Setting priorities in waiting lists

Sir,

John Nolan identified a number of frustrations and opportunities for managing waiting lists (vol 63(6), 2002, p. 324). Nolan's main views were based on the premise that there is a mismatch in capacity and demand. The question which needs to be asked is whether the waiting list demonstrates a mismatch between capacity and demand or a backlog? If the length of a waiting list is static, and not increasing, then capacity and demand are in equilibrium and there is not a mismatch; however, an increasing waiting list suggests that there could be a mismatch, or that patients are being treated out of turn, thereby increasing the maximum waiting time.

The Primary Care Collaborative and Cancer Services Collaborative have demonstrated that it is possible to 'do today's work today', by clearing the backlog, shaping demand and capacity and bringing the two into alignment (Oldham, 2001; Thrush et al, 2002). The challenge is to test this approach further in secondary care and to adapt this approach for specialities where demand continues to outstrip supply.

The frustration experienced by many consultants about giving priority to the tail-end of the waiting list is being considered by the NHS Modernisation Agency. A clinically sensitive method will be developed with consultants to identify the relative priorities of patients on the whole waiting list. These data will be used to inform the management of the waiting list, to avoid the common occurrence whereby patients who can wait in turn are seen ahead of urgent patients (M Bushell, personal communication, 2002).

Nolan's view that priority scoring can contribute to the management of waiting lists is echoed by many in the UK, Canada and New Zealand (Kipping et al, 2002). Priority scoring offers a method to bring consistency and transparency to clinicians' decision-making. It can also offer benefits in terms of increasing fairness – the more urgent patients waiting the shortest time – providing the tool is sensitive to the relevant clinical indicators and patient experience (Derrett et al, 2002). It also provides greater descriptive information about the urgency of the spectrum of patients referred and treated, which in turn can help commissioners to identify priorities for investment.

Nolan highlighted a number of problems with booking systems, which have been experienced in practice by some trusts in the NHS who offer patients choice and certainty by agreeing the date for admission in advance (Ham et al, 2002). However, the anticipated increases in capacity and reduced waiting times should alleviate the capacity and time constraints which can make inpatient booking difficult. While New Zealand introduced scoring and booking in tandem, Western Canada has developed priority scoring tools (Western Canada Waiting List Project, 2000) and plans to incorporate it into a booking system (T Nolan, personal communication, 2002), and in the UK we are moving towards a fully booked service but the method of prioritization is currently less developed.

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Intestinal ischaemia

Sir,

My only criticism of an otherwise excellent account of acute gut ischaemia (vol 63(6), 2002, p. 354) is that, despite the acknowledgement that the diagnosis depends on a sufficiently high index of suspicion, the authors did not proceed to spell out the steps required to 'compile' this index of suspicion.

These consist of the recognition of risk factors for systemic thromboembolism, namely, atrial fibrillation, myocardial infarction, left ventricular aneurysm (Sachs et al, 1982), infective endocarditis, and, rarely, paradoxical embolism (Meister et al, 1972). It is when acute, and otherwise inexplicable abdominal pain occurs in the context of these risk factors that a timely diagnosis can be made, articulated as 'mesenteric embolism until proved otherwise' as opposed to 'acute peritonitis of unknown cause'.

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Correction

In the article on *Intestinal ischaemia* (Vol 63(6), 2002, p. 354) , the figure legends for *Figures 5* and *6* were accidentally transposed. The legend for *Figure 5* should have read 'Plain abdominal X-ray showing pneumatosis intestinalis.' and the legend for *Figure 6* should have read 'Plain abdominal X-ray showing air in the biliary tree.'. We would like to apologise for any confusion caused.