Managing waiting lists in the COVID-19 era

Louise Caney discusses the impact of COVID-19 on surgical waiting lists and highlights some key strategies to support recovery for operating theatres. She offers an insight into how digital operating theatre systems can assist with managing the backlog and finding additional capacity.

There are many facets to managing a surgical waiting list. A multi-disciplinary, co-ordinated approach – involving clinical, administrative, organisational, and technological resources – is needed to ensure patients on the waiting list are scheduled for surgery as efficiently and safely as possible. Under normal circumstances, operating theatres are busy, complex places, experiencing challenges every day, while managing elective and emergency cases. The goal has always been to ensure patients receive the surgical interventions they require within an acceptable time frame while maximising the productivity of operating theatres.

Everything changed at the beginning of 2020. Operating theatre activity was severely disrupted as the Coronavirus pandemic became the biggest challenge the NHS has faced since in a century. The *BMJ* stated last year, "The number of people who had been on waiting lists for more than 18 weeks in July [2020] was the highest since records began in 2007... Just 46.8% of patients were treated within 18 weeks in July [2020], against the 92% target – the lowest since records began." (September 2020).

The importance of increasing pace and working more efficiently and smarter is now an immediate priority as planned surgery resumes and, with the Government spending £160 million to tackle the waiting list backlog, a period of recovery has begun. However, extra funding is only part of the solution.

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Professor Tim Briggs, chair of the Getting it Right First Time (GIRFT) national programme, highlighted some hard-hitting statistics and raised some important points during the *Effective Operating Theatres Summit* on 9 June 2021. Currently 5 million people are waiting for elective surgery in England compared to 3.7 million in 2003/4. The GIRFT national programme improves treatment and care of patients by using data to drive evidence-based treatments, benchmarking, and a review of services to drive change.

In November 2018, 2,432 people had been on the waiting list for more than 12 months. With an increasing population and increasingly an ageing population, the impact on NHS surgical teams and operating theatre has never before been more intense. During the Effective Operating Theatres Summit (which took place online), several strategies were identified that need to be considered and implemented to manage this situation. Theatre productivity and efficiency, along with the patient experience, were front and centre of the virtual summit. Discussions included the considerations and strategies needed to manage the impact caused by the pandemic on surgical services. Some of ▶

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these are already in place – in particular, the creation of surgical hubs, pooled surgical lists, utilisation of the private sector and the move towards more day surgery.

The GIRFT programme's key messages regarding the management of the challenge we face focused on shared decision making, increasing capacity and productivity, and reducing patient length of stay and unnecessary surgery. Ring fencing operating theatre services by creating specialist theatre hubs, so waiting list surgery can continue during the pandemic, has already been deployed across the country. The Royal College of Surgeons has called for the creation of specialist hubs focused on just routine surgery – hip and knee replacements and cancer surgery, for example. In May 2020, a specialist cancer hub was created by the Royal Marsden NHS Foundation Trust and, in just the month of May, operated on 761 patients from the 10 Trusts across London, with this number increasing.

Meeting the challenge to balance the need for cancer surgery against the risk to individuals of coronavirus was highlighted by Vin Diwakar NHS medical director for London, back in 2020. MacMillan, the cancer charity, has supported the need for ring fencing cancer services, including surgery, to prevent a delay in treating patients with cancer (November 2020).

Pooled waiting lists are another way of managing the waiting list situation by increasing capacity and efficiency by placing some patients onto the shortest waiting list of a surgeon who may not necessarily be the patient's original surgeon. A patient needs to be a suitable candidate for a pooled list but there are benefits if the right balance is struck between some patients being added to their surgeon's waiting list and others to another surgeon's list.

Day surgery is a well-established approach to managing surgery, but now more than ever it needs to be considered for a wider range of surgical interventions.

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Being able to see what is available and where within an organisation's operating theatre department is ideally achieved digitally and in a format that gives a bird's eye view of theatre capacity in a centralised way, up to six weeks in advance.

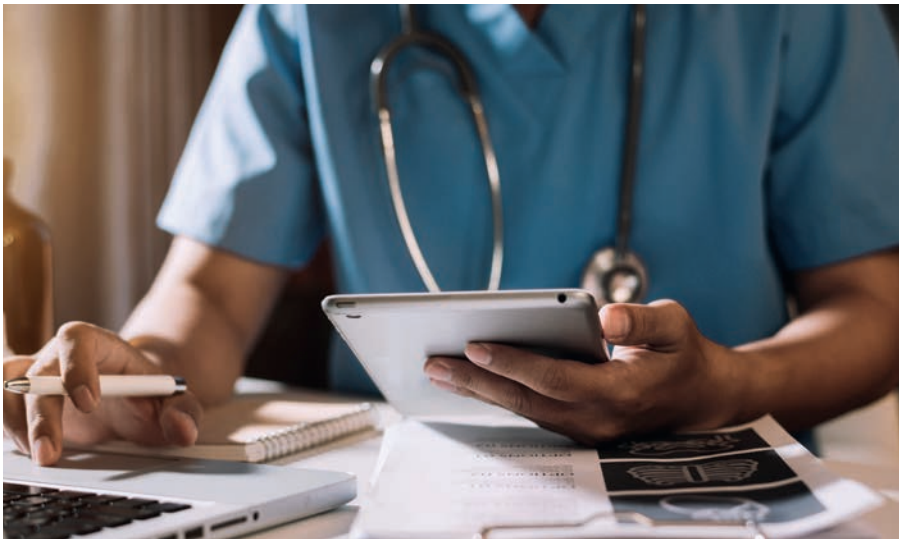
Managing surgical cases as a day case leaves inpatient beds for those who cannot be managed as a day case and prevents prolonged length of stay, a risk for elderly patients in particular.

