The importance of a prudent approach to planned surgical services in Wales

Authors
Peter Lewis, Consultant, Aneurin Bevan University Health Board, with support from Leighton Phillips, Deputy Director of Strategy and Planning, Department of Health and Social Services, Welsh Government

Introduction

Following the Minister for Health and Social Service, Mark Drakeford's speech about prudent healthcare at the Welsh NHS Confederation conference in January 2014, I have been considering the implications for surgical practice in my role as divisional director for scheduled care at Aneurin Bevan University Health Board.

Aneurin Bevan University Health Board was chosen by Professor Drakeford as one of the pilot sites to test the application of the prudent healthcare principles in orthopaedics. The findings from this work, coupled with my 20 years’ experience as a surgeon, have resulted in the thoughts set out in this chapter.

With more than 230,000 elective procedures - inpatient and day case - undertaken by the Welsh NHS every year, the opportunity for applying the prudent healthcare principles becomes immediately clear.

Writing this chapter was a timely opportunity, particularly as I take up my role as clinical director of the national planned care programme.

Defining prudent healthcare in surgery

When I first heard about prudent healthcare, I wanted to understand what it really meant for surgical practice in NHS Wales.

The word prudent is derived from the Latin prudens meaning farsighted. The Oxford English Dictionary defines prudent as sensible, sound judgement, following the most profitable course.

The implications for planned surgical services in Wales are therefore fourfold.

1. Making the best use of resources

Prudent healthcare implies that only services which provide the best value for money should be offered by the Welsh NHS. A value for money assessment requires looking at service quality and cost. But we know that, just like other healthcare systems, in parts of the Welsh NHS, procedures
are still performed which are both costly and do not have a significant impact on clinical outcomes or a patient’s quality of life.

Recent research by the Academy of Royal Colleges [1] has highlighted how avoiding waste and promoting value are about the quality of care provided to patients. This should be a doctor’s central concern. One doctor’s waste is another patient’s delay or potentially lack of treatment. Protecting resources and promoting value is therefore important at any time. When resources are increasingly constrained - and likely to become more so in the future - this becomes a necessity. But promoting value for money is not simply about cost; it is about supporting doctors and other clinicians to ensure NHS resources are used in the most effective way possible to provide the best possible quality and quantity of care for patients.

The Academy's report also estimated around 20% of mainstream clinical practice brings no benefit to the patient as there is widespread overuse of tests and interventions. If a value-for-money test was applied today in Wales, how many of the 230,000 elective procedures undertaken by the NHS in Wales would be considered appropriate? What might that mean for those waiting for treatment?

2. Changing service models

Much of today's healthcare management is focused on maximising productivity and efficiency - doing things better within current models. In a healthcare system under considerable pressure, prudence implies we need to change service models to achieve sustainability.

The recent report by the Nuffield Trust, A Decade of Austerity in Wales? [2] about the funding pressures facing the NHS in Wales to 2025-26 powerfully demonstrates the limited time available to both the NHS and to policy makers in Wales to make the necessary changes to service models so we can continue to provide safe, sustainable and high-quality services over the course of the next 10 years.

For surgical services, the implications may include thinking about optimising the opportunities for developing centres of excellence, sometimes on fewer sites, as well as considering alternative care pathways for individuals who are likely to receive similar, and sometimes better, outcomes from non-surgical care.

3. Taking a balanced approach

There is no magic bullet, which will lead to sustainable high-value services. The experience in Canterbury, New Zealand, has demonstrated that prudence relies on a systems approach involving the whole of the patient pathway.
The health board for the South Island’s largest and most populous region has moved from a position where, in 2007, its main hospital in Christchurch regularly entered gridlock - with patients backing up in its emergency department and facing long waits as the hospital ran out of beds - to one where that rarely happens [3].

Waiting times for elective surgery are down. GPs have been provided with direct access to a range of diagnostic tests. This has shortened the wait for them, in some cases dramatically. As a result growing numbers of patients arrive for outpatient appointments already worked up - with their need to see a specialist established.

A range of conditions that once were treated purely or mainly in hospital are now provided in general practice - for example, the removal of skin lesions in a country with a high incidence of skin cancer, and treatment for heavy menstrual bleeding. The Canterbury health system can claim it has saved patients more than a million days of waiting for treatment in just four clinical areas in recent years.

