



Investigating the Implementation of a National Pilot Project on Wait List Management using Pooled Inpatient and Day Case Surgical Waiting List between a Level 4 Hospital and a Level 3 Hospital in Ireland: Patient Experiences and Provider Perspectives

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Background:

In Ireland, there have been numerous attempts to address long waiting lists through various initiatives. Between 1993-2003, the Department of Health and Children introduced a Waiting List Initiative spending €246 million during this period. The National Treatment Purchase Fund (NTPF) between 2004 and 2011 focused on patients waiting the longest period of time for a procedure on a public hospital waiting list, and proceeded to purchase the treatments required primarily through private hospitals in Ireland and the UK.

The introduction of the Special Delivery Unit (SDU) since 2011 has been an attempt to address the structural challenges and long term nature of reforms. However, as it tries to address the long-term structural nature of the reforms required to streamline the patient pathway through the public system, the removal of short-term funding to address the longest-waiting patients has meant that maximum wait times have been breached on an ongoing basis throughout the year, and resulting in a waiting list 'blitz', as it comes to the end of the year. Consequently, when funding is withdrawn following the period in which the target has been achieved, the waiting lists begin to rise again.

The research is based on a pilot project that took place between two public hospital sites - a Level 4 Tertiary care Hospital in Dublin and a Level 3 Hospital 120kilometers (km) away. The unique feature of this project was that patients were initially referred to, seen and assessed by a consultant in the Level 4 hospital (the originating hospital site), who listed the patients on his/her surgical waiting list for major surgery requiring a general anaesthetic (GA) i.e. repair of hernia, removal of gallbladder, repair of varicose veins, etc. Subsequently, the patient had his/her procedure completed in the Level 3 hospital (the receiving hospital site) under a different surgical consultant, who had not previously seen the patient, and was given direct access on the receiving Consultants' Theatre List in the Level 3 hospital. The objective of the pilot project was to begin pooling the longest-waiting routine surgical patients on the waiting list in the Level 4 hospital, and utilising the available capacity in the Level 3 hospital. Pooling procedures for routine long-waiting patients should, in theory, reduce the variation in the maximum wait time for surgery across all consultants within their speciality, and across the Hospital Group. This is the first project of its kind in the newly formed Hospital Group.

While there is much grey literature espousing the benefits and potential positive impact of pooling referrals on waiting lists and wait time, there are is very little on pooled waiting lists in practice, or in the Irish context. There is also a gap in the literature about the pooling of waiting list in Irish hospitals, and the challenges faced on implementing and sustaining a pooled waiting list across hospital sites both in Ireland and internationally.

Methods:

It is a mixed methods study that uses quantitative and qualitative methods. For the qualitative method, interview were conducted with the project team; and for the quantitative method, anonymous questionnaires were conducted with the patient group.

The target list for the patient group was based on the inclusion criteria for patients who had their surgery completed under the pilot project. A senior member of the Healthcare Records Department was appointed by the Healthcare Records Manager to review the patients' health care records to ensure they met the inclusion/exclusion criteria. Exclusion criteria applied to patients who were deemed by the senior member of the Healthcare Records Department to be considered vulnerable or under the age of 18. The number of patients who fulfilled the inclusion/exclusion criteria was n=79. A census of the target population was conducted, given the small number of patients completed under the project.

Descriptive statistics were generated from the questionnaires with patients. Questionnaires were paper based and posted to the patient group.

