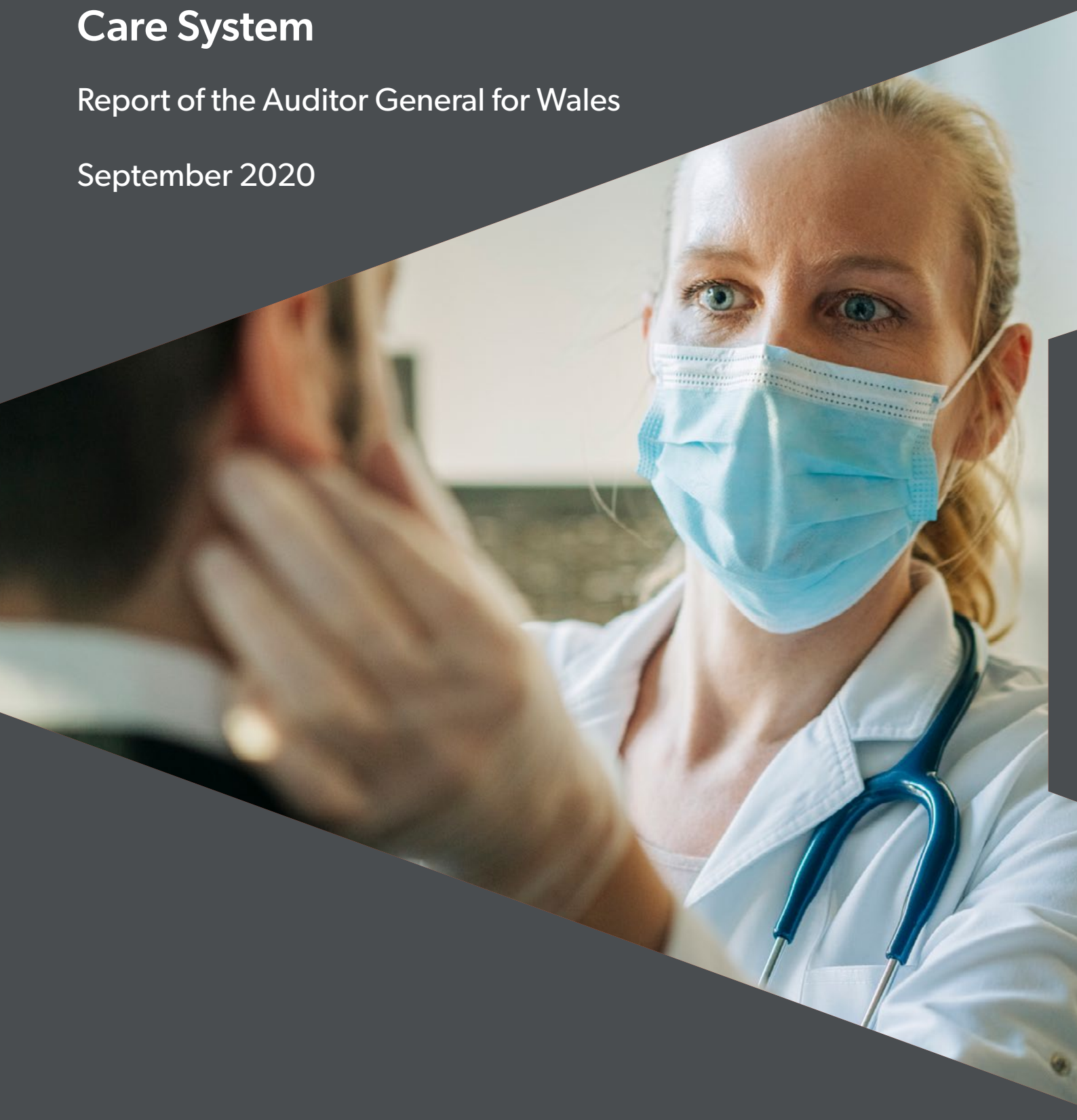
Archwilio Cymru
Audit Wales

10 Opportunities for Resetting and Restarting the NHS Planned Care System

Report of the Auditor General for Wales

September 2020



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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Summary report