Good system design and a focus on patient value has also brought about financial benefit. A health system that in 2007 was almost NZ$17m in deficit on a turnover of just under NZ$1.2bn was in 2010-11 on track to make an NZ$8m surplus.

4. Focusing on the patient experience

Professional involvement remains a cornerstone of service delivery. However, the prudent approach places most emphasis on the patient experience. The goal of using patient experience to achieve best use of resources requires a form of co-production involving not only clinical and patient-reported outcome measures but patient involvement in service redesign and improved patient decision making.

This cultural shift - similar to that achieved in Alaska with the Nuka System of Healthcare [4] - is fundamental to the prudent healthcare approach. It also gives the prudent healthcare approach to surgery described within this paper its Welsh moniker of Grymuso Cleifion, the empowered patient.

How do we make prudent healthcare happen in relation to planned care services?

I am proposing we take four steps:

1. Continue to develop a strong prudent planned care programme

This is perhaps an unsurprising suggestion, given my new role as clinical director of the planned care programme for Wales but I am using this chapter to set out its key components.
The enduring austerity we face in public finances and increased demand on our health services means that continuing to change services in an incremental and piecemeal manner is no longer an option. A carefully-designed programme for planned care will avoid this and has the following three components, which are described in greater detail in the following four sections:

1. Integrate Care Systems
2. Measure the Value Added to Patients' Lives
3. Prioritise by Clinical Need

The key question on the practical actions which follow should be - can we use the planned care programme to deliver one approach for NHS Wales?

2. Prioritise by clinical need

The current system is predicated on waiting lists, with patients assuming their place in a long queue of people waiting to see a specialist, often with only limited consideration of relative need. Grymuso Cleifion seeks to transform this approach.

Prioritising by clinical need represents a consensual judgement on which pathways patients with surgical conditions should follow. It is based not only on the speed with which patients should access surgical services but a judgement about the risks and benefits of surgery and a more holistic approach to patient wellbeing.

As an initial practical step, all health boards and NHS trusts should ensure they - and their surgical teams - adhere to National Institute for Health and Care Excellence (NICE) “do not do” guidelines [5] and those guidelines which cover interventions not normally undertaken, which are already in the public domain. Each local health board in Wales publishes their Interventions Not Normally Undertaken (INNU) policies on their website. Public Health Wales provide a useful overview of these policies. These have been developed following a high-level of clinical engagement.
The development and implementation of clinically-appropriate guidelines can have a substantial and quick impact on practice. For example, the Scottish Intercollegiate Guidelines Network (SIGN) developed a national clinical guideline for the management of sore throat and indications of tonsillectomy [6]. The guideline aims to ensure that patients experiencing unacceptable morbidity, inconvenience and loss of education and earnings as a result of sore throats are prioritised over those with relatively minor and self-limiting conditions. The guideline covers the whole pathway of care including diagnosis, pain management, antibiotic use, indications for surgical management and post-operative care for acute and recurrent sore throat in adults and children.

By focusing on the right things and putting clinical need central stage, its acceptance and implementation by clinicians has been significant. Independent research found that 84% of clinicians surveyed felt they adhered to the guidelines in their practice [7].

The planned care programme in Wales will be considering how similar guidelines can be developed or refined for health boards and NHS trusts, alongside the development of an approach to ensure compliance.

Clinical value prioritisation is, of course, about more than adherence to guidelines. In many elective services, patient enrolment provides a teachable moment in which the broader health risks and holistic needs of individual patients may be agreed and optimised. This particularly applies to the so-called lifestyle challenges of obesity and smoking, which not only affect the risk of peri-operative complications and length of stay but also threaten a person's general quality of life and longevity. The peri-operative period is the the duration of a patient's surgical procedure; this commonly includes ward admission, anaesthesia, surgery, and recovery. We must take every opportunity to understand what would add value from a patient’s perspective before selecting a course of action together.

The Welsh Health Specialised Services Committee's (WHSSC) commissioning policy for bariatric surgery has been developed with these points in mind [8]. Bariatric surgery is designed to reduce weight and to help an individual maintain weight loss by restricting their body's ability to intake and absorb food. It is well recognised that the success and benefits from surgery will be improved if patients are encouraged to modify their eating habits and commit to daily exercise as part of a wider change in lifestyle.

