Royal College of Anaesthetists

FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists

Safe. Sustainable. Effective.

Developing a long-term plan for the NHS

A joint submission from the Royal College of Anaesthetists (RCoA) and the RCoA's Faculty of Pain Medicine

September 2018

Contents

Introduction

This joint response represents the views of the Royal College of Anaesthetists (RCoA) and the RCoA's Faculty of Pain Medicine (FPM).

The RCoA is the professional body for anaesthetists in the UK. Anaesthesia is the single largest hospital specialty in the UK, accounting for around one in six of all hospital doctors. Anaesthetists play a crucial role in the delivery of safe and effective patient care for two-thirds of all hospital patients[1] and will be critical to the sustainability of the health service for the lifetime of this plan and well beyond.[2,3,4]

The FPM is a faculty of the RCoA and the professional body responsible for the training, assessment, practice and continuing professional development of specialist medical practitioners in the management of pain in the UK.

This response is provided on behalf of a combined membership of almost 22,500 fellows and members, across the three specialties of anaesthesia, intensive care and pain medicine.

Medical Royal Colleges and Faculties remain the institutional memory of the health service, as our development mirrors changes in technology, medical knowledge and patient demand and expectation.

For anaesthetists, the development of perioperative medicine is evolving the way healthcare is delivered, changing the inpatient pathway in a way that integrates services both inside and out of the hospital walls, through a multi-disciplinary team (MDT) approach. Through perioperative medicine new concepts such as 'prehabilitation' are evolving and new links between primary, secondary and tertiary care are being formed.

Owing to the crosscutting work of anaesthetists, this submission addresses a number of the work-streams of NHS England's long-term plan. The submission covers issues that impact through the entirety of the ***Life Stage Programmes***, supporting a number of ***Clinical Priorities*** – with a focus on ***Cancer***, ***Cardiovascular and Respiratory*** – and contingent on a range of ***Enablers***, notably ***Workforce, Training and Leadership***, ***Clinical Review of Standards*** and ***System Architecture***. The delivery of perioperative medicine will be both a catalyst for **Integrated and Personalised Care for People with Long Term Conditions and Older People with Frailty (including Dementia)** and a means of facilitating a focus on **Prevention, Personal Responsibility and Health Inequalities** – particularly in the secondary care setting.

The challenge for the NHS is to structure itself in a way that facilitates not only the next generation of innovation, but also the adoption of ideas that can deliver improvements to patient care. There remains a library of insight and analysis gathering dust because either then, or now, it did not slot into the architecture of the health system. Cutting-edge information technology, artificial intelligence and the application of smartphones to support population health all present undeniable opportunities that must be embraced.

However, the NHS cannot become the 'Novelty Health Service', investing in new technologies in the hope that they will solve the fundamental problems that exist: this will be a blueprint for failure. Low morale, poor mental wellbeing and endemic risk of burnout is familiar to many of our members and fellows[5], within a system that incentivises volume and

output over quality and outcomes. The development of this long-term plan is an opportunity to change that.

This joint submission from the RCoA and the FPM provides a number of recommendations for how, over the next decade, the NHS can transform the way it delivers care and treatment for patients and the support received by the staff that provide these essential services.

Summary of recommendations

Section One: Appropriate Care and Effective Treatment

Recommendation 1: All surgical patients should be managed on a perioperative pathway of care, which incorporates appropriate interventions before surgery, the operation itself and recovery after a procedure

Perioperative medicine is a natural evolution in integrated healthcare, using existing skills and expertise to provide an improved level of patient care[6] that closely aligns with the underlying principles of the transformation agenda.

Perioperative medicine is now an essential part of the UK anaesthetic training programme reflecting the ambition for the anaesthetist of the future to perform the role of the 'perioperative physician' in the NHS.

With the evolution of perioperative care, we also want to see a cultural shift toward patient-focussed perioperative outcomes, incentivised by an appropriate payment system. A perioperative care pathway that incorporates comprehensive assessment in advance of any procedure may lead to a clinically appropriate decision that surgery is not the best option for a given patient. Also, see recommendation 2 on non-surgical treatment and 15 and 16 on the payment system and the tariff.

Recommendation 2: Clinically appropriate alternatives to surgical treatment, including the option of 'no surgery' should be explicitly discussed with all patients before referral onto a surgical pathway

This is a fundamental element of shared decision making during the perioperative period, that should involve pre-operative assessment and consultation in advance of an elective surgical or other interventional procedure. Offering 'no surgery' as a legitimate option can be clinically advantageous, support alleviation of hospital pressures and, as detailed in a recent judgement, can have legal implications regards to patient consent if not clearly communicated.[7] Also, see recommendation 6.

Recommendation 3: The Department of Health and Social Care should commission an independent review of the provision and effectiveness of public health services, with a mandate to consider the option for returning responsibility for public health to the auspices of the NHS

Underinvestment and poor coordination of public health services since becoming the responsibility of local authorities in April 2013 has undermined their ability to reduce the

prevalence of preventable disease and made the ambitions for preventive medicine in NHS England's *Five Year Forward View* all but impossible to progress.[8]

Particular focus must be placed on strategies to reduce health inequalities. Inequalities in health outcomes between the most affluent and the most disadvantaged members of society are longstanding, deep-seated and have proven difficult to change. The 'coexistence' of smoking and socioeconomic disadvantage for example, underlines the need for equity in health outcomes, acknowledging that an approach in which resources are distributed evenly and not tailored, could in fact result in less being achieved overall.[9]

Recommendation 4: We support the recommendation of the Royal College of Paediatrics and Child Health for the introduction of statutory and comprehensive personal, social and health education programmes and sex and relationship education across all primary and secondary schools[10]

The strongest determinants of child health across every indicator are social, educational and economic factors. Education is needed to equip children with the skills and knowledge to make sensible choices to lead healthy lives and reduce lifestyle-related illness in the future. Though we recognise that the implementation of this recommendation falls outside of the control of NHS England, it is important to identify where achieving the expectations placed on the NHS are determined by coordinated action across a number of government departments and areas pf policy.

