respond to communications utilising their first name, survey response likelihood of 1.22 (Edwards et al., 2009) and the BIT (UK) has shown that including the person's 1st name at the start of an SMS increased payment rates of court fines (BIT, 2014).
Format Give relevant information in the right order; and help people to understand this information quickly. Recommended in *How to use plain English when writing* (NALA, 2015).
Salience Important messages are highlighted using different techniques. People's attention span is limited. Highlighting key features can draw people's attention to important information quickly (Halpern et al., 2010). *Flow:* the steps involved are presented in bullet points. *Chunking image:* The steps involved in completing and returning the survey have been broken into discrete tasks or "chunks" and highlighted in a table.[1] Breaking tasks into easy to complete chunks has been effective in helping jobseekers complete CV's and smokers to order quit kits (BIT, 2014). [1.] The image draws on previous scoping work by Karl Purcell and Robert Murphy.

Messenger Effects

The letter is closed by a named staff member rather than a job title/department. The direct phone number of the staff member is also provided.

We are heavily influenced by who communicates information. Our response to a message depends greatly on the reactions we have to the source of that information. We are affected by the perceived authority of the messenger (whether formal or informal): we are more likely to act on information if experts deliver it, but also if the messenger has demographic and behavioural similarities to ourselves. We are also affected by the feelings we have towards the messenger (Halpern et al., 2010).

Consequences and Observer - made more salient

"If you **don't send** us back this page by **16th November 2017**, then we will take it that you do not require this procedure and **you will be removed** from our waiting list. Your GP (family doctor) will be informed."

Previous research by the BIT (2015) in the UK shows people's behaviour changes when they feel like they are being observed.

Apology

The text "I apologise you are still waiting." is included.

Evidence on the effect of including an apology is mixed – some suggesting it improves wait tolerance, others noting the opposite (Cheng et al., 2014; Munichor et al., 2007). The results are dependent on context; since some existing validation letters do include an apology and since we feel it is very pertinent this text is included.

Intention, Value, Resource (IVR)

The effect of adding "We want to provide our valuable services to our patients as soon as we can. That is why we are checking our waiting list" is included.

Lab research shows that clearly articulating intention (altruism), cost and value of the service positively influences customer/ client response (Bridger et al., 2017).

Illustration of Letter B – Test Letter, not to scale, appeared on HSE headed paper

Mr Robert Murphy
Hawkins House
Hawkins St
Dublin 2

Strictly Private and Confidential

2nd November 2017

Please reply to this letter

Dear Robert

You are on our General Surgery waiting list for a procedure with Deirdre Robertson. I apologise that you are still waiting. We want to provide our valuable services to our patients as soon as we can. That is why we are checking our waiting list.

	Read this letter
	Fill in the form
	Return this form

We need you to please:

1. Answer the question below and sign.

2. Return this page to us in the freepost envelope enclosed.

Please do this **even if** you have recently been in contact with the hospital.
If you **don't send** us back this page by **16th November 2017**, then we will take it that you do not require this procedure and **you will be removed** from our waiting list. Your GP (family doctor) will be informed.

Question: Do you still require this procedure? (tick one box only)

☐ Yes, I still require it ☐ No, I had it done elsewhere ☐ No, other reason

If "No, other reason" please give reason: _____

Please sign: _____ Medical Record No. 12345

If you have any questions about the above, please phone 01 635 3122.

Kind regards,

Carol Taaffe, Scheduled Care Department

2.3 Randomisation

Participants were randomly allocated to receive a letter type (A or B). The validation administrator for participating Hospital Groups provided the RSU researcher with the total number of patients on the validation list (e.g. 800). Block randomisation was used by the RSU to achieve equal size groups. Randomisation was carried out with the random.org list randomiser, and the RSU researcher returned to the administrator a list on which each number (e.g. 1 to 800) was randomly allocated to the letter type (A or B).

2.4 Test Sites

At the time of the study different hospital groups used different validation letters, and in some cases different hospitals in the same group used different validation letters. As there was not a single validation letter two different existing letters were included in the control group. The two letters in the control group were the existing validation letter for five of the six hospitals (University Hospital Limerick; St. John's Hospital Limerick; Nenagh Hospital; Ennis Hospital; Croom Hospital) in the University Limerick Hospitals Group (ULHG) and a compilation of letters used in three hospitals (Our Lady of Lourdes Hospital, Drogheda; Cavan and Monaghan Hospital; Louth County Hospital) which are part of the RCSI (Royal College of Surgeons in Ireland) Hospitals Group.

