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## What's New?

- Pilot testing of the draft prioritisation forms in hip/knee replacement, general surgery, MRI, and cataract surgery is underway in the seven regional health authorities. The children's mental health pilot is expected to begin early in the New Year.
- At the second round of panel meetings, results of the pilots will be reviewed and the tools will be tuned as necessary. The second phase of pilot testing—verifying reliability—will commence.
- In addition to David Hadorn's report, two additional papers in this issue provide insights from Manitoba (on changes to waiting times for elective surgery) and from the University of Birmingham (on an evaluation of the "booked admission" program).
- The more observant among you will have noted that this newsletter is not quite as "monthly" as originally intended. Nevertheless, I hope it is effective in keeping you abreast of progress with the Western Canada Waiting List Project. And we will continue to include short articles on related topics; submissions are welcome.
- Merry Christmas and a Happy New Year to all!

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## Research Director's Progress Report

The five clinical panels that comprise the Western Canada Waiting List Project have all met successfully and have agreed to develop prioritization tools in the form of point-count scoring systems (as discussed in WCWL Background Paper #2 — Priority Criteria: Technical and Conceptual Issues). Panels agreed on the major clinical factors within their respective areas for use as priority criteria, as well as on the levels within each criterion (e.g. none, mild, moderate, severe) reflecting the relative degree of severity or urgency.

The next step in developing prioritization tools is getting clinicians to gain actual experience in assessing patients using the nominated criteria. Toward this end, we have begun an empirical phase of the project, in which we will obtain information concerning the following: (1) are the criteria relevant to assessing patients' relative urgency? (i.e. are they the right criteria?), (2) have any important factors been omitted? and (3) are the criteria clear enough that observers can confidently assign each patient to a particular level within each criterion?

By becoming familiar with the challenges associated with assigning patients to specific levels on the various criteria, panelists will be better positioned to revise and further define these levels at our next round of meetings. This will include attempting to develop operational definitions of "mild," "moderate," etc.

Participating clinicians will be asked to document any difficulties or discrepancies encountered during this initial field-testing process; experiences will be summarized and reported to the panels, which will revise the forms as necessary.

This initial pilot testing phase of the project will, therefore, provide information relevant to the process of developing tools for assessing patient priority, both from content and operational perspectives. In addition, this exercise provides an opportunity to gather information concerning the weighting scheme that might best be applied to each panel's set of criteria. This will be done by asking clinicians to estimate the overall urgency attributed to each patient and assessing the correlation

between these estimates and the responses to the various priority criteria. The information from this analysis will be presented to the panelists at their next meeting and used as a starting point for discussion.

During this initial empirical phase, we expect to receive information from approximately 200-250 cases under the auspices of each panel. Forms will be completed both by clinicians who are panel members and by designated colleagues of the panelists.

The operational and statistical information and experience derived from this empirical phase of activity will be summarized and analyzed for panelists for consideration at their next round of meetings in late January – mid February. If all goes well, the criteria will be revised and a second round of empirical work begun following these meetings, including studies of inter-rater reliability of the criteria. A method for conducting such testing will be developed prior to the next meetings and discussed there.

The criteria are available on our website at:  
<http://www.wcwl.org>

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## Waiting Times in Manitoba

Researchers at the Manitoba Centre for Health Policy and Evaluation (MCHPE) used administrative data to try and estimate the magnitude of the wait for elective surgery, and to determine if waits had changed in recent years.

A pre-operative visit to the surgeon was chosen as the "flag" to mark when waiting time began. We focussed on nine elective surgical procedures chosen because they represented a variety of commonly performed surgeries. Also, these were procedures for which there was generally only one pre-operative visit; for patients with more than one pre-op visit (32.7% of cases), the visit closest to surgery was used as the marker. We analyzed data from 1992/93 to 1996/97 inclusive.

We studied eight "core" procedures: cholecystectomy, hernia repair, excision of breast lesions, varicose veins, carpal tunnel release, TURP (for benign disease), tonsillectomy, and carotid endarterectomy. Here is what we found:

- For the core procedures, median waiting times for the five years combined were from 25 to 35 days. For breast tumour surgery, the median wait was 16 days. The longest waits were for varicose vein repair (40 days) and tonsillectomy (51 days).
- Over the five-year period, waits for only two procedures increased: varicose vein and carpal tunnel repair. For cholecystectomy, TURP, and tonsillectomy, waits decreased.
- The system seemed to do a good job in providing equal access to different groups. That is, rural residents did not wait longer than urban dwellers; women did not wait longer than men; and poorer people did not wait longer than wealthy people. For some procedures—varicose veins, carpal tunnel release, and TURP—patients over sixty-five years had an advantage over younger people.

