WHC/2015/034

WELSH HEALTH CIRCULAR

Issue Date: 29 July 2015

Llywodraeth Cymru
Welsh Government

STATUS: FOR ACTION

CATEGORY: POLICY

Title:

NATIONAL ORTHOPAEDIC IMPLEMENTATION PLAN

The planned care programme has developed an integrated national implementation plan for orthopaedics.

Date of Expiry : September 2017

For Action by:
Local Health Boards
NHS Trusts

Action required by:
September 2015

Sender:
Rebecca Jones

DHSS Welsh Government Contact(s) :

Olivia Shorrocks
Head of Major Conditions
Delivery and Performance Division
FFon / Tel: 0300 062 5545
E-bost / E-mail: Olivia.shorrocks@wales.gsi.gov.uk

Enclosure(s):
National Orthopaedic Implementation Plan

Yr Adran Iechyd a Gwasanaethau Cymdeithasol
Department for Health and Social Services

Llywodraeth Cymru
Welsh Government

Our ref: A11411991

Date 29 July 2015

In December 2013 the Minister for Health and Social Services announced his intention to establish a Planned Care National Work Programme for NHS Wales.

"Our planned care system is also facing challenges. Some of these are a consequence of the pressure in our unscheduled care system. However, others relate to working practices and delivery arrangements. Whilst there are many areas of strength, there are others which now need to be modernised. There is a need for significant and urgent change I have therefore decided to replicate the model introduced last year for Unscheduled Care through a National Planned Care Programme"

In April 2014 it was confirmed that Chris White, Chief Operating Officer, Cwm Taf Health Board, would be the Executive lead for the Planned Care Programme and would be supported by Welsh Government and the Programme Management Unit.

In September 2014, Peter Lewis was appointed as the National Clinical Lead for Planned Care and will be seconded to work on the Programme for three days a week. He is supported by the Welsh Government.

A Planned Care Programme Board has been established. The Chief Executive on the Board representing the Chief Executives is Judith Paget. The sponsoring group is the NHS Chief Executives Group.

The Planned Care Programme Board identified orthopaedics as one of its top three priorities, where urgent action is needed to ensure the development of a sustainable service. Orthopaedics is the biggest single planned care service in Wales, where demand for treatment is increasing significantly for reasons including: ageing population, growing levels of obesity and advancements in clinical practice which has lead to unacceptably long waits.

The "National Planned Care Programme: National Orthopaedic Implementation Plan" pulls together all the requirements for orthopedics in a single place and presents the actions for health boards within the three drivers of the programme: integrated care, clinical value prioritisation and best in class.