We wanted to test if the redesigned letter (Letter B) resulted in a lower non-response rate than the control letter (Letter A). That is, if the percentage of people who did not reply to the letter, indicating if they still required a procedure or not, was lower. We followed standard practice and tested with 80% power and at the 5% significance level. Based on three studies of attendance at healthcare appointments (we did not find any previous validation studies) we estimated a possible reduction of 18%. Ex-ante power calculations suggested that a sample of 2,718 was required. We achieved the required sample size, approximately 800 from RCSIHG and 2,000 from ULHG. An addressed freepost envelope was included with each letter. Examples of Letter A (control) used in each hospital group are provided in the following pages.

Table 2.2: Specialties and wait time bands included

	RSCIHG	ULHG
Hospitals	Cavan General	Croom Orthopaedic
	OLOL Drogheda	Ennis
	Louth	Nenagh
		St John's Limerick
		University Hospital Limerick
Specialities	Urology	Ophthalmology
	General Surgery	Orthopaedics
	Gynaecology	Pain Relief
		Rheumatology
		Urology
		General Surgery
		Vascular Surgery
		Dermatology
		Gynaecology
		Gastro-Enterology
		Respiratory Medicine
		Maxillo-Facial
		Cardiology
		Otolaryngology (ENT)
Min. Wait	3 months	3 months
Max. Wait	36 months	15 months

2.5 Statistical Analysis

As the letters were allocated randomly there is no need to control for differences in personal characteristics across the two groups when comparing non-response rates. The basis for judging an effect is by using proportion tests. A separate multilevel model, which does not assume the units of analysis are independent, was also undertaken. The analysis was undertaken on irreversibly anonymised (i.e. non-personal data).

2.6 Quality Assurance

In preparing this report, the authors followed the Irish Government Economic and Evaluation Service (IGEES) quality assurance process, seeking feedback on:

- the analysis format (structure)
- clarity (quality of writing)
- accuracy (reliability of data)
- robustness (methodological rigour), and
- consistency (between evidence and conclusions).

The report was circulated for review to the following:

- Internal/ Departmental
  - Line management – Research Services and Policy Unit
  - Other divisions/ sections – Scheduled and Unscheduled Care Performance Unit
- External
  - A behavioural insights advisory group
  - The National Treatment Purchase Fund and the HSE
- Other
  - Participating hospitals

Illustration of Letter A – Control Letter, not to scale, appeared on HSE headed paper

<Title> <Pt Forename> <Pt Surname>
<Pt. Address Line 1>
<Pt. Address Line 2>
<Pt. Address Line 3>
<Pt. Address Line 4> <Current Date>

Ref: <MRN>

Re:<Consultant Last Name><Waiting List Name> Validation

Dear <Title> <Pt Surname>

You have now been on the <Insert Speciality> waiting list for <Insert Wait Time Frame>. We regret that it has not been possible to offer you a date for your procedure but wish to assure you that your name is still on the list and hasn't been overlooked.

We find sometimes that patients obtain treatment elsewhere or no longer require their procedure. We periodically contact patients on our waiting lists to check whether this is the case.

We would be grateful if you could complete and return the attached validation slip to let us know if you still require a procedure.

If we do not hear from you within two weeks of the date of this letter, we will assume that you no longer wish to have this procedure, we will remove your name from the waiting list and inform your GP.

Yours sincerely,

<Insert Department/ Section Name>
<Insert Department/ Section Telephone>

Please tick: **Ref: <MRN>**

□ I still require this procedure
□ I no longer require this procedure. Please indicate the reason:

_____

_____

Signed: _____

Date: _____

Illustration of Letter A – Control Letter, not to scale, appeared on HSE headed paper

Ospidéal na hOllscoile, Luimneach,
Bóthar Naomh Neasáin, Tuar an Daill, Luimneach V94 F858
Teil: 061 301111 Facs: 061 301165

University Hospital Limerick,
St. Nessan's Road, Dooradoyle, Limerick V94 F858
Tel: 061 301111 Fax: 061 301165

1st November 2017

<Title> <Patient First Name> <Patient Surname>
<Address 1>
<Address 2>
<Address 3>
<Address 4>

Patient Record Number: < >

Dear <Title> <Patient Surname>,

You are listed for a procedure on <Consultant Name> <Speciality> Waiting List. We want to ensure our waiting list is accurate and up to date. Accordingly, we would be grateful if you could complete this form and return it to us at your earliest convenience.

If we do not hear from you by **November 15th 2017**, we will assume that you no longer require the procedure and your name will be removed from the waiting list. Your Consultant and GP will be informed.