1 On Friday 13 March 2020, the Welsh Government announced that it would be halting all non-urgent planned care treatment in hospitals. This came ahead of similar announcements for England, Scotland and Northern Ireland. Stopping non-urgent activity meant the NHS could free up capacity – beds, staff and equipment – to respond to the impending wave of COVID-19 cases. At the time, there were deep concerns that the UK was on a similar path to Italy, where the healthcare system was starting to become overwhelmed.

2 The NHS has continued to treat the most urgent patients. But hundreds of thousands of people in Wales are now 'parked' on waiting lists (**Box 1**). Between the end of January and May 2020 the total number of patients on a waiting list fell slightly from around 462,000 to 453,000. In part this fall was because, during the peak of the lockdown, there were far fewer people referred for a first outpatient appointment by their GP or other health professional. However, the numbers of patients waiting for long periods grew substantially. In May, around 148,000 had been waiting more than six months (up from 77,000 in January). Of those long waiting patients, 79,000 were still waiting for their first outpatient appointment (up from 33,000 in January).

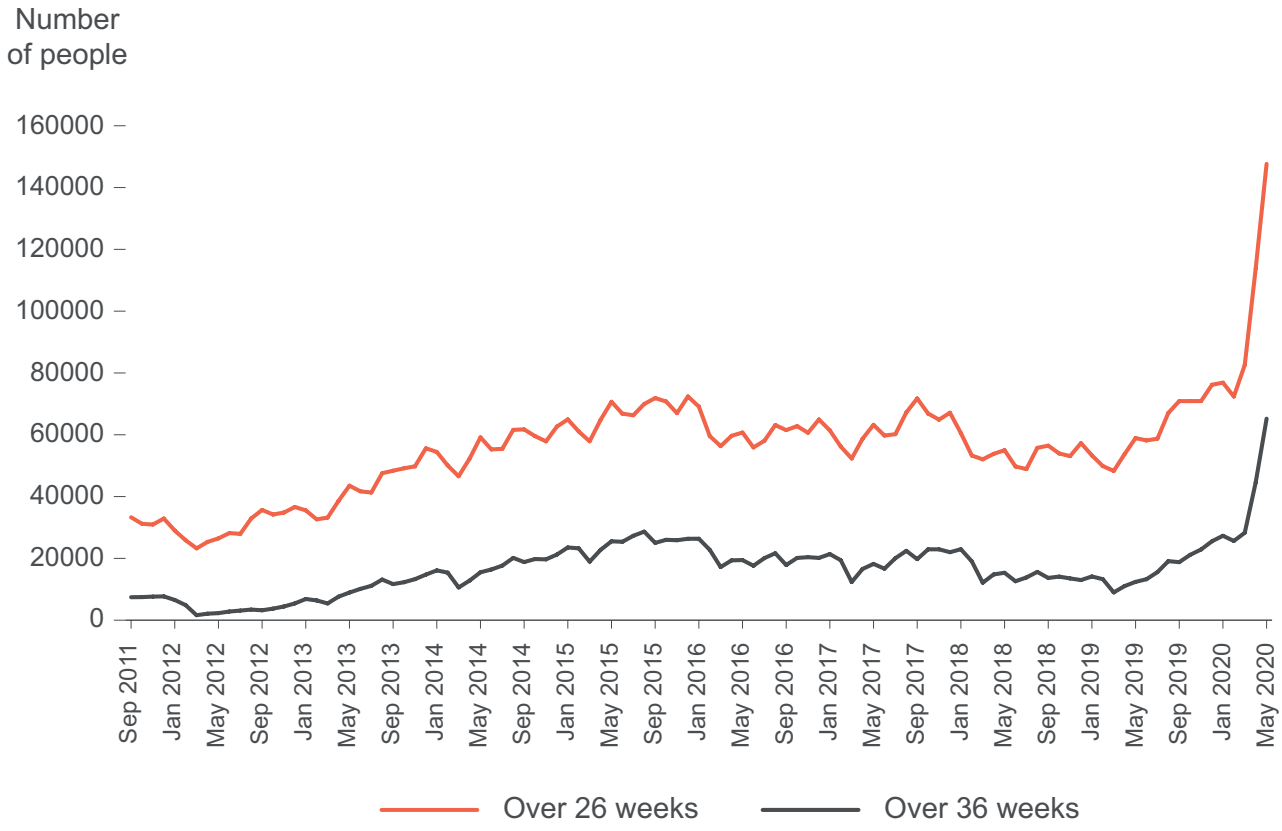
Box 1 – Waiting lists and waiting times

While NHS Wales is a complex system, waiting lists are essentially just queues. The NHS has various visible and less visible queues. The waiting list for planned care is one which is not visible, existing largely on computer systems with the patients doing the bulk of the waiting in their homes. The queue for cancer treatment is similar. The queue for emergency treatment is more visible, with patients waiting in waiting rooms, cubicles, sometimes in ambulances and on trolleys.

The Welsh Government has set targets for how long people in each of these queues should wait. The challenge for the NHS is to balance and prioritise within and between these queues because often they are competing for the same capacity: consultants, doctors, nurses, beds, appointment slots and operating theatres. Before COVID-19, the NHS was not meeting the waiting times targets for planned, cancer or emergency care.