Recommendation 5: All patients undergoing elective surgery should undergo a preoperative assessment that is led or overseen by an anaesthetist and that includes screening for alcohol intake, smoking, obesity and physical activity[11]

Based on a study of around 6,500 patients, 98% of patients will have a face-to-face preoperative assessment before their admission for surgery[12], however there is wide variation as to when this assessment takes place. Preoperative assessment taking place *only* on the day of elective surgery does not allow for the comprehensive 'prehabilitation' that enables optimal surgical outcomes for those patients with pre-existing conditions or modifiable risk factors, such as anaemia or poorly controlled diabetes.[13]

Recommendation 6: The Department of Health and Social Care should produce a long-term marketing strategy, supplementary to the long-term plan for the NHS in England, with the aim of enabling better self-management of personal health and decisions about an individual's own health and care

Public information campaigns that focus on personal health and social issues have been proven as a catalyst for behaviour change[14,15] and now, more than ever, they are needed to disarm harmful misinformation regarding 'rationing' of care and the trivialisation of surgical procedures.

As a member of the Academy of Medical Royal Colleges (AoMRC), we support the Choosing Wisely UK campaign and the core message that 'More doesn't always mean better'.[16] Public information should promote the four questions for patients to ask their doctor or nurse to make better decisions together:

- What are the benefits?
- What are the risks?

- What are the alternatives?
- What if I do nothing?

Over investigation, over diagnosis and over treatment can be positively harmful to patients, and improving patients' understanding of their options and healthcare professionals' understanding of a patients desired outcomes is vital.

Properly funded and accessible public health services, that are part of an integrated pathway of care, are a vital component to achieving better self-management of individual health. Also, see recommendation 3.

Recommendation 7: Equitable access to high-quality pain services must be available for all patients and include specialist pain management integrated with other key services, including psychological support

The consistent and comprehensive adoption of Core Standards for Pain Management Services in the UK (CSPMS UK)[17] that cover all aspects of pain management in all settings, would be a significant step towards better, effective care of patients with acute and chronic pain.

Integrated patient pathways between community, primary and secondary care would significantly improve patient management by reducing system delays and increase healthcare workers understanding of effective management strategies. Improved education around pain and its management for the public, healthcare professionals and policy-makers is essential if the impact of pain on individuals, and society in general, is to be reduced.

Medications (including opioids) should be optimised – including withdrawal of drugs that are not working – in order to minimise side-effects and maximise benefits. This requires ongoing monitoring of both function and quality of life.

Interventional, psychological and rehabilitative approaches should be included as an integral part of management with the focus adapted to the situation.

Recommendation 8: Day surgery should be considered the default for planned (elective) surgical procedures where clinical evidence of outcomes supports this. Unwarranted variation in day surgery rates needs to be corrected

Variation in the use of day surgery should be measured and this information should be made available to patients to inform proper shared-decision-making in treatment decisions. Capital funding must be available to hospitals that are able to demonstrate that current limitations of capacity, facilities and equipment restrict their ability to extend the use of day surgery and improve rates of same-day-discharge.

Recommendation 9: Paediatric surgical services should operate under a single delivery framework that appropriately stratifies patients according to the acuity of their need. This framework should be structured as a 'hub and spoke' model, centred around a tertiary children's hospital as a 'hub'

Within this framework, a group of the 'spoke' hospitals would be stratified as 'high acuity centres' with inpatient paediatric facilities, including at least level-2 critical care beds. Those remaining 'spoke' hospitals will not have inpatient facilities but may still be required to

stabilise critically ill children admitted through their Emergency Department and deliver safe emergency surgery and anaesthesia.

Section Two: Supporting Our Workforce

<u>Recommendation 10:</u> A single, coordinated plan to recruit, train and retain an adequate workforce in anaesthesia, critical care and pain medicine should be published

Reflecting the broader challenge of health and social care recruitment, anaesthetists in training report significant and frequent pressure to fill gaps in rotas.[18,19] This compromises the ability to deliver safe and timely perioperative care and adds to the workload of an already overstretched workforce, that may lead to training opportunities being missed. Consequently, this contributes to the erosion of staff health, welfare and morale.

In the medium-term, there needs to be an increase in core training (CT1) and Acute Care Common Stem (ACCS) training posts to increase the numbers eligible for specialty training (ST3) appointment.

Between 2010 and 2015 there has been a 28% increase in the number of consultant anaesthetists aged between 50 and 59 years, indicating an ageing of the consultant population.[20] This age profile is also seen in the specialty and associate specialist (SAS) grade; nearly four in 10 of whom have experience of a decade or more as an SAS anaesthetist.[21]

Retaining the skills and experience of a growing cohort of older doctors will be crucial to service delivery in the short-term and for the training of new doctors in the long-term. This will demand adjustments in the type of work being performed and the design of rotas. The development of perioperative medicine, making use of the broad expertise of anaesthetists as physicians, pharmacologists and technicians, provide opportunities beyond what has been understood as the traditional role of an anaesthetist within the operating theatre environment.

In addition to increasing numbers of staff in the system, the NHS – as the country's leading employer – needs to demonstrate an ability to accommodate contemporary working patterns, such as through the facilitation of less than full time (LTFT) roles – including during clinical training programmes.

<u>Recommendation 11:</u> Medical Associate Professions (MAPs) should be regulated in statute and government should bring forward legislation without further delay

Statutory regulation of MAPs has the potential to improve patient safety by providing a standardised framework of governance and assurance across the UK for the clinical practice and professional conduct of MAPs.

The development of MAPs roles is a core component of a comprehensive workforce plan, however, the expansion of these non-physician roles will be diminished if their contribution to the delivery of patient care, including prescribing and ordering investigations, is obstructed by a lack of statutory regulation.

Recommendation 12: All employers should support a cultural shift towards a 'no-blame' learning environment that prioritises the safety of patients

There is no conflict between a culture that supports robust efforts to reduce incidents of avoidable harm and maintain professional accountability, with one that avoids apportioning individual blame to instead focus on learning across the system

There should be structured and meaningful feedback from reported adverse incidents to ensure that these are used for learning and improvement. The outcomes from investigations into reported adverse incidents should be communicated promptly to mitigate any associated risk and anxiety for all involved.

Recommendation 13: The Department of Health and Social Care, in coordination with the relevant devolved organisations and arm's-length bodies, should support the development of a national morale and welfare strategy for all NHS staff

The RCoA urges the production of a national strategy that makes practical recommendations for improving working conditions for staff and identifies the facilities necessary in order to provide safe and sustainable patient care.

