

Waiting list initiatives: crisis management or targeting of resources?

R P Mills MPhil FRCS J M Heaton MA BM BCh
 Ninewells Hospital, Dundee DD1 9SY
 Department of Otolaryngology,

Keywords: waiting list initiatives; efficacy; ENT surgery

Summary

To investigate the impact of a waiting list initiative on an ENT surgical waiting list, we have evaluated the outcome of the Tayside ENT Waiting List Initiative. Four hundred and forty-five patients were offered dates to come in during the initiative. Of these, 280 underwent surgery and 16 indicated that their operations were no longer necessary. The maximum wait for routine operations falling within the criteria for inclusion in the initiative was 28 months prior to the initiative and 7 months afterwards. A waiting list initiative can be effective in reducing waiting times for routine surgery. However, it is too early to describe the Tayside initiative as an unqualified success, as it remains to be seen whether or not the waiting list will lengthen again now that it is over.

Introduction

Waiting lists for surgical operations have been a feature of the National Health Service since its inception^{1,2}. It is debatable what may be considered an acceptable time to wait for surgery. Frankel believes that it is unacceptable for people to wait more than a year for non-urgent treatment¹. The author of an article in *Which* magazine suggests that the aim should be to reduce the maximum wait to 6 months³.

A waiting list is easily created. If a clinician consistently adds more patients to the list than are removed, it will steadily grow. This can easily occur, especially if patients who are unable to attend for surgery cannot be replaced, as available operating time is not fully utilized. Other factors influence the situation. Inadequate funding leads to the clinician being allowed to see new patients and add them to his or her list, but prevented from operating on them by a lack of beds, theatre time or anaesthetic support. Variations in waiting times for the same procedure may in some cases be due to different surgeons' varying thresholds for advising surgical treatment. It has been suggested that waiting lists may be manipulated by surgeons for various purposes. A long waiting list may be viewed as a status symbol, or may be used as a political weapon to increase funding⁴ or as a means of provoking patients to seek private treatment⁵.

Long waiting lists are commonly composed of patients requiring a limited range of operations. Frankel proposes that 'waiting list conditions' are those which are embarrassing, are associated with ageing and are not found stimulating by the medical profession¹. In our own specialty the common operations which fall into this category are tonsillectomy and minor nasal operations, notably those on the septum. The patients involved are relatively young

and while senior members of the surgical staff may find their enthusiasm for performing such operations waning a little, the junior members are likely to find them stimulating.

While a waiting list is easily created, it is not so easily reduced given a constant level of resources, regardless of its causes. This has led to the current trend for 'Waiting List Initiatives', in which extra resources are targeted to reduce the numbers of routine cases on a department's waiting lists over a limited period of time. We have recently completed such an initiative, and this paper reviews our experience of the process and seeks to draw lessons for the future.

Materials and methods

Our department is situated in a teaching hospital, and provides all ENT services for the Tayside Region of Scotland, which has a population of just under half a million. The surgical staff consists of four consultants, one associate specialist, one senior registrar and three registrars. We have a dedicated theatre suite comprising two operating theatres, located within our unit.

The initiative ran for a total of 18 months, being divided into two phases. Phase 1 ran for 6 months and patients listed for routine surgery were drawn from the four longest waiting lists (see Table 1) in the department. Patients were selected by the consultant in charge of the initiative (RPM) and surgery was carried out on specially arranged additional operating lists by one or other of the registrars. The junior staff gave up a research/study session to cover the lists. These sessions were protected from encroachment by

Table 1. Waiting times for minor ENT surgery before and after the surgical waiting list initiative

Target list initiative	Wait before initiative (months)	Wait after initiative (months)
Phase 1		
Minor nasal operations (Team C)	28	10
Minor children's operations (Team C)	15	6
Adult tonsillectomy (Teams A+C)	16	7
Team P	21	12
Phase 2		
Team C	10	7
Team B	9	7

cases which did not qualify as 'initiative cases' as far as possible. On at least two occasions, however, lists had to be cancelled at the last minute because of emergencies.

Patients who had previously been offered dates for admission and failed to come in were excluded. Patients approached during the initiative were instructed to contact the department by telephone to confirm that they were able to come in by a specified date, one week prior to the relevant list. Patients who failed to confirm were replaced when possible.

The funds provided by the Scottish Home and Health Department for the initiative were used to employ an anaesthetist on a sessional basis and to employ extra nurses to cover the extra work on the wards. In addition, money was made available for the purchase of a second air drill, so that cases requiring the use of a drill could be carried out simultaneously in our theatres, and for the surgical supplies required by the additional cases.