Regards

Peter Lewis
National Planned Care Clinical Lead

Parc Cathays • Cathays Park
Caerdydd • Cardiff
CF10 3NQ

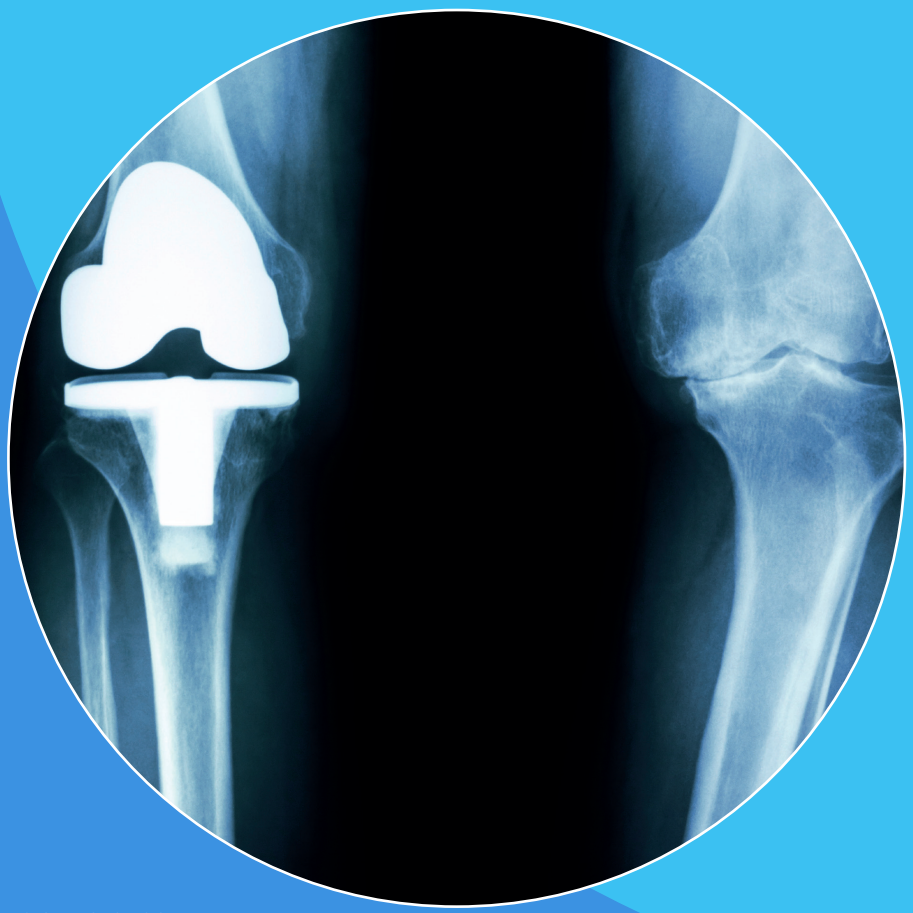
GIG CYMRU NHS WALES

Llywodraeth Cymru
Welsh Government

www.gov.wales

Planned Care Programme

Wales National Orthopaedic Implementation Plan



WG25586 Digital ISBN 978 1 4734 3772 2

1. **Summary**

The purpose of the National Orthopaedic Implementation Plan is to optimise patient experience and outcomes, whilst delivering a sustainable service. The plan builds on a series of developments in Wales to provide effective and efficient planned care for implementation by health boards across Wales.

The plan requires health boards to measure and understand demand and capacity for the main subspecialties in orthopaedics.

The three primary drivers for service change will be:

- Clinical Value Prioritisation - making sure that only the right patients are managed in secondary care.
- Integrated Care - establishing collaborative care groups (between hospital, community and primary care) and empowering patients to manage their health.
- Best in Class - measuring value for money and benchmarking against top performing organisations.

The plan has been developed by the planned care programme board after stakeholder consultation and contains fifteen key actions for health boards to implement.

The plan is issued as a Welsh Health Circular (WHC/2015/034). Health boards' delivery against the plan will be reviewed at each meeting of the Welsh Orthopaedic Board.

The plan will be supported by advice and recommendations from the planned care reference groups with involvement and support from patients and the third sector.

2 Background

2.1 National planned care programme

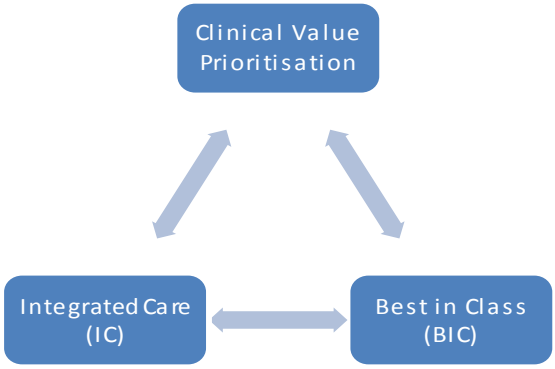
The purpose of the national planned care programme is to:

- Provide “sustainable” planned care services.
- Optimise patient experience of using planned care services.

2.2 How will change be achieved?

The planned care programme requires measurement and management of demand and capacity in each of the major subspecialties.

The programme will employ a balanced service change approach based on the three primary drivers of clinical value prioritisation, integrated care and best in class.



Clinical Value Prioritisation will include:

- Identification and eradication of NICE “do not do” and “interventions not normally undertaken”.
- Evidencing agreed pathways of care to ensure correct thresholds of care and management of variation.
- Agreeing urgent and priority patient groups.
- Taking a holistic approach to patient care including life style modification.

Integrated Care will include:

- Establishing effective systems in health boards (collaborative care groups) bringing together primary and secondary care clinicians with management support and patient input with agreed terms of reference to ensure that the "right patient is in the right place at the right time".
- Providing patient empowered entry into the planned care system incorporating education, decision-making aids and a supportive environment for decision-making and a range of treatment options and ongoing care arrangements.

Best in Class will include:

- Establishing outcome measures for each planned care service.
- Measuring the cost of providing services using pathway specific tools, ensuring efficient and effective use of resources.

The National Planned Care Programme will be delivered according to "managing successful programmes" protocol and will be monitored by a national programme board.