We analyzed cataracts separately. Over the years of the study, cataract surgery was available both publicly and privately in Manitoba. In the public sector, patients did not pay any out-of-pocket fees. In the private clinics, the surgeon was paid by Manitoba Health, but patients were required to pay a facility or "tray" fee of approximately \$1000 per procedure. As of January 1999, private clinics have been prohibited from charging patients.

- The growth in the private sector was not due to a cutback in the public sector. At the same time that the number of procedures performed privately increased from 471 to 672, the number of public procedures increased from 4,249 to 5,610.
- There were differences in the public sector wait depending on whether or not the surgeon also had a private practice. Patients whose surgeons also had a private practice could anticipate longer waits than surgeons who operated exclusively in the public sector; in 1996/97, the difference between the two was 13 weeks. It is not clear what the reasons for these differences are.

The results of these analyses are currently being updated with two more years of data (97/98 and 98/99). Preliminary findings suggest that waiting times for elective surgery might be increasing.

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## Modernising the NHS: Booking Patients for Hospital Care

Since the 1997 British general election, ministers have launched a series of initiatives to improve access to NHS services. In the case of primary care, these initiatives include NHS Direct, a nurse-led telephone helpline, and walk-in primary care centres. As far as hospitals are concerned, the National Patients' Access Team (NPAT) was established in 1998 to support Trusts and Health Authorities achieve reductions in waiting lists and to help redesign elective patient processes. This includes overseeing the introduction of the National Booked Admissions Programme to pilot a range of approaches to enable patients to pre-book their appointment or treatment.

The Programme is designed to make the NHS more accessible and convenient, and to use resources more efficiently. Ministers have said that they wish booking hospital appointments to become as easy as booking travel tickets and hotel reservations in the future. Figure 1 (at end of article) illustrates the difference between booking and waiting. In essence, booking systems seek to streamline patient care by reducing unnecessary stages in the process of diagnosis and treatment. As such, they offer patients greater certainty, and enable resources to be used more efficiently.

Twenty-four pilots, incorporating sites containing some of the most visionary and progressive staff, have been chosen to lead the way by testing new ways of working with each other and with patients. They make up the first wave of the Programme running from October 1998 to March 2000. These projects include GP direct access to outpatient clinics, day-case surgery, or procedure; and booking by hospital consultants for day case surgery or procedure and in-patient admission.

The Health Services Management Centre has been commissioned by the Department of Health to evaluate the Programme. The first report of the evaluation has recently been published and the Centre will report again in a year's time. The main lessons for action on booked admissions are:

- The introduction of booking systems requires strong project management including the involvement of Trust Chief Executives, the appointment of full time project managers, and senior clinical participation.
- Consultant commitment is key to the implementation of booking systems and can be facilitated by the phasing in of booking, starting with the enthusiasts and extending to others at a later date.