3 At the time the UK went into lockdown, we were concluding our work to follow up progress against our 2015 reports on waiting times for elective care and orthopaedic services. Across both studies we had found the same story: many patients still face long waiting times (**figure 1**). Some progress has been made in specific areas but we have not seen the sorts of whole system change that is needed to make the planned care system sustainable.

Figure 1 – patients waiting over 26 weeks and 36 weeks as at May 2020



Source: Figures to January 2020 are from StatsWales, figures from February to May are from Welsh Government data

Note: figures for February to May have not been subject to the usual verification processes

4 Against the backdrop of COVID-19 we have reframed the findings and key messages from both reviews to inform the emerging plans for restarting planned care and the wider discussions on what a post COVID-19 NHS needs to look like. In this report we present ten key opportunities – five longer-term opportunities to reset the system and five immediate opportunities to restart the system (**figure 2**).

5 Taking these opportunities will help create sustainable changes to the system of NHS planned care in way that aligns well with the five ways of working set out in the Well-being of Future Generations Act, namely focusing on the long-term, collaboration, integration, prevention and involvement. We do not pretend that this will be easy but it is perhaps a once in a generation opportunity to strategically reshape a fundamental element of the NHS.

Figure 2 – Our 10 Key Opportunities for the NHS as it restarts planned care

Five opportunities to reset the system

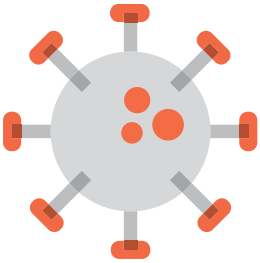
Take brave decisions about the target and accountability regime to align the planned care system around '**what matters**'

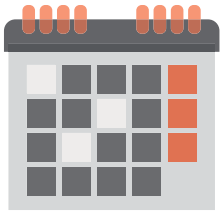
Strengthen **collective leadership** of planned care, learning lessons from COVID-19 and before

Consolidate and expand recent service changes in ways that involve patients

Undertake a **full and frank** review of capacity and the sustainability of the planned care system

Develop performance measures for planned care that align to outcomes and what matters to patients, families and communities





Five opportunities for restarting the system

Continue to **develop systems for prioritising patients** most in need of treatment