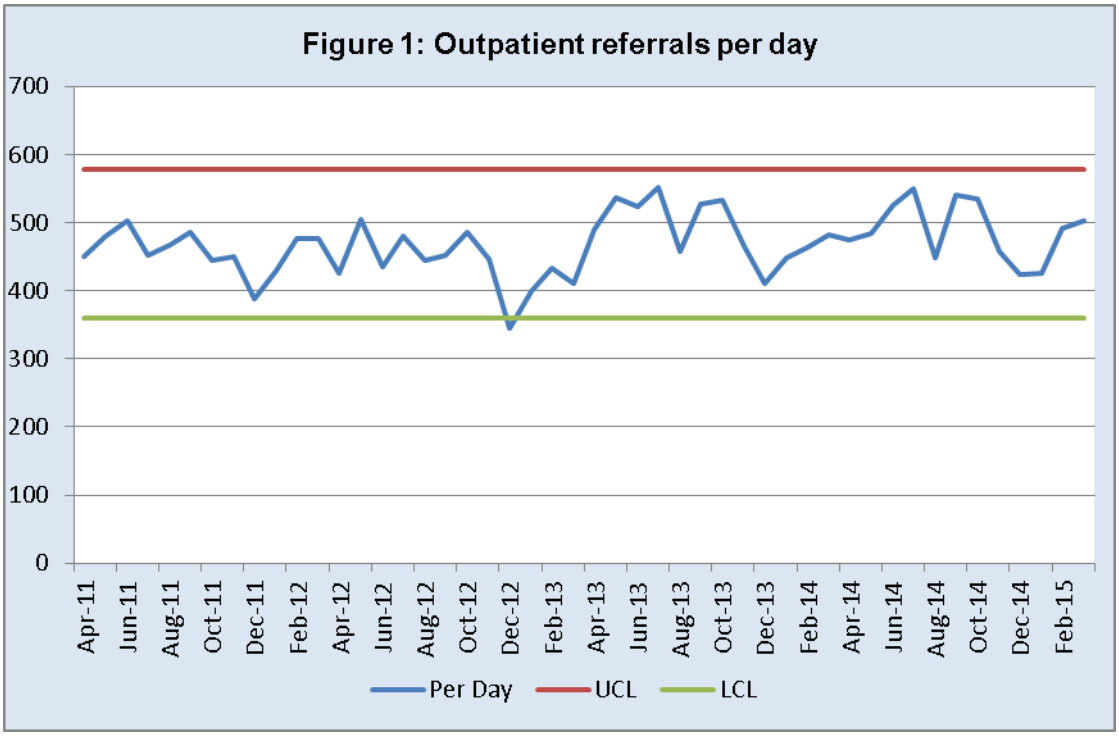
Each national service implementation plan will be delivered by individual health boards and reported through national specialty boards. The programme will be supported by expert reference groups and will rely on patient involvement with contribution from third sector organisations.

2.3 Changes in orthopaedic services

Our planned care system is facing challenges and there is a need for significant and urgent change[1].

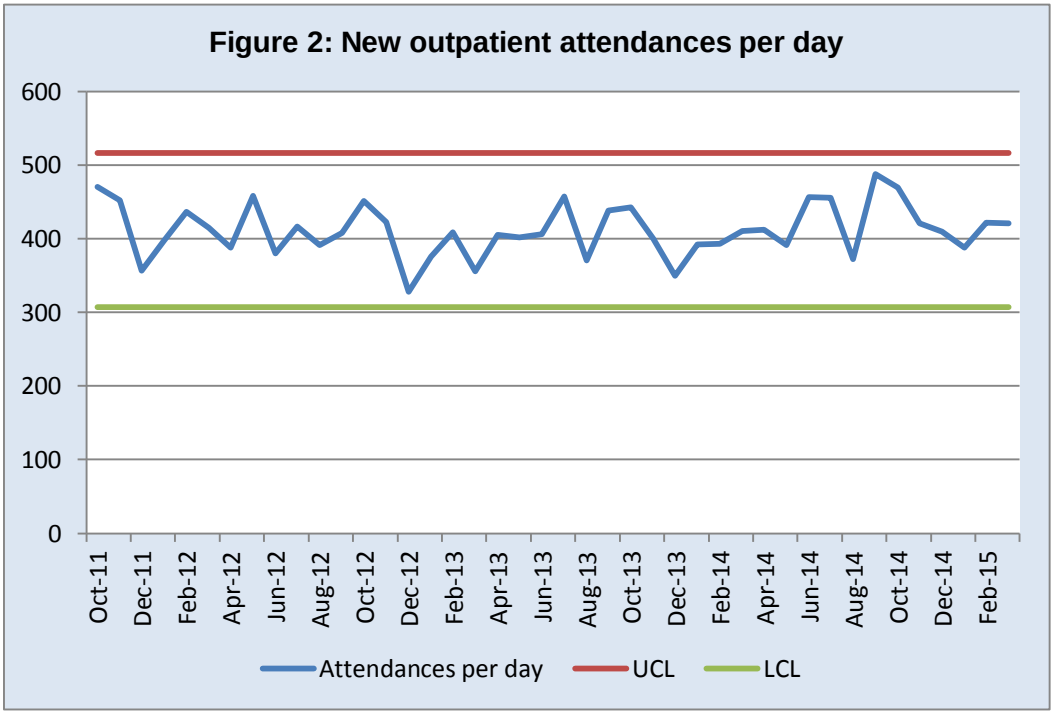
Orthopaedics is the biggest single planned care service in Wales. There are over half a million trauma and orthopaedic outpatient consultations recorded per year. This activity generates approximately 40,000 elective treatments per annum[2].