Underlying issues which are driving an erosion of morale and welfare within the NHS workforce are being amplified by high levels of fatigue, a lack of qualified staff and inadequate facilities. [22,23] RCoA data show that as many as six in 10 anaesthetists in training report that their physical and mental health have been detrimentally affected by their job.[24]

Overworked doctors, demoralised staff and under-resourced hospitals can also undermine the quality of patient care and safety – themes that were interrogated in the *Francis Report* following the Mid-Staffordshire NHS Foundation Trust Public Inquiry in 2013.[25]

Besides the clear clinical and ethical imperative, there is also a powerful economic case to focus efforts on improving the wellbeing of staff. The annual cost of staff absence for the NHS in England is estimated to be £2.4 billion.[26]

Recommendation 14: Dedicated capital funding should be available for the provision of adequate facilities that enable NHS staff to work in a comfortable working environment

The effects of fatigue on doctors of all grades are a threat to patient safety[27] and action is needed to address the lack of rest facilities. At a minimum, 24-hour rest facilities should be available – free of charge – for healthcare staff working in acute specialities during and after on-call periods, including anaesthetists.

Provision of adequate facilities should include sufficient office, study and IT facilities. In addition, doctors need confidential space for peer-support, discussion of clinical issues and lifelong learning.

We believe that a proportion of the funds identified in the Naylor Review of NHS property and estates[28] would be an appropriate mechanism for providing this investment.

Section Three: Developing a Sustainable Service

Recommendation 15: Payment systems should incentivise integrated care pathways, not isolated interventions, in order to deliver the best outcome for patients

Optimal outcomes are the result of a multi-disciplinary team delivering a cohesive pathway of care. In order to incentivise working in a collaborative and integrated way, services should be paid for the delivery of a seamless pathway of care that delivers optimal patient outcomes rather than being based solely on payment for a surgical operation or other interventional procedure. Best Practice Tariffs should reflect adherence to a principle of a service using its resources in the most clinically effective way.

Recommendation 16: The Tariff must be structured so to ensure that providers will not be financially worse-off for providing consultation and pre-admission that results in a shared-decision to not pursue a surgical treatment option

Pre-admission consultation that leads to a patient agreeing with a 'no surgery' option should be recognised as a viable and sometimes preferable decision, based on clinical judgement and a patient's expectation of outcomes for the clinical episode.

Recommendation 17: No reconfiguration of services which result in reduced capacity of hospitals to diagnose, treat or provide perioperative management of patients should be approved without a fully-costed and clinically-supported plan for the provision of community-based care

We are concerned that targets to reduce hospital activity contained in several of the Sustainability and Transformation Partnership plans are unreasonable and unachievable without significant investment in community-based health and social care services.[29]

Recommendation 18: We support the recommendation of the House of Lords' Select Committee report on the long-term sustainability of the NHS for the establishment of an independent body with a similar operating model to the Office for Budget Responsibility

The House of Lords' Select Committee report on the long-term sustainability of the NHS[30] published in April 2017 recommended the establishment of a new Office for Health and Care Sustainability (OHSC).

We reaffirm support[31] for the statement from the AoMRC, first published in November 2016, 'Delivering a sustainable health and care system'.[32] The health and social care system needs more recurrent resources and we support the establishment of an independent Office for Health and Care Sustainability[33] to inform future funding decisions.

Recommendation 19: The NHS Outcomes Framework, NHS Adult Social Care Framework and Public Health Outcomes Framework should be replaced with a single framework that captures integrated care outcomes

Current frameworks are a mixed measure of inputs, system cohesion and quality of life outcomes. Measurement of health, social care and public health as distinct entities is contrary to ambitions to create joined-up integrated care provision.

Section One: Appropriate Care and Effective Treatment

The evolution of perioperative medicine

- Life course programmes – Integrated and Personalised Care for People with Long Term Conditions and Older People
- Clinical priorities – Cancer, Cardiovascular and respiratory

Anaesthetists are the largest single specialty of hospital doctors in the NHS. Two in three hospital patients will receive care from an anaesthetist in a wide variety of settings, most commonly before, during or after surgery – the perioperative period.

The anaesthetic team is therefore uniquely positioned to engage with patients to support healthier changes to their lifestyle before surgery – 'prehabilitation' – and support optimal recovery after a surgical procedure – rehabilitation – reducing the chance of an avoidable readmission. This 'prehab to rehab' model is at the essence of perioperative medicine, aiming to provide a seamless journey for patients from the moment surgery is contemplated through to a full recovery.

The RCoA is leading the development of anaesthetist-led **perioperative medicine**, with the aim of ensuring that all patients have access to a perioperative pathway of care that offers the best opportunity for an optimal treatment outcome.

However, perioperative medicine is not about re-inventing the wheel and aspects of it already exist across the NHS. The objectives of the perioperative medicine programme closely align with the integrated care systems evolving across the NHS in England, and common principles can be seen in the *Realistic Medicine* agenda in Scotland, the *Prudent Healthcare* programme in Wales and the *Delivering Together* plan in Northern Ireland.

The period around an operation is a 'teachable moment' where perioperative interventions such as smoking cessation, weight management or psychological support services can lead to sustained lifestyle changes[34][35] or reduced short-term postoperative pain.[36][37] (These interventions are discussed in greater detail later in the submission).

There are examples of perioperative strategies, focussed on improving nutrition and mobility before and after surgery, leading to reductions in postoperative complications of more than 50%. In some cases, severe surgical complications can increase a patients' length of stay in hospital by as much as 271%.[38]

With the appropriate preoperative assessment and preparation, patients undergoing elective surgery do not need to be admitted to hospital the day before their operation. There is variation in each hospitals' ability to admit patients on the day of surgery and some patients are inappropriately being admitted to hospital the day before an operation.

The average cost of a day spent in a hospital bed is estimated to be up to £400. Based on an average inpatient length of stay of 6 days[39] reducing the number of surgical procedures (in England only)[40] by just 1% would save around £89 million per year[¤]. Based on figures from

[¤] *Based on an average inpatient stay of 6 days (OECD) at a cost of £400 per bed day (Department of Health) and 3.7 million surgical procedures undertaken in England each year (Royal College of Surgeons)*

NHS Wales, a level-3 intensive care bed costs an average of £1,932 and thus suggests that the figure of £89 million is likely to be an underestimate.[41]

The bottom-line is that the most expensive, ineffective and inefficient care, is bad care. High quality perioperative care is good for patients, good for the NHS and good for the economy as well.

However, healthy patients having planned minor or intermediate surgery do not need routine preoperative tests. There is NICE guidance on routine preoperative testing but variable implementation of the guideline.[42] Adherence requires appropriate preoperative assessment to identify patients who are an exception to the routine.