Patient Group Participant Profile	
Surgical cases completed under the project	n = 80
Individual patients	n = 79
Cases that had surgery as a day case	n = 69
Cases that required an overnight stay	n = 13
Cases that stayed two nights	n = 2
Youngest person	18 years old
Oldest person	83 years old
Average age	44 years old
Male	n = 61
Female	n = 18
Hernia repair was the most frequent procedure	n = 51
Inguinal hernia repair was the most frequent procedure	n = 21

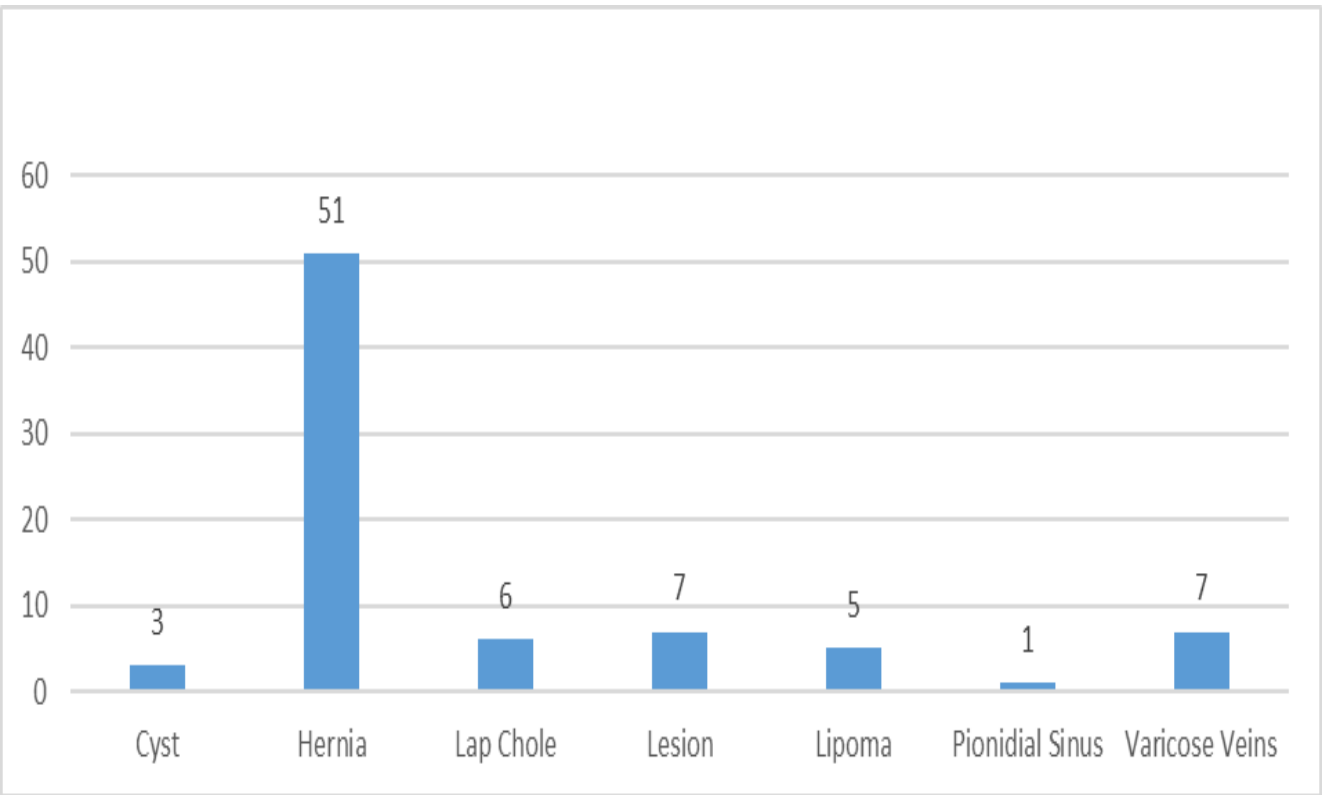


Figure 1: Surgery Type completed under Project (n=80)

Title	Discipline/Background	Length of Service
Lead Consultant Surgeon	Consultant	20+ years
Lead Consultant Anaesthetist	Consultant	25+ years
Consultant Anaesthetist	Consultant	30+ years
Clinical Business Manager	Administration/Previously Nursing	30+ years
Assistant Director of Nursing Surgical Services	Nursing	20+ years
Clinical Nurse Manager II Day Ward & Pre-assessment	Nursing	25+ years
Group Coordinator	Administration/Previously Nursing	20+ years