Yours sincerely,

Validation Officer, UHL

PLEASE UPDATE YOUR CONTACT DETAILS FOR OUR RECORDS

Name:	
Address:	
DOB:	
Contact Telephone Number:	

Please tick the appropriate box:

Yes, I wish to remain on the waiting list		
No, I do not wish to remain on the waiting list		Please indicate the reason:

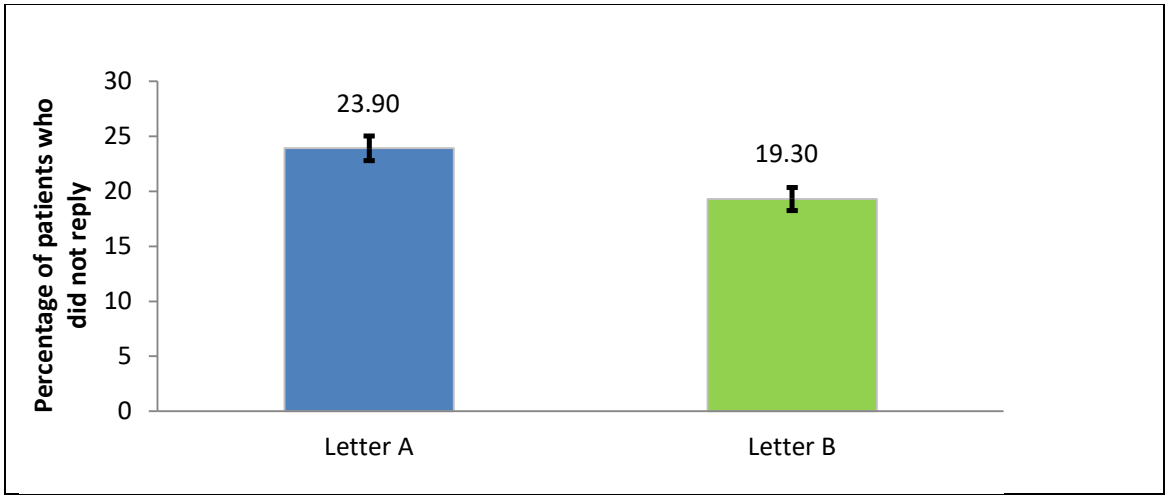
Signed: _____ **Date:** _____

3. RESULTS

The number of patients who did not reply was lower for the redesigned validation letter (Letter B) than for the control letter (Letter A).

As shown in Figure 3.1 patients who received Letter B had a statistically significant lower non-response rate of 19% compared to non-responses for patients who received Letter A of 24%, Z = 2.99, $p < .01$.

Figure 3.1: How to determine the effectiveness of different validation options



As the letters were allocated randomly there is no need to control for differences in personal characteristics across the two groups when comparing non-response rates.

Letter B achieved a 19.3% better performance or resulted in one in five non-responders changing their behaviour.

Running a separate multilevel model, which does not assume the units of analysis are independent observations when testing for differences between the responses to the control and test letters, also shows that the intervention effect holds.

4. CONCLUSION AND IMPACT

Using the redesigned validation letter reduced non-responses. We suspect this is because it makes clearer the importance of the validation process and what the patient is asked to do.

Based on bi-annual validation of 2017 waiting lists of three months plus for inpatient and day cases, it would result in at least 5,000 more patients responding. It would reduce follow-up for non-response, enable better use of resources and help hospitals to meet their requirement in the Protocol that "Postal validation cycles must be completed within a six week timeframe."

A summary of the results of the test of the redesigned letter were provided to the Process Innovation Unit (PIU) in the NTPF in early 2018. During Q1 2018 the NTPF recommended the redesigned letter as the national template for waiting list validation correspondence for inpatient and day case waiting lists.

To support adoption of the redesigned letter the NTPF also circulated the recommended validation letter to all hospital group COOs; all hospital Business Managers, Performance Managers, Schedule Care Leads, Waiting List leads; and all attendees of the NTPF's Training and Development programme for the Waiting List Management Protocol.

This study aimed to improve patient engagement, but it was also difficult to overlook the benefits it highlighted of a larger scale standardised process. In June 2018 the Minister for Health wrote to the NTPF asking it to (a) develop a centralised process for validation and (b) expand its validation remit to outpatients. By September 2018 the PIU had established a National Centralised Validation Unit (NCVU) operating a blended resource model with NTPF staff members using a procured postal service to manage the distribution of validation letters and the automated recording of responses. The letter template used in this process is that designed and tested in this study.

APPENDIX A: ADDITIONAL METHODOLOGICAL DETAILS

The data for this project was collected during the second half of 2017, i.e. before the introduction of the General Data Protection Regulation (GDPR) and the Health Research Regulations 2018 in Ireland[1]. In designing and undertaking the project, the evaluation team considered ethical and data protection issues. Three important factors considered are described below.