Recommendation 1: All surgical patients should be managed on a perioperative pathway of care, which incorporates appropriate interventions before surgery, the operation itself and recovery after a procedure

Recommendation 2: Clinically appropriate alternatives to surgical treatment, including the option of 'no surgery' should be explicitly discussed with all patients before referral onto a surgical pathway

Perioperative Medicine in Action: selected case studies

Case study: PREPARE

What is it? The PREPARE for surgery programme highlights the cost-effectiveness of delivering comprehensive prehabilitation services in advance of surgery by helping 'train' patients for surgery, based on individual need. The PREPARE team look at factors before and after a patient's procedure, including physical activity, diet, psychological wellbeing and medication management.

What happened? Analysis of the PREPARE programme – run by the Imperial College Healthcare NHS Trust – calculates that the cost of the core delivery team is £20,900 per year while identifying an estimated cost saving of £265,000 per year, based on a reduced rate and severity of complications and length of (hospital) stay.[43]

What next?[44] The award winning PREPARE programme[45] is being expanded beyond oesophago-gastric cancer patients to work with urological and lung cancer patients who also require major surgery and intensive recovery. For these patients, national targets dictate they should undergo surgery as soon as possible – usually within two weeks. The programme will therefore be adapted from a four-week, to a two-week timeline for these patients.

Case study: ERAS+

What is it? Enhanced recovery pathways, such as ERAS+ in Manchester[46,47] focus on improving nutrition, exercise and oral health in the six weeks before and following major surgery.

What happened? Patients involved in the pilot ERAS+ pathway had their postoperative complications reduced by more than 50% and saw their length of stay cut by three days.

What next? ERAS+ is part of the NHS Innovation Accelerator programme[48] and is also part of the Health Foundation 'Scaling Up Improvement' project that will see rollout for every patient undergoing major (elective) surgery in Greater Manchester.

Case study: Managing patient concerns and anxiety

What is it? Management of complex surgical pain through psychological support.

What happened? The award-winning[b] acute pain team at the Royal Bournemouth Hospital demonstrated how, by offering patients up to three sessions with a psychologist, concerns and anxieties relating to their orthopaedic procedure could be better managed.

What next? Since the service began last year, over 150 patients receiving hip and knee surgery have taken advantage of the therapy sessions and, on average, are being discharged from hospital two days earlier than patients who didn't receive the service. [49]

Case study: WesFit[50]

What is it? The Wessex Fit-4-Cancer Surgery study (WesFit) is a clinical service that looks to establish the benefits to patients of exercise and psychological interventions in advance of cancer surgery. The program combines the rigour of a randomised control trial with the nimbleness of a clinical service evaluation.

What happened? Developed at University Hospital Southampton NHS Foundation Trust, WesFit aims to provide a robust body of evidence to support the best methods to improve the recovery of patients following major cancer surgery. So far, patients who completed this exercise training have returned to pre-treatment levels of fitness, or even improved and gained a healthier lifestyle.

What next? Now that it has been shown to have such beneficial effects, the team are looking to scale up the exercise programme to see if it can be introduced as an NHS service for cancer patients.

[b] *BMJ Anaesthesia and Perioperative Medicine Team of the Year, 2018*

Integrating public health and behavioural interventions into surgical care pathways

- Life course programmes – Prevention, Personal Responsibility and Health Inequalities
- Life course programmes – Healthy Childhood and Maternal Health

The condition in which patients arrive into secondary care influences not only individual health outcomes, but also system pressure and associated costs related to factors such as length of hospital stay after surgery.[51] [52] Provision of public health services and support outside of hospital is therefore an important concern for anaesthetists, alongside initiatives to improve the quality and effectiveness of services within the hospital setting.

The preoperative period is an important opportunity for addressing lifestyle and fitness considerations that alter surgical outcomes and have a long-term effect on health. The 'Making Every Contact Count' (MECC) approach recognises that 'the opportunistic delivery of consistent and concise healthy lifestyle information enables individuals to engage in conversations about their health at scale across organisations and populations'[53].

Anaesthetists engage with the care of two in three of all hospital patients and are in a position to play an instrumental role in tackling issues including tobacco use, hypertension, alcohol use, being overweight or being physically inactive, that are attributable around 40% of the UK's disability adjusted life years being lost.[54]

Adult patients should be helped to stop smoking, reduce alcohol consumption, improve fitness and nutrition and modify weight where possible. This should be in addition to active measures to optimise individual pre-existing conditions.

Education is also needed to equip children to lead healthy lives and reduce lifestyle related illnesses such as diabetes and cardiovascular disease, if we are to move away from the current 'firefighting' healthcare model and move to a constructive and educative model. It may well be the case that a 10-year window is not long enough to realise this ambition, but it is plenty of time to begin the process. The strongest determinants of child health across every indicator are social, educational and economic factors.[55]

Research from the Nuffield Trust reveals a 41.3% rise in emergency readmissions for "potentially preventable" conditions between 2010/11 and 2016/17. These "potentially preventable" readmissions include patients with pneumonia, pressure sores and venous thromboembolism. One of the authors of the analysis said: "Emergency readmissions to hospital, for conditions that were not diagnosed during their first visit, are potentially a warning sign that a patient's quality of care may have been compromised".[56]

Separately, research from the Health Foundation showed that one in three patients admitted to hospital in England as an emergency (2015/16) had five or more health conditions – up from one in 10 patients less than a decade earlier (2006/07).[57]

Comprehensive prehabilitation is the best option for patients ahead of elective surgery and represents the most effective use of NHS resources. However, the very best way to manage the growing pressures on hospital services is to provide services that help patients avoid the need for surgery altogether, notably by investing in public health and behavioural interventions that are usually delivered in a community setting. Despite a clear case for

investment in public health and prevention services it is estimated that planned public health spending in 2017/18 across Councils in England is 5% lower than in 2014/15.[58]

The *Five Year Forward View* recognised that 'the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health'.[59] This was never going to be realised while public health services were being asked to do more with less.

There is a clear case for the role of public health and prevention services to address avoidable harms which negatively influence surgical outcomes:

- Smokers are more likely to suffer a range of complications before, during and after surgery[60] and smokers are 38% more likely to die after surgery than non-smokers.[61] Smoking doubles the chance of a patient suffering an unwanted problem after their surgery.[62]
- Obesity is associated with prolonged length of stay for patients in critical care.[63]
- Among hazardous drinkers - consuming five or more alcoholic drinks per day - the post-operative complication rate increases to 200–400% compared to rates when consuming 0-2 drinks.[64] Research suggests that a period of abstinence from alcohol for one month in advance of surgery significantly decreases morbidity and mortality.[65]
- The King's Fund estimates that out-of-hospital exercise and activity programmes have delivered a return on investment as high as £23 for every £1 spent[66].