Engage with the public and patients about the options for treatment and the challenges, in line with principles of co-production

Carefully increase activity while sustaining the **focus on safety** and retaining flexibility to respond quickly to COVID-19

Engage clinicians and data scientists to rigorously analyse the backlog waiting lists with a view to reducing the risk of over-treatment

Promote prevention, self-care and behaviour change to **reduce respiratory illnesses** in particular and protect NHS capacity over the autumn/ winter months

Five opportunities to reset the system

01

Take brave decisions about the target and accountability regime to align the planned care system around 'what matters'

1.1 The national strategy for the NHS – A Healthier Wales – sets out the ambition for services to be focused on 'what matters' to patients. While waiting times matter to patients, we don't think it is the whole story.

1.2 For many years, the NHS has focused a great deal of managerial and clinical effort on meeting numerical waiting times targets at the end of March each year. We have come across multiple examples where the drive to meet targets potentially distorts clinical decision making and prioritisation. We think the focus on targets encourages short-term thinking and inhibits NHS bodies from developing realistic plans.

1.3 We heard some positive views about the work to revise the targets for eye care, where there has been a shift away from a one-size fits all target towards agreeing waits that are clinically relevant for each individual. We think there is opportunity to learn from that experience as part of a wider re-think of the approach to performance and accountability in the NHS, so that it aligns with ensuring that services focus on 'what matters' and quality and safety.

Strengthen collective leadership of planned care, learning lessons from COVID-19 and before

1.4 There is always a challenge in the NHS to balance national direction with local innovation in response to local needs and circumstances. Responding to our 2015 reports, the Welsh Government said that an initiative called the Planned Care Programme was going to bring together leaders from across the NHS to provide a national direction for planned care. However, our follow-up work has led us to conclude that the Planned Care Programme has had limited traction. A senior health board executive told us that 'the Programme has dropped little pebbles into lots of ponds but hasn't changed the whole system'.

1.5 In the coming months, the Welsh Government will be turning its attention to the plans for a new NHS Executive which will bring together national leadership and accountability. The Welsh Government will also be developing a new plan for clinical services across Wales. We think these are positive opportunities to reset the approach to strategic leadership.

1.6 We don't claim to have all the answers on what leadership should look like. But we think NHS leaders need to take this opportunity of reset to have a rigorous and evidence-based review of what has worked, what hasn't and why. This should take in learning from the response to COVID-19, where there has been a new approach to leadership, as well as learning from previous and current national programmes. What should be avoided is an automatic default to previous ways of working, as this is unlikely to provide the collective impetus to make the system changes which are needed.

Consolidate and expand recent service changes in ways that involve patients

1.7 Had the pandemic not occurred, our follow-up work would have commented on the slow pace at which the system had addressed issues we identified back in 2015. However, the rapid innovation and transformation that has come about as a result of COVID-19 has shown what can be done, albeit in an environment that is less cost constrained. The challenge now is to consolidate and build on the service change that has happened, including:

a building on the rapid expansion of digital services which provide a foundation for a broader transformation of the traditional outpatient model, while being mindful of the digital divide and make sure that services remain accessible for all patients; and

b building on the cultural change that has seen staff willing to blur and step completely out of traditional professional boundaries to support new and more efficient and effective ways of team working that enable staff to make best use of their expertise and skills.

1.8 In many cases, services have been changed at pace and under pressure. We recognise that it is difficult to fully engage with patients and co-produce the new ways of working. But as these new ways of working become embedded, there is an opportunity to engage with patients both to explain what they can expect and to understand their views and experiences in order to refine and improve.

1.9 Whilst, pre-COVID, change had been slow, it had been happening. In orthopaedics, CMAT[1]s have shown you can meet demand and patient needs outside of the hospital and potentially at lower cost, though there is scope to reduce some overlap in roles. Positively, our 2019 follow-up also shows there has been improved efficiency in many areas, like length of stay, although there are still opportunities to keep getting more efficient and productive.