The total number of referrals received (for trauma and orthopaedics) in the last three years has increased slightly, however this difference appears to be well within the bounds of normal variation and does not appear to indicate a sustained increase in the rate of referrals (figure 1)[3]. This is despite population increases and the assumption of a higher incidence of degenerative joint disorders in an increasingly elderly population.



During this time, orthopaedic outpatient activity (attendances) has remained at a consistently lower level than the demand (figure 2)[4] and has shown little change over the last three years. This consistent gap would potentially produce a large cumulative deficit.

[1] http://gov.wales/about/cabinet/cabinetstatements/2013/plannedcare/?lang=en
[2] Orthopaedic activity :The Patient Episode Database for Wales (PEDW) 2014-2015
[3] NHS Stats Wales
[4] NHS Stats Wales



Whist the data above suggests a gap between demand and activity, the true gap is obscured by the difficulty in disaggregating fracture clinic activity from outpatient data related to GP and consultant-to-consultant referrals (which also include trauma referrals). In addition, the demand data may be skewed by administrative factors such as ROTT (removal for reasons other than treatment) and changes to the data capture system in 2013.

This demonstrates the need for local systems to adapt to enable accurate determination of true demand against activity for each of the different outpatient streams. However, it is still likely that there is a considerable underlying gap between demand and core capacity particularly since much of the new outpatient activity is "additional" (backfill / waiting list initiative).

The impact of a probable demand and capacity imbalance in outpatients is compounded by declining treatment rates during a similar period. During that time, day case rates have remained constant but in patient activity has declined significantly (figure 3 & 4)[5]

[5] NHS Stats Wales

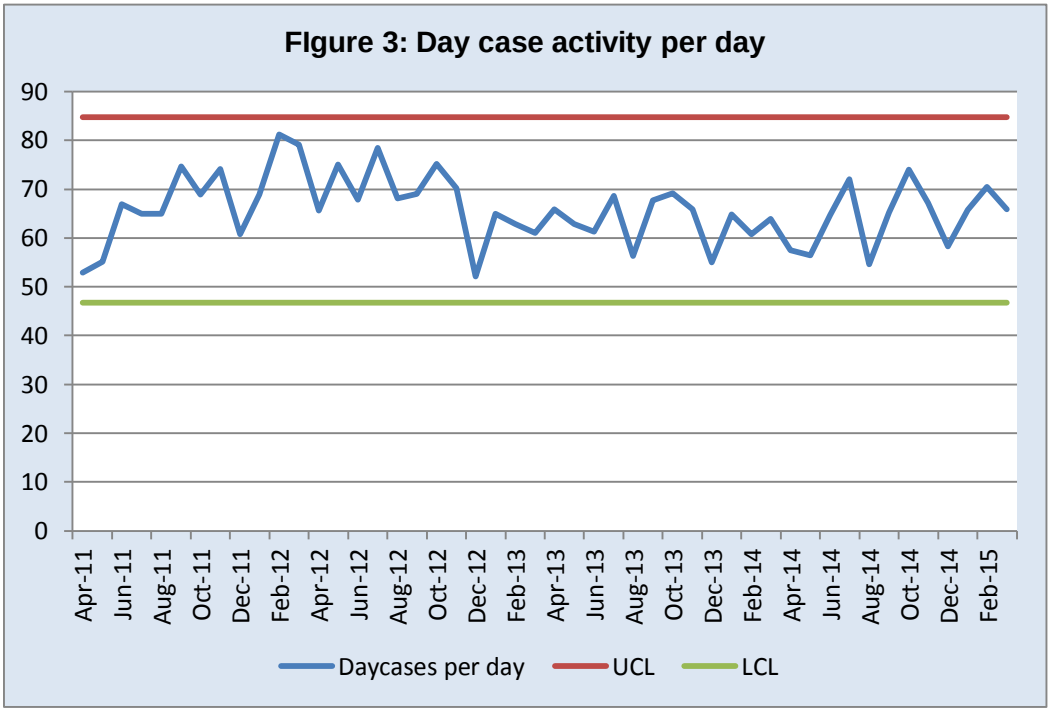


FIgure 3: Day case activity per day
90
80
70
60
50
40
30
20
10
0
Apr-11
Jun-11
Aug-11
Oct-11
Dec-11
Feb-12
Apr-12
Jun-12
Aug-12
Oct-12
Dec-12
Feb-13
Apr-13
Jun-13
Aug-13
Oct-13
Dec-13
Feb-14
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15
Daycases per day
UCL
LCL