Table 2: The Project Team Participant Profile

The validity and reliability of the quantitative data collected is dependent on the response rate given the small sample size for the patient group. The low response rate from the patient questionnaire (n=41 out of n=79) does raise issues as to what extent the experience of those who responded are representative of the experience of all patients treated under the project

The inclusion criteria for the project team includes seven key members of the project team based at the Level 3 hospital. There were no exclusion criteria for the project team, as all members were more senior than the researcher. A census of this target group was conducted. The Level 4 hospital project team (the originating hospital site) was not included in the research given the short time frame

The Interview was structured so that all members of the project team were given the same initial questions in order to address the research question. The researcher took consent from participants at the meeting, prior to interview, and they were given the opportunity to ask any questions they may have about the project. Each interview took approximately 30 minutes. It was recorded by audio-tape and transcribed for analysis. There was a thematic analysis of qualitative data from the interviews with the project team members. The framework designed by Pomey et al. (2013), for classifying factors related to wait time management strategy implementation and sustainability, was used to analyse the organizational and contextual factors that emerged from the interview participants.

As an insider researcher it is not anticipated that the researchers' professional relationship with the project team had any negative impact on the interviewees behaviour that may have caused the interviewees to behave or respond to questions in a way that they would not normally respond. All project team members were more senior than the researcher and none of the interviewees had a dependent relationship on the researcher. The interviews were conducted in as neutral manner as possible to ensure reliability.

Ethics approval was sought and granted from the Health Policy Management/Centre for Global Health Research Ethics Committee in Trinity College, Dublin and the local HSE Research Ethics Committee.

Results:

Of the n=79 anonymous questionnaires sent out, n=41 responses were received back. The patient surveys revealed that most patients transferred to the new hospital were very happy with their experience, and the minor issues experienced were related mostly to the pre-admission process and having more information regarding the transfer process and the transport options to the receiving hospital.