Undertake a full and frank review of capacity and the sustainability of the planned care system

1.10 COVID-19 has shed a light on the stretched NHS capacity including beds, staffing and estate. Stopping all non-urgent planned care for such a long period to manage priority COVID-19 demand was extraordinary. But it was not entirely novel. Health boards have done it in a planned way to manage winter pressures in emergency care and in an unplanned way by cancelling operations at short notice. For years, planned care has been the safety valve when the pressure in the system gets too much.

1.11 In 2015, we concluded that supply was not matching demand for planned care and we think this still holds true. Before COVID-19, the NHS relied on paying clinicians a premium rate to carry out work at the weekends to improve waiting times. This short-term approach left the NHS exposed when the UK Government made changes to pension tax rules[2] and clinicians were no longer prepared to take on the extra work. As a result, waiting times were already on a sharply deteriorating trajectory during 2019-20: well before COVID-19 hit.

1 Clinical Musculoskeletal Assessment Treatment Service (CMAT) were developed to provide a community-based service for the assessment and treatment of musculoskeletal related pain and conditions

2 In 2019-20, new rules covering tax paid on pensions came into force. These had the effect of potentially leaving clinicians facing large tax bills if they carried out additional work. In December 2019, the Welsh Government mirrored a temporary solution to the issue, implemented in England, whereby the NHS would pay for the tax liabilities. The Welsh Government's concerns are set out in a letter from the First Minister to the Permanent Secretary, directing her to implement the same approach as England.

1.12 There are opportunities for the NHS to make better use of existing resources. As highlighted here and in our previous work, these opportunities lie in changing the system and services, making better use of technology, as well as making incremental efficiency improvements. Our 2015 work estimated some of the financial and capacity gains possible from more efficient and effective ways of working[3].

1.13 But alongside the focus on change and transformation, there also needs to be an open and frank discussion about the longer-term funding of the NHS. This should be based on a robust understanding of what it really costs to remove the backlog of patients and provide sufficient core capacity to meet the healthcare needs of the population in Wales.

Develop performance measures for planned care that align to outcomes and what matters to patients, families and communities

1.14 Our earlier point about rethinking the targets does not mean we are saying the NHS should stop measuring waiting times. The length of waits is an important indicator of quality, capacity and flow in the system. Our concern is the excessive performance management focus on a single measure. There are still some things to refine in terms of understanding end-to-end waiting times, like how to count waits for services like CMATS and community services.

1.15 We think that clinical risk and priority needs to feature more prominently in performance measures. In 2015, we said that the Welsh Government should publish waiting times data broken down by ‘urgent’ and ‘routine’ patients, but it didn’t accept that aspect of our recommendation. There is a lot of work going on now to get a better understanding of the clinical risk on waiting lists. We still think there is an opportunity to revisit the spirit of that original recommendation to reflect the current importance of giving boards and the Welsh Government a clear view of how long urgent patients have been waiting.

3 For example, our 2015 report on waiting times for elective care estimated that reducing variation across all procedures could free up capacity equivalent to 32,000 procedures and 47,000 bed days, A 50% reduction in procedures known to be of limited clinical effectiveness could release capacity for 16,800 procedures, 22,000 bed days. The value of this capacity would be in the order of £26 million (in 2014-15 money). Figure 2 of the report sets out further capacity and efficiency opportunities.

1.16 There is also a big opportunity to focus more on outcomes and what matters to patients. There is already work underway to develop patient reported outcome measures to better understand clinical outcomes and support decisions making. But there are opportunities to speed up and expand the work. There are also opportunities to better understand patient satisfaction and engagement, especially around how involved they feel in decisions, how informed they are about processes and what to expect.