Firstly, the project consisted of two core components, neither of which posed ethical concerns, namely:

(a) Redesigning a validation letter for use in two pilot sites. There was no standard validation letter used across hospitals at the time and making changes to the validation letter is part of usual care and management of health systems and services. The redesigned validation letters did not involve the use of any design elements that may be deemed to be inappropriate (they were simply alternative forms of communication based on a review of evidence and reviewed by stakeholders – as described in Section 2.2) and the letters did not have any impact on personal autonomy.

(b) Analysis of secondary non-personal data by the evaluation team. All data for this project is already collected as part of routine care/ service management (no new data was collected on patients) and there is a clear legal basis under both the GDPR and the Data Protection Act 2018 for this by the HSE and the NTPF. The project did not involve the analysis of information (responses to the validation letter) that patients would not expect to be analysed. The evaluation team in the DH did not require access to personal data to analyse the results (i.e., the analysis of results by the evaluation team is based on irreversibly anonymised data).

Secondly, this project is most appropriately described as an evaluation rather than as health research (and therefore does not fall under the Health Research Regulations made by the Minister for Health in August 2018 –see below), and as such the evaluation plan was not sent to a research ethics committee for review. The purpose of the project was to see whether patient engagement with a waiting list management process could be increased (its conduct did not involve changes to allocation to nor changes to treatment/ care/ services – see Sections 1.1 and 1.2) by testing changes to correspondence in two pilot sites (i.e. the

[1] For completeness, it is stated that personal data obtained prior to the GDPR coming into effect but still held for further processing on the coming into effect of the GDPR (26 May 2018) is subject to its terms. Similarly, with personal data obtained for health research purposes prior to coming into effect of the Health Research Regulations (7 August 2018) but still held on that date for further processing for health research purposes.

"sample" was not nationally representative of the inpatient and day case waiting list in Ireland).

For instance, the website of Ireland's Health Research Board, under the section 'GDPR guidance for researchers', provides a definition of what constitutes health research and what does not (namely, a clinical audit, an evaluation study or usual practice) for the purposes of the Health Research Regulations.[2] The HRB's site also states that "The NHS's [National Health Service] Health Research Authority [HRA] in conjunction with the UK's Medical Research Council have developed a useful decision making tool to help you decide if your activity is a research project, clinical audit, evaluation study or usual practice." The HRA's website notes that "The aim of this decision tool is to help you decide whether or not your study is research as defined by the UK Policy Framework for Health and Social Care Research. It is based on the Defining Research table produced by the Research Ethics Service."[3] The responses to the questions in this tool and the result based on the answers for this project are shown below.

Q1: Are the participants in your study randomised to different groups? "Yes"
Q2: Are any treatments, care or services allocated by randomisation? "No"
Q3: Does your study protocol demand changing treatment/care/services from accepted standards for any of the patients/service users involved? "No"
Q4: Is your study designed to produce generalisable findings? "No"
Results: Your study would NOT be considered Research by the NHS.

Thirdly, not requesting informed consent to be part of the Better Letter Initiative (to see whether one form of letter worked better than another) was appropriate. The project was consistent with Principle 10 of the Council for International Organizations of Medicine Sciences (CIOMS)/ World Health Organization (WHO) Ethical Guidelines' criteria for a waiver of informed consent, namely: (a) it would not be practicable to carry out without a waiver; (b) it poses no more than minimal risks to the participants; (c) it has important public benefits. Telling patients that two different letters were being tested would have undermined the project results by introducing bias (practicality), since the purpose was to test responses or non-responses to different validation letters. There was minimal risk to participants as the test did not involve any medical interventions and using different validation letters within the validation process did not have any impact on recipients' future health services. There was no more than minimal risk to privacy and confidentiality as only

[2] https://www.hrb.ie/funding/gdpr-guidance-for-researchers/gdpr-and-health-research/what-is-research/
[3] http://www.hra-decisiontools.org.uk/research/

an irreversibly anonymised dataset (non-personal data) was required by the RSPU for analysis. The project offered public benefit as it was seeking means to most efficiently manage the waiting list and provide more timely access to care. If it was found that the redesigned version of the validation letter worked best, this version would be adopted as the recommended letter for use nationally. The evaluation team was also conscious that trialling the response to different communications with the aim of improving service management without informing service users is part of international and national practice (for example, Hallsworth et al., 2015; Kennedy et al., 2017). The approach adopted is also considered legally sound under both GDPR and the Data Protection Act 2018.

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