

Waiting list management in general practice: a review of orthopaedic patients

Glyn Jones Elwyn, L A Williams, Suzanne Barry, Paul Kinnersley

Abstract

Objective—To review all patients on a current general practice orthopaedic waiting list for outpatient appointments with regard to accuracy of the list, clinical priority, and need for further radiological investigation before hospital attendance.

Design—Record review by one general practitioner and a radiologist, and discussion with patients of management alternatives.

Setting—Six partner city centre urban fundholding general practice, list size 8651 (29% low deprivation payment status).

Subjects—116 adults on an orthopaedic waiting list.

Main outcome measures—List accuracy (patient details and status on waiting list); clinical priority (severity of condition); further investigations (results of tests after radiological review).

Results—32 patients (28%) were removed from the waiting list because of inaccuracies. 14 patients were considered to be high priority and referred to other hospitals by utilising waiting list initiative funds. Of these patients, five agreed to referral to another hospital (treatment completed on average within three months of rereferral), six did not wish to be rereferred, and two did not attend to discuss the offer and remained on the original waiting list. One prioritised patient had further radiological investigations, was reassured, and was taken off the waiting list. 10 patients had further investigations. These resulted in six patients being referred to other hospitals, three being taken off the waiting list, and one seeking private care.

Conclusions—Systematic review of patients on an orthopaedic waiting list of one general practice, though time consuming, led to the identification of inaccuracies in the list and changes in management. Costs need further evaluation, but if the findings occur widely substantial benefits could be achieved for patients.

Introduction

Patients referred to hospital are regarded to be on lists held in secondary care by specialists, whose methods for prioritising cases are not always clear.¹ Fundholding gives general practices access to these lists. Waiting list initiatives challenge general practitioners to prioritise patients according to clinical needs. Moreover, open access to advanced radiological techniques enables patients to be investigated further and may obviate the need for a specialist opinion. Open access used according to guidelines should lead to more appropriate referrals.²

We conducted a survey to identify whether more active waiting list management in a general practice in Cardiff produced benefits. Orthopaedic patients were

chosen because, as elsewhere in the United Kingdom, the orthopaedic list was the longest.

Subjects and methods

The orthopaedic waiting list for the practice was obtained from the local hospital to which patients were usually referred. On 1 April 1994, 116 patients were waiting for appointments. No indication was given whether the orthopaedic surgeon had prioritised the cases. One partner in the practice (GJE) checked the records of each patient for accuracy of registration, address, and waiting status.

To assess clinical priority, crude judgments of pain and disability (mild, moderate, and severe, scored 1-3) were made from the records and the referral letter by GJE, who had personal knowledge of 10 of the patients. (West showed that pain and disability were the greatest problems for patients on waiting lists.³) Patients with high scores for pain and disability were prioritised and invited to reconsult. They were told that they could attend other local hospitals if they wished.

To judge the need for further radiological investigation the general practitioner (GJE) and a local radiologist (LAW) together reviewed the records of all the patients. The general practitioner provided background while the radiologist suggested other appropriate tests. The patients identified were asked to reconsult.

Results

Accuracy of waiting list—The initial waiting list contained 116 patients. Sixteen (14%) were no longer registered with the practice, eight (7%) were duplicate entries, six (5%) had been seen, and two (2%) were excluded for other reasons. These 32 (28%) patients were removed from the waiting list, leaving a residual practice corrected waiting list of 84 patients.

Assessment of clinical priority—The records of the 84 patients were reviewed. Fourteen were identified as having moderate or severe pain and disability and given priority: nine had knee problems, two hip problems, two back problems, and one a foot problem. After consultation five agreed to be referred to another hospital, six declined this offer, and two did not attend to discuss the offer. One patient underwent further radiological investigation, was reassured, and was taken off the list. Patients who had lower scores for pain and disability but who were prepared to travel were contacted. Eventually 16 were sent elsewhere for orthopaedic appointments or procedures (within an average of three months) by utilising £12 918 of the practice waiting list initiative allocation of £26 000.

Assessment of need for further radiological investigation—Twenty (24%) patients were judged as needing further investigation (plain x ray examinations and bone and magnetic resonance scans), but implementation proved difficult. Some patients did not consult and others saw no benefit, preferring to await specialist opinion. As a result only 10 patients had investigations (table 1).

Four Elms Medical
Centre, Cardiff CF1 2AF
Glyn Jones Elwyn, general
practitioner
Suzanne Barry, fundholding
administrator

Cardiff Royal Infirmary,
Cardiff CF2 1SZ
L A Williams, consultant
radiologist

Department of General
Practice, Llanedeyrn,
Cardiff CF3 7PN
Paul Kinnersley, senior
lecturer

Correspondence to:
Dr Elwyn.

BMJ 1996;312:887-8

Table 1— Assessment of need for further radiological investigation

Case No	Investigation	Site	Result	Outcome
1	Magnetic resonance imaging	Knee	Positive for meniscal tear	Patient decided to have private referral
2	Magnetic resonance imaging	Back	Spinal canal stenosis	Urgent rereferral to surgery—waiting list initiative
3	Magnetic resonance imaging	Knee	Meniscal tear	Urgent rereferral to surgery—waiting list initiative
4	Magnetic resonance imaging	Back	Normal	Patient reassured—removed from waiting list
5	Magnetic resonance imaging	Back	Osteoarthritic changes	Patient reassured—removed from waiting list
6	Magnetic resonance imaging	Knee	Normal	Patient reassured—removed from waiting list
7	Magnetic resonance imaging	Knee	Effusion and osteoarthritis	Urgent rereferral for arthroscopy—waiting list initiative
8	Magnetic resonance imaging	Knee	Meniscal tear	Urgent rereferral to surgery—waiting list initiative
9	Magnetic resonance imaging	Knee	Meniscal tear	Urgent rereferral to surgery—waiting list initiative
10	Bone scan	Knee	Loose knee prosthesis	Revision required—urgent rereferral—waiting list initiative

These led to six patients being given priority, three being removed from the waiting list, and one seeking private care.