1.17 We also think there are opportunities to learn lessons from social care on their work around measuring personal outcomes. What matters to patients for example from a knee operation is not necessarily the clinical outcomes like healing of the bone and tissue. It is about the ability to walk to the post office, play football with a grandchild or get back dancing. If ‘what matters’ is actually what matters, then there is a need for a very different approach to what gets measured and some technical challenges to overcome in order to achieve that.

Five opportunities for restarting the system

02

Continue to develop systems for prioritising patients most in need of treatment

2.18 Given the size of the current planned care backlog and the constraints facing the NHS, prioritising patients based on clinical need is a sensible way to 'ration' the scarce healthcare resources in order to minimise harm. However, that inevitably means very long waits for those not considered a priority.

2.19 Traditionally, the NHS splits patients into 'urgent' and 'routine'. In the current circumstances that is not sensitive enough to distinguish between those who need to be seen within days and those within weeks or a few months. The NHS is now distinguishing between different types of urgent patients, but over time will also need to distinguish patients more generally.

2.20 In 2015, the Public Policy Institute for Wales (now Wales Centre for Public Policy) carried out an international review of approaches to prioritising elective care, highlighting some of the risks around points-based approaches to prioritisation. We think the NHS in Wales should look to international experience, including the live experiences of those slightly ahead of the UK on the pandemic curve, as it further refines its approach to prioritisation.

2.21 There is a lot of hard work involved in changing the underpinning systems to ordering by clinical priority. Booking systems and many other detailed aspects of planned care services have been based on prioritising people by how long they have waited. Also, the 'rules' of the game, such as what happens when patients cancel or don't attend are all part of a system focused on putting people in a time-based order. These will need to be updated. There is an opportunity to learn the detailed lessons from the implementation of the new eye care measures[4].

4 In June 2019, the Welsh Government announced a new approach to eye-care appointments, which involved prioritising patients' waiting times on the basis of their clinical need. Further detail can be found in the Health Minister's statement.

Engage with the public and patients about the options for treatment and the challenges, in line with principles of co-production

2.22 We think that there is an opportunity for the Welsh Government and the NHS to engage positively with patients as a result of the changes the NHS is having to make. The three areas we suggest the Welsh Government and NHS prioritise are:

a **Informing** the public about the scale of the issues facing planned care in the coming months and years. Being clear that some people will potentially wait a very long time for their routine operations.

b **Engaging** patients in decision making with clinicians to review the options and alternatives to surgery. In many cases, given a choice, patients would in any case prefer the least interventionist options. In some cases, this may require clinicians to think differently about what is best for the patient.

c **Being responsive** by keeping in touch with patients who may not be an urgent priority now and ensuring there is a system in place to re-classify them if their condition deteriorates significantly.

Carefully increase activity while sustaining the focus on safety and retaining flexibility to respond quickly to COVID-19

2.23 In restarting planned care, the NHS here is in the same position as many other developed countries in balancing risks. A multi-country analysis published in the Lancet sets out concerns about the risks of non-urgent surgery during the pandemic, which is ongoing. But at the same time, there are potential harms from not carrying out surgery and making patients wait for very long periods.

2.24 The NHS will need to be realistic in balancing the pressures to increase activity and use more capacity against the need to manage infection control and to respond to any local outbreaks. Capacity needs to be carefully managed. Our 2015 work raised concerns about the consequences of high bed occupancy with cancelled operations, patients being in beds usually used for other specialities and a general sense of a system that was highly pressured and reactive, where the focus is on finding beds. We think that during this period of recovery, potentially before a second wave in winter, the NHS should be thinking about what it needs to do to avoid returning to that sort of environment.

2.25 There is also the question of what to do with the surge capacity the NHS created to respond to COVID-19. Some of that was created by re-purposing operating theatres and wards, which would be needed to significantly increase planned care. With the possibility of a second wave in winter, decommissioning the surge capacity to accommodate more planned care needs to be carefully thought through and done in ways that can be reversed swiftly if required.