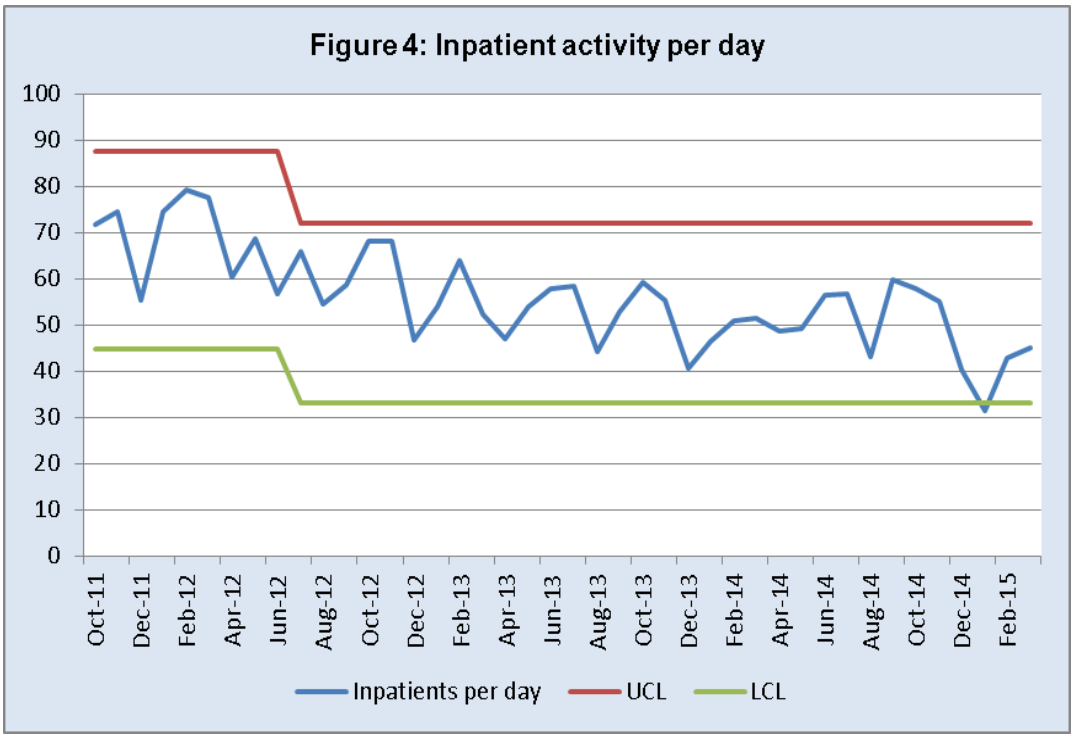
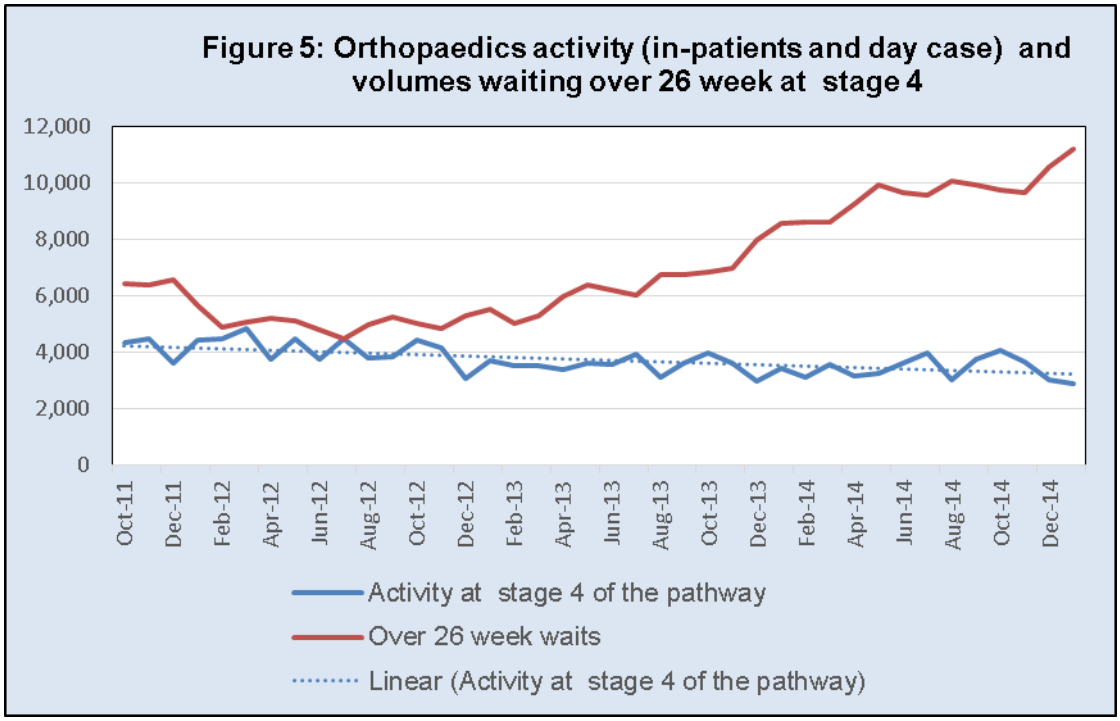