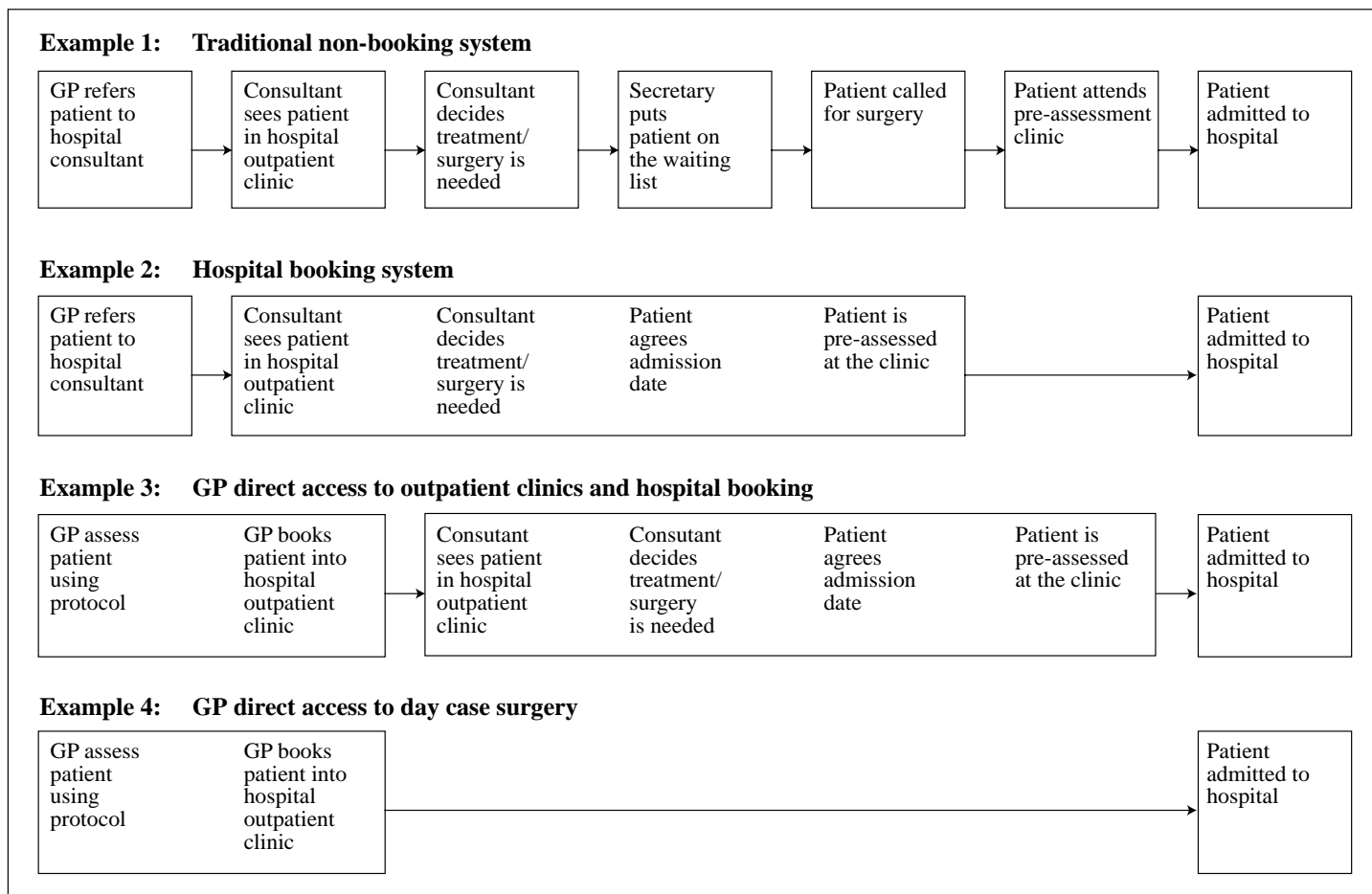
- An investment in training and development has eased the introduction of booking systems and has generated greater understanding of the changes being made among clinical and non-clinical staff.
- The close involvement of Health Authorities and Primary Care Groups (PCGs) is essential in securing widespread ownership of booking systems and continuing funding and support beyond the pilot phase.
- Although not dependent on IT solutions, booking may require changes in existing systems and additional investment in hardware and software. The innovations being undertaken at some of the pilots may identify lessons of wider relevance as this happens.
- GP direct access is a feature of some of the pilots and appears to be most likely to succeed where there is effective communication between GPs and consultants, including the adoption of referral protocols.
- Patients appear to welcome the certainty of booked appointments and the opportunity to choose a convenient date, although not all wish to agree a date for their treatment at the time of consultation. As booked admissions are extended to in-patients, managers and clinicians need to explore innovative ways to redesign patient care. A flexible response is necessary, for example, some pilots have responded by offering the option of a return visit for assessment and the choice of booking a date by telephone.
- The extension of booking to in-patients enables managers and clinicians to address the redesign of patient care as whole and in the process is opening up a challenging agenda for the future.

The fundamental changes in working practices brought about by booking systems underlines the ambition of the booked admission programme and the challenges that lie ahead. To exaggerate only a little, if booking is to become the accepted way of providing care in the NHS, in line with the aspiration expressed by the Prime Minister, then major changes will be required in how consultants, nurses, managers, and others treat patients. In a service like the NHS, in which professionals enjoy considerable freedom in organising their work, these changes will have to be introduced with the full involvement of doctors and nurses throughout the implementation process. This will require skilful leadership as well as the provision of resources to ease the process of modernising hospital services. The benefits to patients of being able to choose a date for their appointment or admission should encourage the change in culture, as should the positive experience of NHS staff who have already embraced the change. This evaluation will continue to monitor whether this happens and what factors affect the sustainability beyond the pilot phase.

For further information about the evaluation or the report, please contact Dr. Ruth Kipping at Health Services Management Centre, University of Birmingham, 40 Edgbaston Park Road, Birmingham B15 2RT.

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**Figure 1: Examples of Access to Hospital Services**



## Upcoming Events

- January 25 — Meeting of the WCWL Steering Committee
- January 29 — Meeting of the WCWL Hip & Knee Replacement Panel (note new date)
- January 30 — Meeting of the WCWL General Surgery Panel
- January 31 — Meeting of the WCWL Cataract Surgery Panel
- February 10 — Meeting of the WCWL MRI Scanning Panel
- February 11 — Meeting of the WCWL Steering Committee
- March 12 — Meeting of the WCWL Children's Mental Health Panel
- November 22-24, 2000 — 3rd International Conference on Priorities in Health Care

## UPDATE

### WESTERN CANADA WAITING LIST PROJECT

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