

Healthcare workers' views on the management of routine cases

Ann R Coll
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The resources available for consultation and surgery by National Health Service consultant surgeons are finite.

Attempts to reduce operating waiting lists have come from successive governments. Urology, ENT and trauma and orthopaedics have come under the most intense scrutiny recently with an examination of NHS waiting lists in England by the National Audit Office. In broad terms two types of waiting list

management exist for consultant surgeons in the NHS. In the first, patients are seen as soon as possible in outpatients but wait on a waiting list for surgery if required. In the second, patients are put on a waiting list to see a consultant surgeon and given a date for surgery within three months if required. Each of these management policies has their advantages and disadvantages.

Methods

Healthcare workers (HCWs) were asked by questionnaire if they would prefer either: (A) to be 'fast-tracked' to see the consultant but be prepared to go on the waiting list for elective surgery if required or (B) to join a waiting list to see the consultant and then be 'fast-tracked' for surgery if required. The scenario suggested was one of referral for routine appointments.

Results

One hundred HCWs were questioned at random during a four-day period. The strategy of choice was 83% for A and 17% for B. There were 76 female and 24 male HCWs surveyed. Occupation (Table 1), marital status (Table 2) and number of dependants (Table 3) made no significant difference to the choice of strategy. Eleven HCWs were in a private health insurance scheme. However, two of these still chose strategy B. Twenty-six HCWs had seen an NHS consultant in the last 12 months. Ten HCWs had to wait less than a month for an appointment with an NHS consultant. The longest NHS wait was 10 months

to be seen. At the time of the survey three HCWs were on an NHS waiting list (2, 3 and 18 months) for surgery

Discussion

Most consultant surgeons have worked hard in the NHS to meet an increasing outpatient demand. The resources available in the NHS cannot meet this demand at present. Therefore, resources must be apportioned fairly until more become available. In the present study a well-informed sector of the population opted to be fast-tracked to see the consultant but be prepared to go on the waiting list for elective surgery if required (strategy A). Although this was a small sample of the HCWs in England and Wales we believe that it is probably representative of the belief that patients would prefer not to have to wait for an expert opinion to get a diagnosis. Waiting for surgery is much more acceptable.

The advantages of strategy A are that the patient is seen relatively quickly and reassured with a diagnosis. Waiting can obviate the need for surgery as some conditions resolve with time

	Doctors	Nurses	Physiotherapists	Ancillary
A	12	37	8	26
B	3	7	3	4

Table 1. Occupation

	Single	Married	Divorced	Widowed
A	39	35	2	0
B	9	13	2	0

Table 2. Status

	0	1	2	3	4
A	50	11	17	5	0
B	11	2	2	1	1

Table 3. Number of Dependents

and conservative treatments. Surges in demand, identified by lengthening waiting lists, could be managed by intermittent waiting list initiatives to cope with this demand without the expense of employing new consultants. On the other hand, long waiting lists for surgery are a politically sensitive area. These lists have traditionally been managed by crisis management often at times of general election.

The advantages of strategy B, in which the patients have to wait to be seen but are given a date for surgery within three months of the time of diagnosis, are that the service demand no longer appears as a waiting for operation statistic. However, waiting to be seen in the strategy B service has disadvantages in that, without a diagnosis, the urgency of treatment cannot be assessed. Also, short waiting times for surgery may not allow those routine conditions that would resolve naturally to do so.

Introduction of strategy B across the whole of the NHS would lead to a bottleneck at the general practitioner referral into the NHS consultant stage. Temporary under-provision of resources, for example, might be incorrectly interpreted as a lack of consultant surgeons and lead to an expansion of available consultants with no increase in resources. One way of managing this problem within the framework of strategy B would be to limit the number of general practitioners that can refer to an NHS consultant by geography. Pressure to reduce waiting times to see a consultant may have already encouraged some consultant surgeons utilising strategy B tactics to manage waiting times by limiting the number of general practitioners eligible to refer patients into their practice. This artificially reduces the waiting times in the strategy B consultant's practice. However it is at the expense of the consultant surgeon with an open door strategy A policy, which as a consequence suffers long waiting times to be seen as well as long waiting times for operation. There is a danger that the newly instituted PCT system could encourage a strategy B system where the consultant resource available goes to the highest bidder. Therefore, we believe strategy B is an

ethically and morally wrong solution for consultants to adopt. Strategy A makes economic sense when compared with strategy B. What does not make sense is the preoccupation with national waiting time figures. The data on waiting times for surgery reflects an individual consultant's practice. Waiting lists for surgery may be long because inexperienced junior staff have unnecessarily listed too many patients. They may be too long because a consultant is seeing more new patients than available operating resources. The responsibility and budgets for controlling the length of waiting lists have yet to be devolved to the individual consultant surgeons who manage their own waiting lists. A system that contracts a consultant to a regular workload and guaranteed maximum waiting list with a budget for times of increased or reduced demand is urgently needed. This system could be easily audited to ensure adequate funds are available and that an individual consultant is not performing too little or too much work. A five-yearly peer appraisal could monitor working practices. Consultants that build up an unacceptable waiting list could have their budgets for new patient consultations transferred to waiting list initiatives. A persistent increasing demand for new patient consultations under these circumstances should then be met by the funding of a new consultant post. This system could control waiting lists to an acceptable limit and allow the identification of areas of need for further service provision. The present economic climate is one of an under-provision of resources to service elective surgery. Increasing the number of consultant surgeons available would not result in an increase in the workload performed in this climate. A balanced strategy is needed to ensure provision of resources before increasing consultant employment according to demand. This survey did not explore the question of what was an acceptable wait for surgery

References

1. Waits and Measures: An Examination of the Accuracy and Management of NHS Waiting Lists. National Audit Office. 2000.