The British Medical Association (BMA) has raised serious concerns about money intended for public health services being misspent by local authorities in an attempt to maintain other threatened services.[67]

The distinction between mandated and non-mandated services – as outlined in the Health and Social Care Act (2012) is manifesting itself in de-prioritisation of stop smoking, alcohol and drug misuse and recovery services.

The *Recovery Partnerships'* State of the Sector report (2017) stated that:

> 'This report demonstrates the concern that local authorities will now have to trade off the number of people accessing services against the comprehensive nature (and therefore overall effectiveness) of the services provided'[68]

The impact on hospital admissions suggests that changes to the commissioning of public health services are not reducing pressures in secondary care. Hospital Episode Statistics for Admitted Patient Care in England suggest that while the total number of finished consultant episodes (FCEs – the episodes of care for admitted patients rather than the number of patients) rose by 2.7% between 2014-15 and 2015-16, the number of alcohol-related FCEs rose by 8.5%.[c]

A January 2018 report from Cancer Research UK and Action on Smoking and Health concluded that 'services for smokers have greatly diminished since the NHS have given up control of them in 2013'.[69] In June 2018, a report from the Royal College of Physicians stated

[c] Based on FCEs coded to X45, X65, Y15, Y90 and Y91 in Hospital Episode Statistics, Admitted Patient Care England – 2014-15 (https://files.digital.nhs.uk/publicationimport/pub19xxx/pub19124/hosp-epis-stat-admi-ext-caus-2014-15-tab.xlsx) compared to Hospital Episode Statistics, Admitted Patient Care Activity, 2015-16 (http://webarchive.nationalarchives.gov.uk/20180328130140/http://digital.nhs.uk/media/29869/Hospital-Admitted-Patient-Care-Activity-2015-16-External-causes/Any/hosp-epis-stat-admi-ext-caus-2015-16-tab) coded to the same lines

that the falling numbers of smokers accessing stop smoking services 'signify a failing model of service provision' and that 'A rational approach would be to move responsibility for smoking interventions back into the NHS in England…'[70]

Former Secretary of State for Health and Social Care, Rt Hon Jeremy Hunt MP, has suggested that CCGs and Councils not being co-terminus has created difficulties in the development of integrated health and social care.[d] The relative success or failure of public health interventions has a downstream impact on hospital services.

Evidence demonstrates that patients are not being optimised in advance of elective surgery, including patients with pre-existing conditions such as diabetes. The Perioperative Quality Improvement Programme (PQIP) study found that at the time of surgery, as many as four in 10 patients (41%) were anaemic - 88% of this patient cohort were having planned surgery indicating that time of anaemia management should have been available.[71] The same study indicated that as many as one in five diabetic patients have an HbA1C level greater than the recommended threshold for elective surgery.[72] Current recommendations suggest that if a patient's HbA_{1c} is greater than 66mmol/litre, elective surgery should be postponed.[73]

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Treating pain – Information from the Faculty of Pain Medicine

- Clinical priorities – Cancer, Cardiovascular and respiratory
- Enablers – Clinical Review of Standards

Pain is recognised as a disease in its own right on the International Classification of Diseases[76] and is also a component of a range of other conditions. It is estimated that around eight million people in the UK suffer with moderate to severely disabling chronic pain.[77,78]

Management and treatment of pain intersects with all areas of medical practice and is the responsibility of all healthcare professionals. Reflecting the scale of the prevalence of pain and its impact on society, training in pain management should have a higher priority within

[d] *Comments made by The Rt Hon Jeremy Hunt at an event hosted by the Institute for Government, 'NHS England. The World's Biggest Quango?' 24 May 2018*

undergraduate and postgraduate curricula for all groups of healthcare professionals. It is important to educate clinicians so that they can respond appropriately when such a large proportion of patients they interact with will suffer from pain to some degree.

However, complex cases of acute or chronic pain will require input from a specialist as part of an MDT. Currently, insufficient capacity in specialist pain services is creating inequality in access.[79] The consistent and comprehensive adoption of Core Standards for Pain Management Services in the UK (CSPMS UK)[80] that cover all areas of pain management in all settings, would be a significant step towards better, effective care of patients with pain.

Improved management of pain requires a multi-disciplinary approach covering the medical, psychological and social components of a patient's pain. Management strategies should be balanced (according to the presentation) with active patient involvement.

Managing and treating pain must be a core component of any strategy to address social, economic and health inequalities in a meaningful way. The exact cost of chronic pain is unknown, though it is estimated that the cost to the Exchequer of back pain alone is around £5 billion per annum.[81] This figure largely arises through welfare (incapacity) benefit, highlighting the impact that chronic pain has on the well-documented relationship between being out of work and the drastic exacerbation of social, economic and health inequalities.

There is an urgent need for the resources to help patients manage with varying degrees of chronic pain. The majority of the diseases causing pain are not cured and many patients need support to assist with mobility and day-to-day functions, such as constructive occupational health in order to remain in work, as permanent changes, not just temporary adjustments.

Cancer survivors (those living with and beyond cancer) represent a rapidly increasing demographic within the population, large numbers of these individuals – perhaps as many as 60%[82] – list pain as a major unmet clinical need alongside other physical symptoms such as fatigue.[83] As a specialty, pain medicine is ideally positioned (with its multi-disciplinary, biopsychosocial ethos) to make a marked contribution to the successful and sustained rehabilitation of these patients.

Case study: Liverpool Angina Management Programme

What is it? At the Royal Liverpool and Broadgreen University Hospital NHS Trust a brief cognitive-behavioural chronic disease management programme (CB-CDMP) for patients with chronic pain of cardiac origin, in who cardiac misconceptions are common, was implemented for patients from 40 referring CCGs.

What happened? The CB-CDMP has been shown to reduce unplanned admissions of referred patients by one-third (32%) and reduce associated days in hospital by 38%.

What next? Analysis of the CB-CDMP demonstrates a significant reduction in frequency and duration of patients' unplanned admissions. The CB-CDMP has an important role to play in meeting national targets for reducing unplanned admissions.

The transition from acute pain (defined as pain of less than three months in duration[84]) to chronic pain, the high incidence of persistent post-surgical pain and long-term opioid use in the community following surgery or trauma, all inform the need for the greater integration of pain medicine in pathway design. Integration of a transitional pain service within an appropriate perioperative medicine pathway should include structured engagement with primary care – both before a patient admission to hospital and following discharge.