Following the perceived success of the first phase, a second phase lasting 12 months was undertaken, starting immediately after phase 1. The waiting lists had been reorganized by this time, partly because of the impact of phase 1 and partly because of computerization. Two waiting lists were targeted (see Table 1) and the procedure was the same as before, except that patients were asked to confirm 2 weeks prior to the admission date which they had been offered. This change was made to allow more time for replacements to be arranged. Funds were provided to buy a new operating microscope, so that the more demanding types of middle ear surgery could be carried out simultaneously in our operating theatres, and for a third air drill, as the need to sterilize drills between cases had caused problems in the past.

Results

A total of 68 extra lists were carried out during the 18 month period of the initiative. Four hundred and forty-five patients were offered dates for surgery. Of these, 280 underwent operations and 16 indicated that they no longer required the operation for which they had been listed. A total of 296 names were therefore removed from the waiting list. Thirty-nine patients were unfit for operation and 116 either cancelled for other reasons or simply failed to attend. These patients were returned to the waiting list of the team originally responsible for them and were subsequently offered alternative dates on non-initiative operating lists. The changes in the length of the targeted waiting lists are summarized in Table 1, while the numbers of the operations performed are presented in Table 2. It should be noted that a number of patients underwent more than one procedure simultaneously. Table 3 summarizes the expenditure during the initiative.

Table 2. Numbers of operations during surgical waiting list initiative

Operation	Numbers of operations
Minor nasal surgery	213
Tonsillectomy/adenoidectomy	158
Myringotomy/grommet insertion	34
Miscellaneous	5
Total	410

Table 3. Additional funding to facilitate the running of the waiting list initiative

Funding	Phase 1	Phase 2	Total
Capital	£8000	£24 000	£32 000
Revenue	£21 500	£21 500	£43 000
Total	£29 500	£45 500	£75 000

Discussion

It is clear that a relatively modest injection of additional resources, targeted at reducing waiting times for surgery, can result in significant improvement. However, the results must be interpreted with caution. Ours must be considered to be a relatively well-staffed and resourced department by UK standards. In such circumstances, one would expect such an outcome from a well-run initiative, but one could not necessarily expect the same in a department with less initial resources.

There is a risk that an initiative could result in improvements in one area, while indirectly causing deterioration in another. In any case the real effectiveness of a 'one off' measure such as this can only be assessed when the situation is re-evaluated some time after the initiative has finished. If lists steadily climb back to their pre-initiative levels, then the exercise must be considered a qualified success. We shall monitor our future performance in Tayside to elucidate this point. The increased efficiency of utilization of theatre time which has resulted from the equipment purchased from waiting list initiative funds will of course continue in the future.

Examination of our local situation indicates that the most important underlying cause of our waiting list problems has been inadequate staffing levels in our anaesthetic department, such that not all our lists can be covered all the time. It could therefore be argued that the money spent on the initiative could have been used to employ an additional anaesthetist on a permanent basis. This would of course have long-term cost implications, but would benefit other surgical departments as well as our own. Such an approach could be considered preferable because the main cause of the problem would be dealt with, rather than its symptoms.

The effectiveness of our initiative was significantly reduced by patients who failed to attend for one reason or another. We made strenuous efforts to minimize the effect of this problem, but were not able to eliminate it. Patients are more likely to attend for admission for general surgical procedures if a date is arranged at the time of their outpatient consultation than if they are contacted later⁶, although this does not necessarily apply in ENT practice⁷. There is a tendency to blame patients for loss of operating time due to non-attendance, but in practice this is not usually the case. The 'closing date' system used in the Tayside initiative would appear to be the best available in these circumstances, though it is far from perfect. At this point in time the Tayside ENT surgical waiting list initiative can be said to have targeted resources effectively at a group of patients with 'waiting list conditions'. This approach to the problem is not the only one available, nor is it necessarily the best. If waiting times gradually increase over the coming months, this opinion will

have to be revised. Under these circumstances, the initiative could reasonably be viewed as an ineffective piece of crisis management.

References

- 1 Frankel S. The natural history of waiting lists - some wider explanations for an unnecessary problem. *Health Trends* 1989;21:56-8
- 2 Goldacre MJ, Lee A, Don B. Waiting list statistics 1: relation between admissions from waiting list and length of waiting list. *BMJ* 1987;295:1105-8
- 3 Anon. Waiting for the NHS. *Which?* 1980:490-2
- 4 Williams B. The use and misuse of bed occupancy and waiting list figures. *Lancet* 1968;i:1029-30

- 5 Sanderson HF. Thresholds in cataract surgery. Thesis, University of London, 1978
- 6 Houghton PWJ, Brodribb AJM. Failure to attend for operation: a comparison between booked admissions and the waiting list system. *BMJ* 1989;299:1139-40
- 7 Morrissey S., Alun-Jones T, Leighton S. Why are operations cancelled? *BMJ* 1989;299:778
- 8 Frankel S, Farrow A, West R. Non-admission or non-invitation? A case control study of failed admissions. *BMJ* 1989;299:598-600

