High intensity, high impact: tackling waiting lists one HIT at a time

BY LULU RITCHIE

A monthly high intensity theatre list in Sheffield shows how smart planning, teamwork and focus can dramatically reduce long ENT waiting lists.

Finally, after many years of training, I've started my first consultant post – only to become part of the long waiting list dilemma. Waiting lists aren't new. Throughout my training, supervisors often commented on the declining effectiveness of lists but the pandemic, with its long months of inertia, has led to alarming delays for many patients. Most concerning is the vast variation between trusts – those with the resources or initiative to resume operating earlier have created an even starker postcode lottery.

On the TAU at 8am to meet the first 10 families with Ravi, Rob and Jen.

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Ravi Thevasagayam and his anaesthetic colleague, Rob Hearn from Sheffield Children's Hospital, have gone the extra mile to tackle their waiting list by running a high intensity theatre (HIT) list once a month. One of the main hurdles was overcoming the understandable concern that trying to fit 20 patients into two sessions might lead to corner-cutting, compromise safety or prove too costly. Intrigued by a video explaining the process – posted on the BAPO website – Jen Magill, my counterpart at the Royal London Hospital, and I decided to take a road trip to see it for ourselves.

January 11 dawned at -5°C in Sheffield but that didn't stop 20 families from arriving for surgery. The theatre admission unit (TAU) was a hive of activity, with two nurses and three support staff busily checking children in. In the preceding week, Ravi and Rob dedicated two hours each to prepare detailed paperwork:

Rob's spreadsheet to calculate drug doses.

Ravi, Jim, Rob, Fiona, Zoe and Debbie ready for their next patient.

The ENT dream team. (L-R): Fiona, Timeout-Tina, Zoe, Debbie, Louise, Jen and Lulu.

patient lists, anaesthetic charts, operation notes and discharge summaries. Consent forms are completed in clinic. The day began with 10 coblation intracapsular adenotonsillectomies, followed in the afternoon by 10 adenoidectomies +/- grommets. Grouping cases like this clearly enhances efficiency.

Rob walked us through the anaesthetic setup: he draws up master syringes using a female-to-female luer lock and prepares each patient's medication using a spreadsheet that calculates weight-based doses instantly. Anaesthesia is delivered via TIVA and an LMA, allowing the child to go straight to recovery post sign-out.

Ravi explains that patient selection is critical. One unexpected pre-med can throw off the whole schedule, so only straightforward cases are included to maintain flow. To Jen and me, it's clear that by handling the less complex cases on the HIT list, the weekday lists are freed up for those requiring more urgent or inpatient care.

Watching the theatre team in action is like witnessing a professional orchestra. As Ravi scrubs in, the child is positioned on the shoulder roll with a Draffin rod bar in the anaesthetic room. When they wheel the patient in, Ravi is gloved and ready. The scrub nurse is stationed at the head of the table with a pre-counted set and primed instruments. It's effortless – like a theatrical set change – and makes me reflect on how much energy I spend just trying to get our operating lists started.

Ravi places the gag during the timeout, but surgery doesn't begin until 'Timeout Tina' gives the all-clear – she runs the timeout all day and insists on perfection. Five seconds later, the coblator starts. Everything runs like clockwork.

Fifteen minutes later, the surgery is complete and the used set is packed up for fast-tracking. They have 20 streamlined adenotonsillectomy sets and borrow four more from a local hospital, just in case the on-call team needs them. The ODP cleans the anaesthetic machine and passes the bar and shoulder roll to the second ODP, who is already prepping the next patient. Sheffield Children's precious theatre escorts bring patients down, keeping them entertained with games and ensuring a steady supply of trolleys. The ODP monitors surgical progress and sends for the next patient accordingly.

We leave buzzing with energy, grateful to the incredible Sheffield team for their hospitality. Ravi shares outcome and costing data which is undeniably impressive. In just 26 lists, 432 children have had surgery. Could this be scaled up? Could it work in London?

My team is tired. They already work their socks off, and I worry that asking more might be the breaking point, or that management will see us operate on 20 patients in a weekend and expect the same midweek. But when I quietly ask Ravi's nurses, they say the pay makes it worthwhile, they're proud of the project and they enjoy working with Ravi and Rob. Rob adds that inefficiencies in the standard week demotivate theatre staff too, and they gain real satisfaction from a productive, well-run day.

Even Lewis Hamilton would envy this pit crew. They may not change tyres – but blink, and you'll be missing your tonsils.

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AUTHOR

Lulu Ritchie, MBChB BSc Hons, MRCS, DOHNS, MD, FRSC-ORL,
Paediatric ENT Consultant, St Georges Hospital, UK.

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