The daily 'hot' surgical clinics described by the GIRFT programme is an approach that enables patients on an ambulatory emergency pathway to be reviewed by senior clinical decision makers, access diagnostic services and be booked onto a hot list while in the surgical assessment unit, returning for surgery at a specific time. Utilising the private hospital sector has also reduced the burden on acute NHS hospitals waiting lists, a strategy used by several Trisoft customers.

Capturing activity in these private hospitals was managed easily by configuring the digital theatre system to add these new locations, so theatre activity could be captured.

To understand why elective and, in some circumstances, urgent cases have been so severely impacted during the pandemic, we need to look at some of the leading factors: reduced capacity, reduced efficiency and productivity, and unavailability of healthcare professionals. As the number of hospital admissions of patients with coronavirus overwhelmed wards and critical care beds, it was necessary, in some cases, to use operating theatres to care for critically ill patients. Certainly, theatre capacity for emergency cases and obstetric surgery was preserved but patients waiting for non-urgent, elective surgery were placed on the waiting list with, in some cases, no date for their surgery in sight.

It is worth mentioning how the impact on the pandemic affected healthcare teams and the impact this had on surgical activity. Healthcare workers themselves became infected with the virus or had to self-isolate if exposed to the virus, having a devastating effect on hospital services. Patients needed to be tested prior to admission and, if positive, surgery was cancelled and theatre lists re-ordered. The delays caused by testing, although clearly essential, added another layer of complexity to a patient's route to surgery. A year on since the start of the pandemic, the processes needed to ensure patients and staff are tested, have



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arguably become streamlined and routine, which was not necessarily the case 12 months ago.

Protecting staff and patients by minimising the volume of outpatients moving through and congregating in a hospital setting has been essential since the beginning of the pandemic.

The strict social distancing rules has meant the way patients interact with their care providers needed to change quickly. Telehealth and online consultations have become the norm and may well continue once we return to non-pandemic conditions.

There has also been an increasing trend towards patient self-assessments being completed using digital platforms or portals. This started years before the pandemic as a way of improving efficiency and reducing the need for patients coming to hospital. However, a face-to-face consultation, particularly with an anaesthetist, will in many cases be necessary.

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Digital operating theatre systems

It is important to give a shout out to the contribution technology and, in particular, the digital operating theatre system has made and continues to make under normal conditions, but certainly during and after the pandemic, as surgical services return to normal – assisting with the 'heavy lifting' needed to manage capacity, scheduling, theatre pathways and pre-operative assessments.

With the pressure to manage the waiting list backlogs now on, key to moving patients safely and efficiently from the waiting list to an appropriate session is a streamlined interface with an organisation's patient administration system (PAS) waiting list. Details of each patient including priority should be included in the waiting list so a scheduler can understand who needs to be added to a list and when.

Clinically, having a more detailed understanding of the patient's situation is vital. Their condition needs to be shared and available, if not via the waiting list interface, then via other clinical noting, accessible to the surgical team.

With an increase in pace and a rapid roll out of new ways of working, the benefits of a digital theatre system cannot be ignored. The complexities around theatre session management include being able to create session plans easily and then changing, deleting or adding *ad hoc* single sessions. Placing a session no longer required on offer to other teams, splitting sessions, making changes to an existing session, adding resources, or requesting that a session be locked by a consultant, are all easily achievable using a digital theatre system. It may also be necessary to cancel or postpone a patient at short notice and re-order a list.

A top priority already mentioned is ensuring operating theatres and operating theatre personnel are deployed effectively, utilising the available theatre space as much as possible, so as many patients as possible receive their surgery. Being able to see what is available and where within an organisation's operating theatre department is ideally achieved digitally and in a format that gives a bird's eye view of theatre capacity in a centralised way, up to six weeks in advance. This means partially optimised theatres are not left that way.

How operating theatre services recover will depend on many factors. We cannot yet return to normal but, as of 2 June, we are in a very different place with a significant reduction in hospital admissions thanks largely to the successful vaccination programme. Despite the calamitous situation of the last 15 months, surgical services have, wherever possible, found a way to manage the waiting list backlog, putting the patient at the forefront of surgical operations and that is important.

Preserving staff morale and wellbeing continues to be an essential part of the recovery process, while ensuring the patient experience is the best it can be. Many lessons have been learnt and the different way of managing surgical services may well continue for many years. CSJ

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About the author

Louise Caney has spent the last 13 years working in the health informatics industry in the UK, including working as the clinical informatics specialist and clinical safety officer for Trisoft's operating theatre software re-development: Theatreman AQUA.