Figure 4: Inpatient activity per day
100
90
80
70
60
50
40
30
20
10
0
Oct-11
Dec-11
Feb-12
Apr-12
Jun-12
Aug-12
Oct-12
Dec-12
Feb-13
Apr-13
Jun-13
Aug-13
Oct-13
Dec-13
Feb-14
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15
Inpatients per day
UCL
LCL

Whatever the causes of this reduction in treatment numbers the impact on RTT has been significant as highlighted in figure 5[6].



There appears to be both a requirement to change the service model for orthopaedics as well as an urgent requirement to improve capacity.

The National Orthopaedic Implementation Plan addresses the need for service change building on previous national orthopaedic developments as well as the prudent health care principles described by the Bevan Commission and adopted by NHS Wales.

Clinical value prioritisation is based on the prudent health care principles of

- "do only what is needed, no more, no less; and do no harm"
- "reduce inappropriate variation using evidence based practises consistently and transparently"
- "care for those with the greatest needs first"

[6]NHS Stats Wales

There is a growing consensus around using presentation with musculoskeletal disease (as with many other conditions requiring elective treatment) as a “teachable moment” for modification of lifestyle factors that not only adversely affect the comorbidity associated with surgery but also long term survival.

Integrated care is based on the principle of achieving “*health and wellbeing with the patient and public as equal partners through co-production”*. The National Orthopaedic Implementation Plan aims to remodel the relationship between user and provider by empowering patients to become more confident in making the correct treatment decision using a variety of related approaches including patient “activation” decision support tools and a suitable physical environment.

Finally the principle of *“making the most effective use of all skills and resources”* addresses methods of measuring quality and costs of services, making the concept of “value for money” real and transparent thus enabling health board to develop actions to match top performing services and organisations.

The National Orthopaedic Implementation Plan is a service change initiative that builds on these new approaches to develop sustainable services with optimal patient experience.

3. The National Orthopaedic Implementation Plan

3.1 Measuring outcomes

The purposes of the planned care programme are to optimise patient experience and outcomes and provide sustainable services.

Patient reported outcome measures (PROMS) provide a patient focused “high level” measure of orthopaedic services. PROMS have been validated and are already in use in the UK. As a minimum, health boards will collect data preoperatively and 1 year following major joint surgery.

The Welsh Orthopaedic Board will make a recommendation (via the Planned Care Programme Board) concerning any IT solution that will facilitate management of PROMS.

The National Orthopaedic Implementation Plan also aims to optimise patient experience using a standard measure of patient reported experience measure (PREM “Orthopaedics”) which will be developed in a collaboration between the Welsh Orthopaedic Board and the Community Health Council.

In order to magnify the focus on quality of orthopaedic services, clinical outcomes and risk assessments will also be incorporated in the implementation plan to provide assurance that orthopaedic services in Wales are being delivered to the highest quality possible. These are described in “best in class” below.

The concept of a sustainable service will be managed by measures of capacity and demand.

In order to demonstrate progress towards a “sustainable” service, each health board will adopt a standard national data set for each of the orthopaedic subspecialties at the high-level pathway points of “new” outpatients, diagnostics, treatment and “follow-up” outpatients for the following subspecialties:

- Major joint
- Shoulder
- Hand
- Foot and ankle
- Back

Action 1 - Health boards will put in place systems to collect patient reported outcome measures for major joint surgery.

Action 2 – Health boards will put in place systems to measure and report "capacity and demand" according to an agreed set of national (all Wales) parameters for each of the pathways above.

3.2 Clinical value prioritisation

3.2.1 Do not do

Prudent healthcare principles encourage clinicians to "do no harm". The list of procedures that clinicians should avoid includes NICE do not do's, "interventions not normally undertaken" (INNU) and health board decisions on procedures that should not be undertaken. This list will include:

- Arthroscopic lavage and debridement (unless there is a clear history of locking).
- The use of glucosamine, chondroitin and rubefactants in osteoarthritis.
- Any radiology requests for non specific back pain without red flag signs.
- Therapies (including laser, interferential, ultrasound TENS and facet joint injections) in patients with non-specific lower back pain.

Action 3 - Welsh Orthopaedic Board will review and where necessary amend the list of "do not dos" to health boards and review responses from the Medical Director or Chief Executive Officer.

Action 4 - Health boards will undertake a waiting list "validation" to remove patients on the waiting list who don't require an outpatient appointment or who don't need treament.

3.2.2 Thresholds

The prudent health care principle involves carrying out only the necessary interventions while focusing upon a smaller number of areas with greater impact and outcomes.