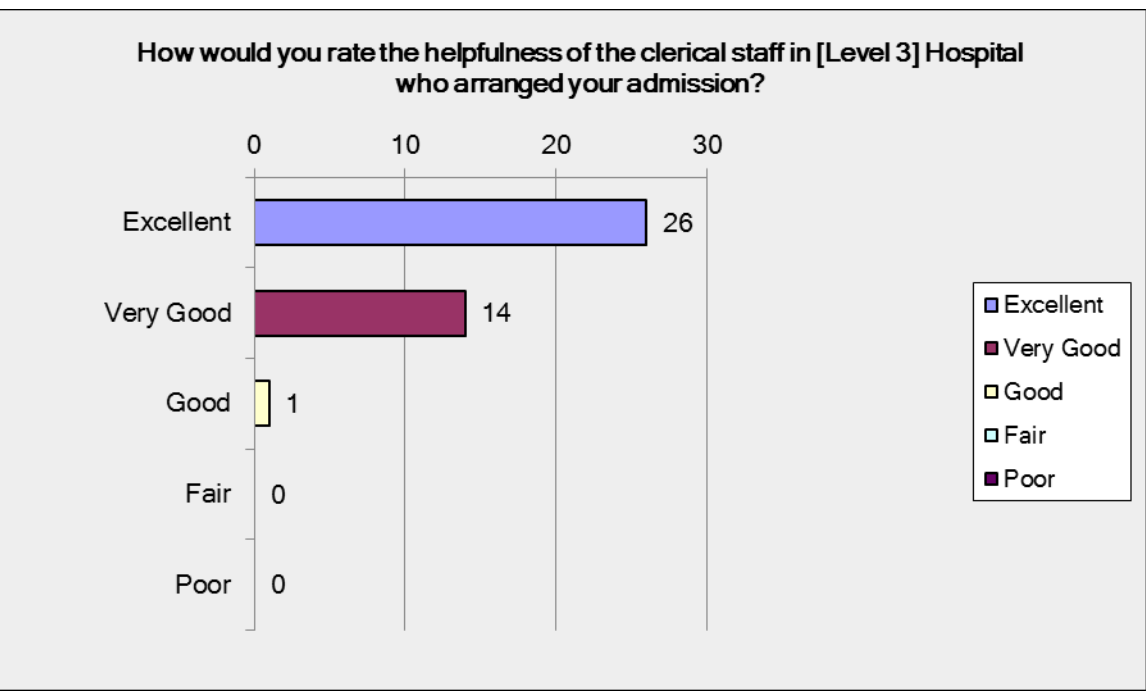


Figure 3: Response to Question 3

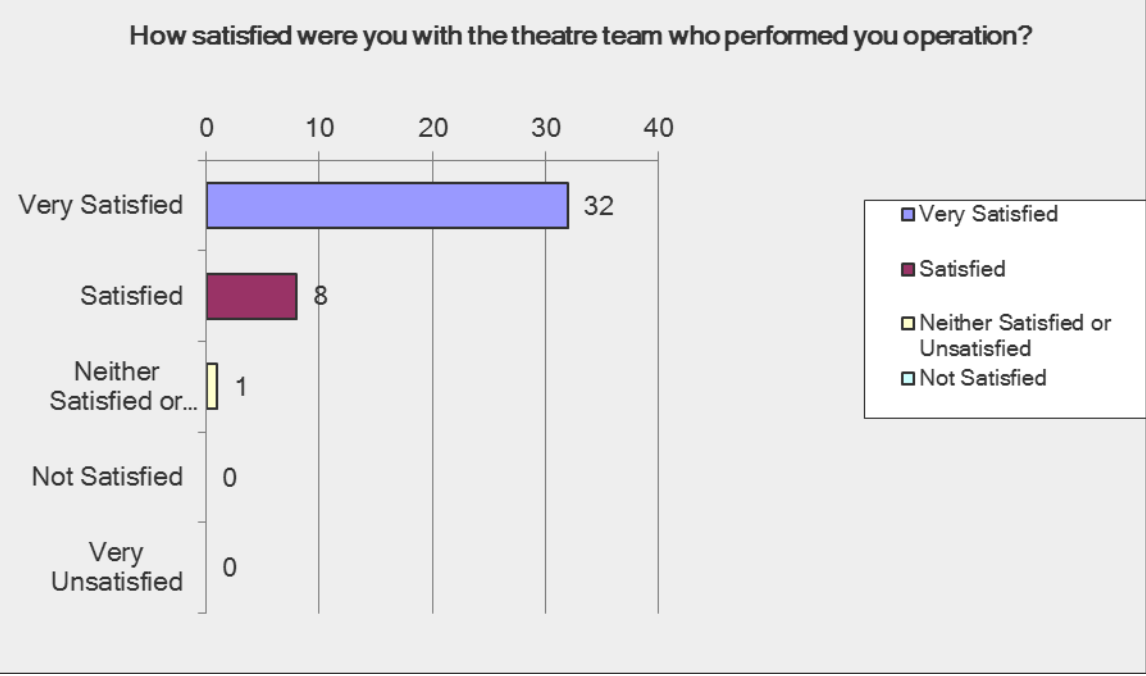


Figure 6: Response to Question 12

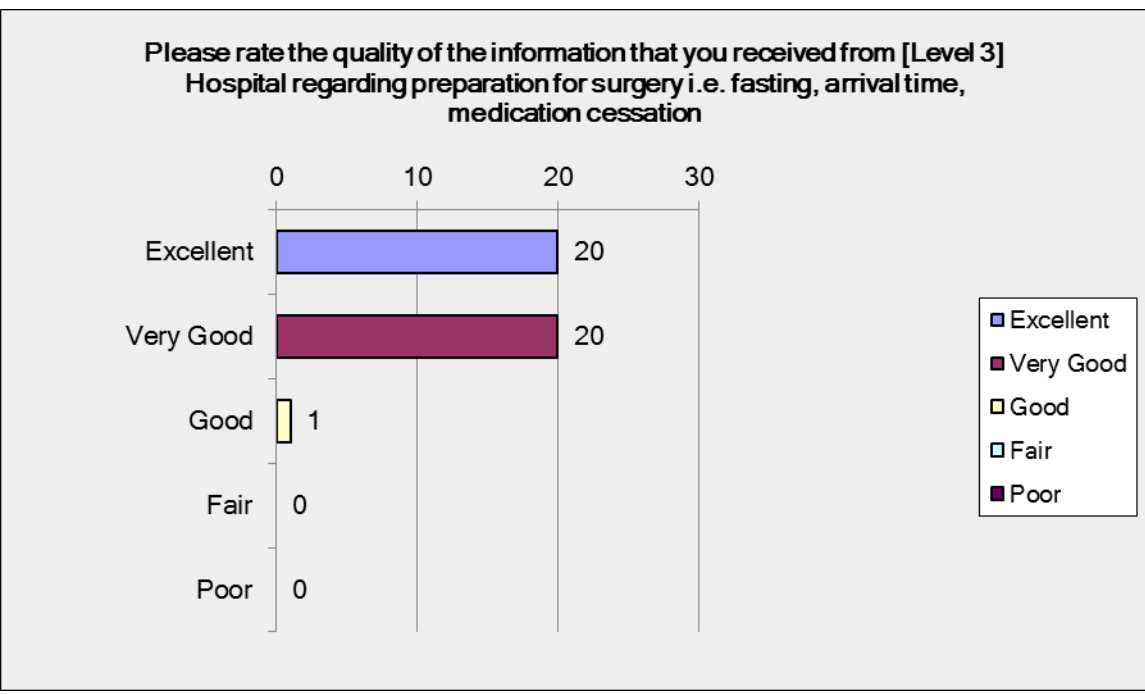


Figure 4: Response to Question 4

Open ended Responses
Let people know that they can use [Level 3] Hospital as soon as they go on waiting lists. (Q18R15)
Clear and concise direction to the ward/admission centre that I was attending. (Q16R14)
Seeing I had to travel from [County A] to [County B] I had to leave at 5:40am and then I had a long wait till I had the operation. So I think that waiting period could be shorter. (Q16R15)
Who to contact if things go wrong. 2) More realistic recover time. (Q17R16)
Guest house for family members. (Q18R10)
Arrange transport for them. (Q18R13)
To have comfortable waiting area for people who are attending with patient as it is a long wait for them. (Q18I2)

Table 3: Response to Open ended Questions

The qualitative findings:

Contributing factors to Successful Implementation	Openness and Willingness of both Hospital Sites to try something new Teamwork Open Communication	Critical success factor: It's probably the openness of both sites [...] to try, trial and error type thing, but you know, if you haven't got that willingness and openness in the first instance [...] it doesn't work. [...] (6528) It's all teamwork and we are all working together with the assistance of the anaesthetist, the coordinator and the consultant and the secretary involved. (1318) So I think with adequate communication, having a consultant sitting down, explaining that, you know, this is safe, we're going to, we're meeting with anaesthetists, looking at documentation, looking at the process, looking at putting in safety mechanisms that would, that would assure staff that actually these patients aren't just going to walk in fasting and have their surgery, all of the relevant necessary actions will have, will have been taken in the meantime (1314) I think the other thing that was key was the enthusiasm of the lead consultant, I think if people aren't enthusiastic and don't believe in it, then it never works. (606)
Barriers to Implementation	Lack of dedicated project administrative staffing Lack of clinician involvement from the originating hospital site in transfer criteria setting communication challenges across the hospital sites the geographic distance between the two hospital sites	So it means there's nearly an emergency type response from the staff within the hospital to try and get a number of patients identified, contacted, all of their paperwork together and, and get them treated elsewhere. So that usually entails that group of staff parking their usual day job and doing something else, so it's not quite a sustainable model. (618) I think the other piece is we need to win over clinicians on the other site, it's, in other words clinicians, surgeons in [Level 4 hospital] (434) Physically meeting and getting people into a room is difficult, given the locations the geographical challenges (606) It's probably about fifty percent of patients that are suitable but it's, it probably looks like only about half, less than half of those again that are actually going. (618)
Facilitating Factors	Further development of a pre-screening questionnaire Establishing a proof of concept A single point of contact on each hospital site Larger role for the Group Clinical Director in getting agreement between clinicians on both hospital sites Infrastructure and informational resources, and Administrative and clinical capacity challenges	Our problem is, barrier is we are not getting enough patients. (556) We've also had frequent updated meetings with the coordinator regarding the documentation and a few little things have been changed, and at the moment there's some further development in process. (326) So there is a [sic] element of fear by the surgeons, that why should we allow patients to go on our list, we have never seen them, never spoken with them. It and it's trying to overcome that cultural barrier? Yeah. (550-52) One of the big things is there's not a single point of contact I suppose in [Level 4], it falls between two directorates (602) The options around that was the [Group Clinical Director] is going to pull the seven sort of general surgeons together and actually get ... very clear direction as, right, we're happy as a group to let A, B, C, D go from a procedure perspective (1616)
Constraining Factors	Lack of clarity in national waiting protocol	In relation to I suppose particularly the, the scale of it, I think the size of our day ward, if we had, if we had more day ward beds, obviously if we had more, if we had more theatre capacity and more resources, I think those are going to, are going to inhibit the, the scale of the project. (136) the logistics of all the paperwork, getting them from one site to the next, dealing with the, the phone calls that may come in in relation to that, so I think there's a huge knock-on effect, a huge workload, specifically to the clinical admin waiting list office side on, on both sites, and trying to sustain that and build that into a model (654) At the moment, because it's a new initiative and we're sort of in phase one to see what it looked like, if patients were being phoned and offered something and said no, they wanted to remain on the Beaumont list, they remained on the Beaumont list for now I suppose. If they remained active? Yes. If: as opposed to suspended? Yeah. (673)

Discussion:

One of the things that differentiates this project from so many others is that it involves a waiting list initiative that is not contained within one hospital site. The literature review identified some pooling of procedures within departments in the same hospital.

The distance required to travel by patients was identified by interviewees as potentially contributing to the low uptake of patients on the project. The uptake from the number of patients offered the opportunity to have their procedure completed in the Level 3 hospital was identified by one of the interviewees to be as low as 25%. This is quite low compared to other research. Coulter *et al* (2005) who did a study of the London Patient Choice (LPC) Scheme found that 62% of patients offered the choice of quicker elective surgery chose to have their treatment in a different hospital.

The key empirical contribution of this research is that it is the first project of its kind in Ireland looking at pooling patients across two public hospital sites in different geographic locations. The research has made a key contribution to the literature by identifying and adding some new critical factors that influence the successful implementation and sustainability of waiting time management strategies at the local level. The new critical factors include the need to establish proof of concept, the importance of central coordination and single point of contact and the role of geography.

A clear majority of patients were very satisfied with their experience in terms of the care they received and the admissions process. This is similar to a survey conducted by the National Treatment Purchase Fund (2010) that found that 99% of patients were satisfied with the care they received on an alternative hospital site, although in this case the majority of patients (97%) were treated in private facilities.

Lessons Learnt Policy/Practice Impact:

Major recommendations from this study include the need for clinician involvement on the originating hospital site in setting transfer criteria and better patient education in preparation for travel, and the need for central coordination for the Hospital Group. Pooled Waiting Lists are shown to work as a potential mechanism for improving patient flow between hospitals. It is also being used as a template to expand pooled waiting list to other specialities in the Hospital Group such as endoscopy procedures.

Conclusion:

The research corroborated key findings in the literature and added new evidence on factors not previously explored in the literature for the successful implementation of a wait-list management project. The project has since expanded to include Outpatient appointment and endoscopy appointments across the Hospital Group. The project continues to be implemented and improved on an ongoing basis and is part of an effort to improve patient flow through the Hospital Group across multiple specialities.