There remains a patient cohort that attend A&E or are admitted to hospital with complex pain problems. The development of teams to manage complex inpatient pain has delivered demonstrable benefit, both to these patients and the local health economy, resulting from reduced length of stay, optimised medication, appropriate input from other therapy areas and reductions in GP consultations.[85,86,87]

These dedicated teams will engage formal chronic pain management processes by utilising clinicians across physiological and psychological specialties, and allied health professionals, including physiotherapists, to support patients.[88]

The current ways of working and commissioning inhibit true integration of service. Altered ways of working and service delivery could be developed (including some specialist level pain service activity delivered by appropriately trained personnel away from the hospital setting) but require active clinical input into developing the structures and commissioning rules for implementation. How pain services interact and integrate with specialties such as spinal & orthopaedics, obstetrics & gynaecology and mental health services will be crucial to their successful development.

Best practise such as the chronic pain and low back pain pathway at Sheffield Improving Access to Psychological Therapies (IAPT) Service demonstrate the feasibility of effective self-management.[89]

<u>Recommendation 7:</u> Equitable access to high-quality pain services must be available for all patients and include specialist pain management integrated with other key services, including psychological support

Optimising advances in clinical practice

- Life course programmes – Integrated and Personalised Care for People with Long Term Conditions and Older People
- Enablers – Clinical Review of Standards
- Life course programmes – Healthy Childhood and Maternal Health

The development of day surgery has been one of the most significant clinical advancements within the NHS in recent decades. The King's Fund notes that 'Some of the most important gains in productivity have been achieved through changes to clinical practice'[90], with the adoption of day surgery and reductions in average patients length of stay in hospital, made possible by advances in anaesthetic techniques.[91]

The growth in the use of day surgery has coupled the reduction in general and acute NHS hospital beds and likely been a catalyst for this significant reduction since 1990.[92] [93]

Between 1998 and 2013 day cases, as a proportion of elective activity in the NHS in England increased from 67% to 78%. By 2023/24 it is estimated that 87% of elective patients could be

treated as day cases that would in effect enable the NHS to have treated 1.5 million extra cases with no real increase in spending.[94]

The Centre for Health Economics recently published a review of the financial incentives for same-day hospital discharges (SDD).[95] The study analysed patient data for 191 conditions for which same-day discharge was clinically appropriate – of which 32 were incentivised – between 2006-2014. The authors note the unusual setup where hospitals are – through the Best Practise Tariff – explicitly over[paid]…for the cheapest care pathway'. Despite this 'novelty' incentivisation, the study found that this economic nudge did not increase the use of SDD pathways for all conditions and that for some conditions, there was a negative response (i.e. lower SDD rates).

This study may go some way to explaining the massive variation in day surgery rates that persists.[96] This represents unwarranted variation, as lack of access to day surgery undermines patient experience and the potential efficiencies that the system might otherwise be able to deliver:

- Patient satisfaction with day surgery is excellent due in part to the preference of being in their own surroundings to recover, rather than requiring a hospital stay.[97]
- The cost of treating a day case patient is nearly five times less than an overnight inpatient[98]

Even where financial payments incentivise the use of SDD, individual hospitals may not be able to extend its use due to limitations on capacity and facilities that demand investment of capital funding. Capital budgets that were intended for the maintenance of facilities and rollout of new technologies and equipment have been used to fund shortfalls in revenue budgets and reduce provider deficits in 2014/15, 2015/16 and 2016/17.[99]

The changes to surgery since the 2007 Darzi report ('*Saws and Scalpels to Lasers and Robots*'[100]) with the emphasis on endoscopic, laser, robotic and day case surgery has caused a shift in where the bottlenecks in the surgical pathway arise. Operations management and in particular the need to identify where the bottlenecks are in the patient pathway is crucial.

Hitherto, when patients spent days or weeks on the ward, the rate-limiting step was ward bed capacity. This is no longer the case. Whereas it was once common to undertake around four cases per list, only one or two (who are discharged the same or the next day) is common practice and the bottleneck may have shifted to theatre capacity.[101,102] Growing theatre capacity will require capital investment that has not been available over the last decade.

Issues relating to capacity also demand that the precious expertise that exist in specialist services are optimised. Though applicable across the entire health system, this is a particular challenge for paediatric surgical services. As such, the delivery framework for paediatric services needs to enable the most effective use of the tertiary children's hospitals across England.

A restructured model of care that takes a tiered approach based on the acuity and complexity of cases, would respond to the change in the demands on paediatric services over the past 10-15 years. An increasing number of children are living with long-term, complex conditions and, due to a lack of alternative provision, many of these children continue to be cared for in a paediatric critical care setting, despite this not always being optimal.

Options should be explored to allow these children to be cared for to the highest standard in expanded critical care units, in either the high acuity centres or the tertiary centre;

depending on the patient's dependency needs. Overall the provision of staffed paediatric critical care beds needs to increase to accommodate this change.[103] Taken together with the higher proportion of general surgery being undertaken in specialist centres, the problem of increased waiting times for specialised paediatric surgery will not be resolved without changes to the care model and adequate staffing of critical care services.

Children should not receive paediatric care in a hospital setting if the same standard of care could be provided in a local, community setting. Of those that do require hospital care, many are unnecessarily admitted to a tertiary centre.[104] Preventing unnecessary admissions will free up resources in specialist centres to concentrate on looking after the most complex surgical and medical cases.

Accompanied by the availability of 24/7 primary and community care, this model of care can be delivered in-line with the Guidelines for the Provision of Paediatric Anaesthesia Services (2018) as long as commissioners are mindful of requirement for access to support services (2.7 – 2.16) in pathway design.[105]

Recommendation 8: Day surgery should be considered the default for planned (elective) surgical procedures where clinical evidence of outcomes supports this. Unwarranted variation in day surgery rates needs to be corrected

Recommendation 9: Paediatric surgical services should operate under a single delivery framework that appropriately stratifies patients according to the acuity of their need. This framework should be structured as a 'hub and spoke' model, centred around a tertiary children's hospital as a 'hub'

Section Two: Supporting Our Workforce

Staffing required for a safe and effective service

- Enablers – Workforce, Training and Leadership
- Enablers – Engagement

Ensuring the provision of a sustainable medical workforce is a vital component in the long-term planning process for health and social care services.