(Accepted 31 October 1990)

Some recent books

Clinical and Biological Research

Acute Myelogenous Leukemia: Progress and Controversies (UCLA Symposia on Molecular and Cellular Biology New Series, Volume 134). Robert Peter Gale (pp 422 \$85.00) ISBN 0-471-56872-4, New York: Wiley-Liss 1990

Advances & Prospects in Clinical, Epidemiological and Laboratory Oncology (Cancer Surveys, Volume 9, Number 1, 1990). T M Dexter (pp 235) ISSN 0261-2429, Oxford: Oxford University Press 1991

Application of Molecular Genetics to the Diagnosis of Inherited Disease. Kay E Davies (pp 95) ISBN 1-873240-03-1, London: Royal College of Physicians of London 1990

Genetics and Human Nutrition. Philip J Randle, John Bell and James Scott (pp 210 £32.00/US\$62.00) ISBN 0-86196-236-2, London: John Libbey 1990

Lipid Biochemistry - An Introduction (4th edn). M I Gurr and J L Harwood (pp 406 £19.95) ISBN 0-412-26620-2, London: Chapman & Hall 1991

Molecular Genetics of Chromosome 21 and Down Syndrome (Progress in Clinical and Biological Research, Volume 360). David Patterson and Charles J Epstein (pp 294) ISBN 0471-56838-4, New York: Wiley-Liss 1990

New Strategies in Bone Marrow Transplantation (UCLA Symposia on Molecular and Cellular Biology New Series, Volume 137). Richard E Champlin and Robert Peter Gale (pp 457 \$140.00) ISBN 0-471-56065-0, New York: Wiley-Liss 1990

Serotonin Receptor Subtypes. Basic and Clinical Aspects (Receptor Biochemistry and Methodology, Volume 15). Stephen J Peroutka (pp 236 \$69.95) ISBN 0-471-56840-6, New York: Wiley-Liss 1990

The Molecular Biology of the Retina. Basic and Clinically Relevant Studies (Progress in Clinical and Biological Research Series, Volume 362). Debora B Farber and Gerald J Chader (pp 245 \$80.00) ISBN 0-471-56069-3, New York: Wiley-Liss 1990

The Endothelium. An Introduction to Current Research. John B Warren (pp 317 \$54.95) ISBN 0-471-56828-7, New York: Wiley-Liss 1990

The Doubly-Labelled Water Method for Measuring Energy Expenditure. Technical Recommendations for Use in Humans. A Consensus Report by the IDECG Working Group. A M Prentice (pp 301), Cambridge: University of Cambridge and Medical Research Council 1990

Health Care

Biotechnological Innovations in Health Care (pp 310 £19.95, pb £45.00 hb) ISBN 0-7506-1493-5 (pb) ISBN 0-7506-1497-8 (hb), Surrey: Butterworth-Heinemann 1991

Concerning the Carers. Occupational Health for Health Care Workers. J A Lunn and H A Waldron (pp 155 £12.50) ISBN 0-7506-0022-5, Surrey: Butterworth-Heinemann 1991

Health Care Provision Under Financial Constraint: A Decade of Change (International Congress & Symposium Series No. 171). Hugh L'Etang (pp 227 £25.00) ISBN 1-85315-144-0, London: Royal Society of Medicine 1990

Herbal Medicine and Health Promotion. A Comparative Study of Herbal Drugs in Primary Health Care. Amanda le Grand and Peter Wondergem (pp 80) ISBN 90-6832-033-5, Amsterdam: Royal Tropical Institute 1990

Hospital Management in the Tropics and Sub-tropics. James A Willan (pp 426) ISBN 0-333-52257-5, London: Macmillan Education Ltd 1990

Integrity in Health Care Institutions. Humane Environments for Teaching, Inquiry, and Healing. Ruth Ellen Bulger and Stanley Joel Reiser (pp 180 \$27.50) ISBN 0-87745-300-4, Iowa: University of Iowa Press 1990

Les Soins de Santé Primaires. Jarl Chabot and Pieter Streufand (pp 207) ISBN 90-6832-035-1, Amsterdam: Royal Tropical Institute 1990

Liberating Medicine. David Seedhouse (pp 175 £11.95) ISBN 0-471-92844-5, Chichester: John Wiley & Sons Ltd 1991

The Place of Special Villages and Residential Communities. The Provision of Care for People with Severe, Profound and Multiple Disabilities. Stanley S. Segal (pp 111 £15.95) ISBN 0-907360-16-5, Bicester: AB Academic Publishers 1990