Therefore, the policy sets out referrals will only be considered if:

- The individual is aged 18 years or over;
- The individual has a body mass index of 40 or more;
- Morbid/severe obesity has been present for at least five years;
- The individual has received, and complied with, an intensive weight management programme at a multi-disciplinary weight management
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- A clinic (level two or three of the All Wales Obesity Pathway) for at least 24 months duration, but has been unable to achieve and maintain a healthy weight;
- The individual is approved for surgery by the bariatric multidisciplinary team (MDT) at the Welsh Institute of Metabolic and Obesity Surgery.

3. Adopt a meaningful approach to advancing integrated care

Integrated care relates to the structures which enable patients to access the most suitable and appropriate services and, in doing so, provide them with the ability to make an informed choice about the options available.

For many patients, the key point in their illness is when consideration is being given to a referral for surgical treatment. At this time they require:

- Access to information about their illness and the treatment options;
- Methods to enable optimum decision making;
- The best environment in which they can openly discuss and make decisions about the important and sometimes life-changing decisions about their treatment requirements;
- The knowledge, skills and confidence to manage their own health and healthcare. This is often referred to as "patient activation" [9].

This last point is particularly important as it has been demonstrated that people who have low levels of activation are less likely to play an active role in staying healthy. They are less good at seeking help when they need it; at following a doctor’s advice and at managing their health when they are no longer being treated. Their lack of confidence and their experience of failing to manage their health often means they are less likely to think about it.

Patients with low activation levels are more likely to attend A&E departments; to be hospitalised or to be re-admitted to hospital after being discharged. This can lead to higher costs.

A study following diabetes patients over a six-month period found that more activated patients were more likely to perform foot checks, obtain eye examinations, and exercise regularly than less activated patients [10]. Another of patients’ adherence to physical therapy regimens after spine surgery found that more highly-activated patients were more adherent to and engaged in their physical therapy than less activated patients [11].

It follows that for planned care services, patient activation is a key concept to help us understand the co-production principle of prudent healthcare. To make prudent healthcare happen, health boards should give urgent consideration to how they use:

- Patient forums;
Patient activation, measurement, and decision-making tools;
Structures in primary care (surgical interface clinics) which can direct patients to the most appropriate service.

Local decisions about how these structures are provided; the mechanisms to help patients navigate the healthcare system and the performance of these systems should be provided by clinical groups of primary and secondary care clinicians supported by management and expert patients.

For a limited number of clinical areas - starting with orthopaedics, ENT and ophthalmology - the planned care programme will be doing precisely this.

4. Measure the value added to patients’ lives

The challenge to those providing surgical services in Wales should be to measure those things that add the most value to patients' lives. Wherever possible, health services in Wales should also match or exceed the value-for-money comparators of services delivered by top performing organisations across the UK and beyond.

To aid comparison, all surgical services should adopt key quality measures which describe both the high-volume and high-risk procedures with an expectation that they include or make reference to UK national outcome measures and the International Consortium for Health Outcome Measurement (ICHOM) - a pan-European, not-for-profit organisation with the purpose to transform healthcare systems worldwide by measuring and reporting patient outcomes in a standardised way.

The costing methods employed will depend on the service or pathway assessed but should include health resource group costs, with comparisons against both Welsh providers and English standard costs associated with treatment. Healthcare Resource Groups (HRGs) are standard groupings of clinically similar treatments which use common levels of healthcare resource. Systematically considering HRGs, will help organisations to understand their activity in terms of the types of patients they care for and the treatments they undertake. They enable the comparison of activity within and between different organisations and provide an opportunity to benchmark treatments and services to support trend analysis over time.

Failing to adhere to agreed pathways must frequently produce a poor patient experience but may also increase costs indicating poor value for money.

Key points

My chapter identifies how applying the prudent healthcare principles to surgery provides an opportunity to move from incremental change to system
redesign with the potential to add value to a significant number of patients’ lives. The national planned care programme will focus on prioritising by clinical need; integration and measuring success through a value for money assessment that embodies cost and quality. Making the programme happen will be key if we are going to continue to provide safe, sustainable, and high-quality surgical services. Pace is important and, as such, national support and leadership for the programme is required.
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References