Engage clinicians and data scientists to rigorously analyse the backlog waiting lists with a view to reducing the risk of over-treatment

2.26 We think that there is an opportunity to engage clinicians and data scientists in analysing the waiting list, focusing in particular on reducing the amount of unwarranted variation and risk of over-treatment and harm. There are two main opportunities here:

a **procedures that are not normally undertaken**: where there is scope to develop a Wales wide list of which procedures have low clinical effectiveness and to do some analytical work looking at which patients are currently on a list for those procedures;

b **reducing variation across common activity**: where there is scope to compare waiting lists within health boards and across Wales to identify variation in rates of intervention for common procedures, which could indicate signs of over-treatment

2.27 Both pieces of analysis should be used to inform and, if necessary, challenge clinical decision making and ensure the conversation between clinicians and patients is centred around what matters and what is right for the patient.

Promote prevention, self-care and behaviour change to reduce respiratory illnesses in particular and protect NHS capacity over the autumn/ winter months

2.28 Each year, the NHS faces big challenges during the winter. Although this pressure is mostly felt in unscheduled care, it has knock-on consequences for planned care where operations are suspended or cancelled. In large part, these extra winter pressures are driven by flu and other respiratory conditions.

2.29 As a result of coronavirus, there has been a significant change in public behaviour in ways that could help reduce the spread of flu and other seasonal respiratory illnesses. We think there is an opportunity to invest in promoting strong public health measures and messaging to encourage continued hygiene measures social distancing and having clear plans to safely ramp up flu vaccination rates. We also think there is scope to expand the idea of self-isolation and self-care when you have early signs of any viral infections, not only suspected COVID. Such behaviours could help reduce the spread of flu and help protect NHS capacity during the difficult winter months.

Appendices

1 Audit methods

1 Audit methods

We have based the messages in this report on work we undertook to follow-up our 2015 reviews of waiting times for NHS elective care and orthopaedics services. The work was largely carried out over a 14 month period ending January 2020. Following the outbreak of COVID, we adjusted our reporting plans to take into account the impact of the pandemic on NHS planned care, and emergency recovery planning, nationally and locally. We have used discussions with Welsh Government officials and members of the Department for Health and Social Care's Quality Delivery Board to help test and shape our messages.

Further information on our audit methods is set out below.

Waiting Times for Elective Care Follow-up

- Self-assessment: we asked the Welsh Government to complete a self-assessment of progress against a range of areas related to our 2015 recommendations.
- Interviews with Welsh Government officials with responsibility for planned care within the Welsh Government.
- Interviews with a sample of health board executives with responsibility for planned care, in particular to gather their views on progress with the national planned care programme.
- We reviewed a range of documents, including Welsh Government correspondence with the Public Accounts Committee in relation to NHS waiting times, Welsh Government published plans, including the national strategy for the NHS A Healthier Wales. We also reviewed a range of internal documents that the Welsh Government provided as part of its self-assessment.
- Data analysis: we reviewed published data on the length of time people wait for treatment, as well as published data on activity and efficiency measures.

Orthopaedic services follow-up

Our work examined progress in each health board as well as national developments in respect of orthopaedic services. Collectively this involved:

- analysis of publicly available data sets and additional data from health boards;
- observations at relevant national meetings such as the Welsh Orthopaedics Board and Planned Care Programme Board;
- interviews with Welsh Government officials and relevant staff within health boards, typically the executive lead for orthopaedic services, clinical director and general manager for orthopaedic services, and the orthopaedic triage lead;
- a review a range of national and local documents, plans and reports.
- surveys of all health boards to capture qualitative information on orthopaedic services;
- A 'pathway walkthrough' at each health board to understand the process and issues faced on a day-to-day basis both by staff and patients; and
- focus groups with a range of staff involved in the orthopaedic pathway.

Reports setting out the key findings from our local orthopaedic work will be shared with individual health boards during autumn 2020, alongside a national summary of the key messages from this work.

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