Discussion

The longer patients wait for appointments the more inaccurate a waiting list becomes,⁴ resulting in non-attendance and other inefficiencies. Care should be taken before generalising, but this study suggests that waiting lists are inflated by 7-10%, incorrect addresses accounting for a further 20% of inaccuracies. These problems could be reduced by cross checking hospital data and general practice registration databases. Deitch reported this inefficiency a decade ago,⁵ and it requires further attention. Some patients would not have been on the waiting list if appropriate use had been made of open access radiology. But even with open access it takes time before elaborate investigation techniques are used appropriately, and there are cost implications for radiology departments and fundholding general practices.⁵

Deciding clinical priorities was difficult and posed ethical challenges. The method was admittedly crude and reflected the pragmatic nature of decision making in general practice. If clinical need predominates some patients might never be considered troubled enough to get to the top of the waiting list. We invoked the patient's charter guidelines to avoid this possibility. Other sectors have used various methods of prioritising resources.⁷ A secondary care project ranked patients according to the "severity of their condition rather than the time spent waiting for treatment."⁸ Though there is support for general practitioners being well placed to undertake clinical prioritisation,⁹ there are no published examples.

Making use of the internal NHS market poses considerable difficulties.¹⁰ Our study affirms that diverting patients to other providers may be complex and time consuming. Even for patients assessed to have considerable problems ease of transport, ability of the family to visit, and the quality of the alternative hospital were all concerns to patients.

Patients were reluctant to have further investigations or to be referred elsewhere, particularly by a partner other than the original referring doctor. Though review led to a reduction of about 50% in the routine waiting list, the process had substantial opportunity costs and required additional consulting time.

Achieving more accurate diagnoses by radiological investigations seemed to benefit patients. Normal results permit effective reassurance and may eliminate the need for referral. Abnormal results can lead to clinical prioritisation either through the funding initiatives described above or through other local arrangements for "fast tracking" patients.

Though attention is increasingly being drawn to the relative health need priorities represented by waiting lists,¹¹ active management of these lists by primary care doctors (arguably the best placed to assess need) has

Key messages
<ul style="list-style-type: none"> • Waiting lists are inflated by inaccurate, out of date information • Waiting lists contain patients who have differing clinical priorities • It is possible to develop practice based lists • Increased use of elaborate investigation techniques may eliminate the need for referral and can identify those patients who have clinical priority • "Active waiting list management" is possible in general practice but there are substantial opportunity costs

not been facilitated. However, practice based lists are now being developed, particularly by fundholding practices. South Glamorgan Health Authority currently plans to provide resources for non-fundholders to undertake similar reviews (J Blasby, personal communication).

Robinson drew attention to the difficult responsibilities of health authorities as they try to prioritise services¹²—that is, by horizontal allocation.¹³ Possibly the issue of vertical allocation is best tackled at the primary care level. Waiting lists are dynamic and patients have social, personal, and clinical needs which change over time. Regular review¹⁴ should generate shorter, more accurate waiting lists and facilitate clinical prioritisation.

Funding: None
Conflict of interest: None

- 1 Elliot J. *Life in the slow lane: the experience of waiting for treatment*. Cambridge: Anglia and Oxford Regional Health Authority, 1995.
- 2 Roland MD, Porter RW, Mathews JG, Redden JF, Simmonds GW, Bewley B. Improving care: a study of orthopaedic outpatient referrals. *BMJ* 1991;302:1124.
- 3 West R. Waiting for general surgery: a question of priorities. *Journal of Management in Medicine* 1991;5:19-26.
- 4 McGlade KJ, Bradley T, Murphy GJ, Lundy GP. Referrals to hospital by general practitioners; a study of compliance and communication. *BMJ* 1988;297:1246-8.
- 5 Deitch R. Broken NHS appointments: millions wasted. *Lancet* 1984;i:1419.
- 6 Stoddart PG, Holl SG. Radiology is valuable to general practitioners; but who pays? *Clin Radiol* 1989;40:183-5.
- 7 Mills RP, Heaton JM. Waiting list initiatives: crisis management or targeting of resources? *J R Soc Med* 1991;84:405-7.
- 8 Chadda D. The new deal. Salisbury Hospital is ranking patients waiting for treatment by suffering rather than simply by length of wait. *Health Service Journal* 1993;103:12.
- 9 Market and Opinion Research Institute (MORI), British Medical Association. Survey for the BMA conference on rationing. *Health Service Journal* 1993;103:16.
- 10 Stewart M, Donaldson LJ. Travelling for earlier surgical treatment: the patient's views. *Br J Gen Pract* 1991;41:353,508-9.
- 11 Hemingway H, Jacobson B. Queues for cure? Let's add appropriateness to the equation. *BMJ* 1995;310:818-9.
- 12 Robinson R. Blowing in the wind: purchasing priorities. *Health Service Journal* 1993;103:24.
- 13 Øvretveit J. *Purchasing for health*. Buckingham: Open University Press, 1995.
- 14 Martin M. Life in the slow lane. *Health Service Journal* 1995;105:24.

(Accepted 13 February 1996)