Health boards must commission one "surgical" follow-up appointment after routine hip and knee replacement surgery which is expected to be between 6 weeks and 3 months after surgery (unless there are exceptional circumstances). This is accepted practice in other UK health systems. Ongoing out-patient review after this appointment should not be offered. Further assessments should be on a virtual review basis to include imaging and validated PROMS.

In view of the impact of factors such as age and prosthesis type, the WoB will consider national adoption of a risk stratification tool, which will inform the regularity of follow up.

Patients, and their GPs, should be made aware of the post – operative symptoms that suggest a referral for orthopaedic assessment would be appropriate.

There is increasing evidence from Scotland[7] and work undertaken at Aneurin Bevan University Health Board that many patients referred from the Emergency Department may not require a fracture clinic appointment.

Health boards will establish systems to **monitor referrals from Emergency Departments** including virtual outpatient systems where necessary.

The national implementation plan involves transfer of the care of patients with non-specific lower back pain to **community based back pain services**; only those patients exhibiting "red flag" symptoms or signs will be referred to secondary care.

In addition, patients with **carpal tunnel syndrome** will be referred for surgical consideration only if they have experienced symptoms for longer than 3 months and have used wrist splints at night for at least 8 weeks. Neurophysiology testing should

[7] "Fracture Clinics for the Future" www.fractureclinicredesign.org/

not be provided routinely. Routine follow-up for this group of patients should not be necessary.

Action 5 – Health boards will measure and report the number of follow-up appointments per patient after hip and knee replacement as well as adherence to the new policy on long term follow-up for major joint surgery directed by the Welsh Orthopaedic Board.

Action 6 - Health boards will establish systems to manage referral of patients from the Emergency Department to fracture clinic and report changes in patient flows.

Action 7 - Health boards will establish community based services for patients suffering with "non specific" lower back pain and report changes inpatient flows.

Action 8 - Health boards will measure and report the numbers of carpal tunnel procedures performed and follow-up appointments offered on a rolling six monthly basis.

3.2.3 Urgent and priority groups

Most elective orthopaedic patients do not require immediate assessment and the success of their treatment is not influenced by waiting times (unless the wait is excessively long).

However, some patients require urgent assessment either because they have acute injuries that do not require emergency admission or treatment or the timing of surgery is critical. The composition of this "urgent" group will be determined by the Welsh Orthopaedic Board.

Health boards will ensure that all patients categorised "urgent" are seen within 6 weeks of GP referral. When sustainable services are achieved, there should be no need for other urgent categories.

All other elective orthopaedic referrals will be designated routine unless authorised by the collaborative care groups.

Action 9 - Welsh Orthopaedic Board to determine criteria for the urgent category in elective orthopaedics and health boards to put in place systems to provide a maximum 6 week outpatient service.

Action 10 – Health boards to report the Primary Targeting List Scores (PTLS) for routine treatments.

3.2.4 Holistic care

Lifestyle factors can have an impact on the functional results of some elective surgery. In particular, smoking is well known to affect the outcomes of some foot and ankle procedures[8].

In addition, many studies have shown that the rates of postoperative complications and length of stay are higher in patients who are overweight or who smoke.

Furthermore, the mortality rate of patients undergoing elective major joint surgery is approximately 20% at 10 years after surgery, many succumbing to smoking and weight related conditions[9].

Therefore, to ensure optimal outcomes, all patients who smoke or have a body mass index of 35 or greater and are being considered for referral to secondary care, should undergo smoking cessation and weight reduction management, prior to surgery.
In order to enable this health boards should:

- ensure that there are a suitable range of stop smoking and weight reduction support service available to local communities
- appropriate referral mechanisms exist

Since failure to engage with these “preventive services” may influence the immediate outcome of surgery, compliance rates will be monitored in each health board. Failure to quit smoking, or lose weight will not be a contraindication for surgery but patients will be fully informed of the risks associated with the procedure in the context of their life style.

---

[8] Ishikawa SN, Murphy GA, Richardson EG. The effect of cigarette smoking on hindfoot fusions. Foot Ankle International, 2002; 23 (11): 996–8.
National Institute for Health and Care Excellence Commissioning a smoking cessation service for people having elective surgery.

[9] http://www.boneandjointburden.org/2014-report

Action 11 – Health boards will report the number of patients who smoke or have a BMI>35, the proportion that complete either a stop smoking or weight reduction programme prior to elective surgery and the proportion who successfully stop smoking or achieve their weight reduction target.

3.3 Integrated care

3.3.1 Collaborative care groups

New structures (collaborative care groups) are required in each health board to manage the flow of patients between primary and secondary care. Some systems already exist such as the musculo-skeletal referral service in Betsi Cadwaladr University Health Board (CMATS).