We welcomed the Government's decision to provide 1,500 extra medical training places from September 2018.[106] However, the increased cohort of medical students will not graduate until 2023 and are would not be anticipated to complete specialist training in anaesthesia until 2032. The Care Quality Commission (CQC) has noted that inadequate staffing numbers and a lack of skilled staff continues to pose a risk to patient safety.[107] The House of Commons' Public Accounts Committee estimates that the NHS is short of at least 50,000 staff.[108]

While we acknowledge the need to reduce the costs associated with agency expenditure on medical locums,[109] projections indicate significant medium-to-long-term shortfalls in the supply of doctors working in the specialties of anaesthesia and intensive care medicine, which will only be mitigated by protected investment in medical education & training at the soonest opportunity.

A 2015 report by the Centre for Workforce Intelligence (CfWI) found that the number of anaesthetists and intensivist certificate of completion of training (CCT) holders needed to meet demand by 2033 would be 11,800 full time equivalents, representing a 33% shortfall against the 8,000 projected to be trained by this date.[110]

Overall, an additional 2,800 anaesthetists, beyond those anticipated to be in the workforce in 15 years' time, will be needed.

However, training new doctors cannot (and will not) be the single solution. A key component of a comprehensive workforce strategy is the retention of experienced staff.

Experienced anaesthetists retain a wealth of clinical and non-clinical experience that will be vital to the development of the future of the specialty. Across all grades, 46% of respondents to the RCoA's 2016 member survey noted involvement in education, and 35% in training, as part of their non-clinical activity.[111]

At current rates of demand-growth we anticipate that every trust will be short of between 10 and 20 consultants by 2033. The positive impact of a consultant anaesthetist and a consultant surgeon during high-risk surgery, such as an emergency laparotomy, is supported by individual studies such as the July 2016 report of the National Emergency Laparotomy Audit.[112]

Recruitment, training and retention of our workforce

- Enablers – Workforce, Training and Leadership
- Enablers – Clinical Review of Standards
- Enablers – Engagement

It is well-staffed, well-functioning and integrated MDTs that provide safe and effective patient care. Across the specialties of anaesthesia, intensive care and pain medicine, members of the RCoA work with many other health professionals to provide a safe and high-quality service. Anaesthetists rely on anaesthetic assistants and nurses, physician assistants (anaesthesia), recovery nurses, advanced critical care practitioners and specialist pain nurses in order to augment effective service delivery, as well as a host of other medical, nursing and allied health professionals and ancillary workers.

Despite increases in the number of consultant anaesthetists and staff grade, associate specialist and specialty (SAS) doctors, the RCoA workforce census report for 2015[113] highlights that anaesthetic departments continue to have trouble in filling hospital rotas:

- In England, 26% of anaesthetic departments reported a gap in the consultant rota approximately once a week
- Almost 70% of anaesthetic departments across the UK needed to cover gaps in training grade or SAS rotas more frequently than once a week. Nearly a fifth (19%) of departments needed to do so every day
- Nearly half (48%) of anaesthetic departments across the UK rely on consultants 'acting down' to cover gaps in training grade or SAS rotas.

Our workforce data[114] (2016), informed by a census of NHS anaesthetic departments, to which 100% responded[115], reveals the following:

- Nearly three-quarters (74%) of departments reported using external locums and 19% of anaesthetic departments needed to cover training grade or specialist rota gaps every day
- Of the 5,196 UK anaesthetists who took part in the College's 2016 membership survey, one-third cited issues which impacted upon the delivery of safe and effective patient care. Issues included fatigue, a lack of qualified staff and inadequate facilities.[116]

There is a developing issue caused by the impending retirement dates among the consultant workforce that couples the recruitment challenges outlined above.[117] Due to contractual changes, all consultants starting in post today will be expected to work until they are at least 68 years old, which may demand adjustments in rotas and shift work to accommodate doctors working in the later part of their career.

More than half (54%) of all doctors in training (i.e. not just anaesthetists in training) do not progress *directly* from the second year of the Foundation programme (F2) into a specialty training programme.[118] While data show that the majority return to training – with 93% of the 2012 F2 cohort in speciality or GP training within five years – more than one in 20 (7%) have not returned to their training at all.[119]

Overall anaesthesia and critical care numbers remain robust in comparison to other specialties.[120] Latest recruitment data for August 2018 (further to the increase in dentistry and medical student places at English universities) show a positive trend in fill-rates:

- **CT1** – 99.83% (580/581)
- **ST3** – 95.63% (372/389) This an increase from 86.18% the previous year and ending a trend that had seen the ST3 fill-rate decline by 7.5% in three years

This encouraging national picture reflects improvement in regions that have struggled to recruit in recent year, including the Yorkshire & Humber region that has seen an increase at ST3 recruitment from 50% to 77.78% between August 2017 and August 2018.

Though fill rates have recovered over the short-term, the analysis of the current status of rota gaps and the medium to long-term projections indicate that further increases in the number of available training places are needed.

The delivery of appropriate and effective care relies on funding that buys the equipment, the beds and the medication that makes it all possible; but the most important resource is staff and the commodity of their time. Cancer Research UK has explored how the NHS must adapt to care for older patients with cancer, and took the views of a range of patients and staff. One anaesthetist who was interviewed for the piece noted the challenge of finding time for the in-depth conversations that are required to inform treatment decisions:

Today I had a patient who has cancer but has other comorbidities […] so I had to discuss that […] and make it clear to them that these are the risk factors, these are the things that go wrong […] that 20/30 minutes […] gets dragged on to 45 minutes. We can't just stop the consultation because it's been running out of time[121]

Without properly staffed services, patients will not receive the quality of care that should be made available to them. As well as the impact on the individual patient, for the system, this is a false economy. Patients who are not optimised in the perioperative period are more likely to suffer a range of complications that will increase their time in hospital and the chance of presenting as an emergency re-admission within the 30-day period.[122]

<u>Recommendation 10:</u> A single, coordinated plan to recruit, train and retain an adequate workforce in anaesthesia, critical care and pain medicine should be published

Medical Associate Professions

- Enablers – Workforce, Training and Leadership

The changing demographics of the UK population indicate a need for a 25-40% expansion in the anaesthetic workforce by 2035.[123] The RCoA believes that Medical Associate Professions – including Physicians' Assistants (Anaesthesia) (PA(A)s) and Advanced Critical Care Practitioners (ACCPs) – can make a valuable contribution towards a sustainable anaesthetic workforce, but only if these roles are properly regulated. Therefore, we strongly support the introduction of statutory regulation of PA(A)s, ACCPs and other MAPs.

The RCoA currently administers a voluntary register and only recognises those PA(A)s who have qualified, having completed the approved UK training programme and have subsequently been entered on the voluntary register. The further development of these roles requires statutory regulation. The government is yet to respond to its consultation on the regulation of MAPs that ran between October and December 2017.