Each health board will be required to establish an appropriate collaborative care group. This arrangement will vary across health boards dependent on local arrangements; however, the service will have to demonstrate the following functionality:

- Triage referrals before submission to secondary care.
- Provide life style services for all patients who smoke or have a BMI over 35.
- Establish services to improve patient activation and decision-making (using option grid scoring systems).
- Provide the capability to measure patient flow in to secondary care, patient activation (PAM) and decision quality measure (DQM).

While it will be the responsibility of each health board to establish their own collaborative care groups, there will be standard national terms of reference (ToR) which will include monitoring progress against the National Orthopaedic Implementation Plan.

Action 12 - Each health board will establish an orthopaedic care collaborative group in accordance with national ToR with a view to improving the management of patient flow and to facilitate delivery of the National Orthopaedic Implementation Plan.

3.3.2 Patient empowerment

There is abundant evidence that patient activation improves outcomes and decision support tools enhance patient experience. Patients also benefit from a supportive environment in which to make important decisions about their health and well-being. Patients with low levels of health literacy may enjoy particular benefit from this approach.

Action 13 - Health boards will establish community systems to empower patients and report on measures of patient activation.

3.4 Best in class

Service quality is a cornerstone of the National Orthopaedic Implementation Plan. In addition to patient feedback from PROMS, Wales will embark on an ambitious programme of national quality assurance using bundles of clinical outcomes to measure performance in the different orthopaedic subspecialties, starting with knee replacement surgery.

A “bundle” of quality measures for knee surgery (including length of stay, readmission rates, infection rates and revision within 1 year) has been developed in the prudent healthcare “workshop” run by ABUHB. The Welsh Orthopaedic Board will issue a “national quality bundle” for individual health boards to assume responsibility for data collection and internal and external reporting.

It is self evident that in order to demonstrate most effective use of resources, individual services should be able to measure “value for money” in a way that allows comparison with recognised high performing services or “best in class”. The quality measures described above will therefore be set against an indicative cost for the “knee replacement” pathway which will be based on a recommendation by the “Best in Class” national reference group.

Each health board will assume responsibility for managing individual outliers. The Welsh Orthopaedic Board will support actions to improve collective outcomes in individual health boards.

Action 14 - Health boards will put in place systems to record, report and manage the knee quality bundle.

Action 15 - Health boards will establish mechanisms to estimate cost of knee replacement pathway according to a standard national methodology.

4. Reporting and collaboration

Health boards' performance against the National Orthopaedic Implementation Plan will be reported to the Welsh Orthopedic Board on a monthly basis.

The planned care programme team will work with representatives from health boards to facilitate understanding of the actions in the plan and identify where support may be necessary.

Appendix A: List of actions

Action 1 - Health boards will put in place systems to collect PROMs for major joint surgery.

Action 2 – Health boards will put in place systems to measure and report capacity and demand according to an agreed set of national (all Wales) parameters for each pathway.

Clinical Value Prioritisation

Action 3 - Welsh Orthopaedic Board will review and where necessary amend the list of do not dos to health boards and review responses from the Medical Director or Chief Executive Officer.

Action 4 - Health boards will undertake a waiting list "validation" to remove patients on the waiting list who don't require an outpatient appointment or who don't need treatment.

Action 5 – Health boards will measure and report the number of follow-up appointments per patient after hip and knee replacement as well as adherence to the new policy on long-term follow-up for major joint surgery directed by the Welsh Orthopaedic Board.

Action 6 - Health boards will establish systems to manage referral of patients from the Emergency Department to fracture clinic and report changes in patient flows.

Action 7 - Health boards will establish community based services for patients suffering with "non specific" lower back pain and report changes inpatient flows.

Action 8 – Health boards will measure and report the numbers of carpal tunnel procedures and follow-up appointments offered on a rolling six monthly basis.

Action 9 – Welsh Orthopaedic Board to determine criteria for the urgent category in elective orthopaedics and health boards to put in place systems to provide a maximum 6 week outpatient service.

Action 10 - Health boards to report the Primary Targeting List Scores (PTLS) for routine treatments.

Action 11 – Health boards will report the number of patients who smoke or who have a BMI>35, the proportion that complete either a stop smoking or weight reduction programme prior to elective surgery and the proportion who successfully stop smoking or achieve their weight reduction target.

Integrated Care

Action 12 - Each health board will establish an orthopaedic care collaborative group in accordance with national ToR with a view to improving the management of patient flow and to facilitate delivery of the National Orthopaedic Implementation Plan.
Action 13 - Health boards will establish community systems to empower patients and report on measures of patient activation.

Best in Class

Action 14 – Health boards will put in place systems to record, report and manage the knee quality bundle.
Action 15 - Health boards will establish mechanisms to estimate cost of knee replacement pathway according to a standard national methodology.