<u>Recommendation 11:</u> Medical Associate Professions (MAPs) should be regulated in statute and government should bring forward legislation without further delay

Morale, welfare and fatigue

- Enablers – Engagement
- Enablers – Workforce, Training and Leadership
- Enablers – System Architecture

Between December 2016 and January 2017, the RCoA surveyed anaesthetists in training on the issues of morale and welfare.[124] The survey received more than 2,300 responses and revealed the following:

- 85% of anaesthetists in training are at risk of becoming burnt out (using OLBI[e] measure)
- 61% of respondents felt that their job detrimentally affected their mental health and 64% felt that their job had negatively affected their physical health
- 75% of respondents reported working a shift without adequate hydration.

Clinicians working in acute specialties such as anaesthesia are disproportionately affected by a lack of rest facilities due to the 24/7 nature of service delivery, including the overnight resident on-call and late-night shift patterns that they undertake.

A joint survey run by members of the RCoA and the Association of Anaesthetists – the results of which were published in the journal *Anaesthesia*[125] – highlights the impact that fatigue is having on anaesthetists in training in the UK. Overall 2,155 anaesthetists in training responded to the survey (59% of all anaesthetists in training in the UK), which revealed the following key findings:

- 75% of respondents drive to work and 60% have a commute of 30 minutes or more, each way
- During the journey to or from work, more than half of respondents (57%) have had an accident or a near miss
- 84% have felt too tired to drive home after a night-shift
- 74% of respondents said that fatigue has adversely affected their physical health.

Many doctors working unsocial hours in acute care settings have no access to a place to rest and some hospital trusts currently charge staff for the use of overnight rest facilities. In one example, a charge of £37.45 per night is levied for a room that is not subsidised by the trust: '*The trust has a 'hotel' facility on the [site] whereby rooms can be let on a nightly basis. The hotel is mainly there to support clinical staff with difficult shifts who have a long commute…*'[f]

Those doctors employed under the 2016 junior doctors' contract[126] should be guaranteed access to an appropriate rest facility where an individual feels unable to drive home following a night shift. Alternatively, the doctors' employer must make sure that arrangements are in place to ensure safe travel home.

The best way to ensure that clinicians working in acute specialities are able to provide safe patient care during a long-shift and to ensure their personal safety after a shift is to be able to provide rest facilities within the hospital grounds; free of any charges that could act as a deterrent to their use.

With existing pressures and operational deficits on many NHS trusts, it would be unreasonable to mandate the provision of rest facilities without new funding being made available.

[e] OLBI – Oldenburg burnout inventory

[f] *While this information is in the public domain we have chosen to remove reference to the name of the Trust as the example is indicative of the practice of charging – not the practice of just this particular Trust. The reference for the figure is available here and the description is here. The information was accessed at 16.58 on 6 September 2017*

We believe that dedicated capital investment funding for improvements in NHS staff facilities, including for the provision of appropriate rest facilities, should be made available as part of a wider programme of hospital investment. At a minimum, 24-hour rest facilities should be available – free of charge – for healthcare staff working in acute specialities during and after on-call periods, including anaesthetists. We believe that a proportion of the funds identified in the Naylor Review of NHS property and estates[127] would be an appropriate mechanism for providing this investment.

Extending action on NHS staff health and wellbeing was prioritised in NHS England's *Next Steps on The Five Year Forward View* document including through the use of the CQUIN incentive payment - a recognition of the need to address staff welfare through a package of measures.[128]

<u>Recommendation 12:</u> All employers should support a cultural shift towards a 'no-blame' learning environment that prioritises the safety of patients

<u>Recommendation 13:</u> The Department of Health and Social Care, in coordination with the relevant devolved organisations and arm's-length bodies, should support the development of a national morale and welfare strategy for all NHS staff

<u>Recommendation 14:</u> Dedicated capital funding should be available for the provision of adequate facilities that enable NHS staff to work in a comfortable working environment

Section Three: Developing a Sustainable Service

Research from The Nuffield Trust found that some Sustainability and Transformation Partnerships (STPs) are targeting up to 30% reductions in selected areas of hospital activity, including outpatient care, A&E attendances and emergency inpatient care.[129] These reductions are being planned in the face of steady growth in all areas of hospital activity, including the doubling of elective care over the past 30 years. The authors also argue that NHS bodies frequently overstate the economic benefits of initiatives intended to shift the balance of care. NHS bodies may use prices to calculate savings rather than actual costs, which can result in the wrongful assumption that overhead or fixed costs can be fully taken out.[130]

Performance and standards

- Enablers – Clinical Review of Standards

Annual performance against the four-hour A&E waiting time standard was the poorest on record at 88.3% in 2017-18 (a full 10 percentage points lower than peak performance recorded in 2009-10).[131]

It is believed that as many as three million people who come to A&E each year could have their needs addressed in other parts of the urgent care system.[132] The performance element of the provider sustainability fund (PSF)[g] for 2017/18 was linked to achieving performance of the four-hour A&E target. This is despite the standard last being met in the month of July 2015 or 2013-14 if measured as annual performance.[133] This was reaffirmed in the Government's mandate to NHS England for 2018-19[134] although the qualifying criteria for PSF payment was amended to instead measure against year-on-year progress *toward* meeting the standard.[135]

The challenging situation with A&E waiting times is mirrored in other areas such as cancer waiting times, where the target for 85% of patients to begin treatment within 62-days of being urgently referred by their GP with suspected cancer, has been breached for a sustained period of over two years.[136] Data published in August 2018 showed that the 14-day waiting time standard for a first outpatient appointment following urgent referral for suspected cancer has been breached in a full quarter for the first time since records began in 2008/09.[137]

There are also ongoing concerns, amid growth in the elective waiting list and "significant under delivery of elective activity"[138] that the NHS will not be able to meet its 18-week target for elective care[h].

Regardless of whether success is measured through achievement of targets or adherence to clinical standards, it is important to encourage a reward culture, not a regime of punishment, so that value is added to the system if standards are met rather than fines being levied if they are not.

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[g] *The Provider Sustainability Fund was originally referred to as the Sustainability and Transformation Fund. This was amended in the February 2018 joint-planning guidance, published in February 2018, although the change was not reflected in the Government's mandate to NHS England, published in March 2018*

[h] The target included in the government's mandate to NHS England for 2018/19 is as follows: 'At least 92 per cent of patients on incomplete non-emergency pathways to have been waiting no more than 18 weeks from referral'

As an example, the maternity incentive scheme has 10 standards/targets which, if met, entitle units to recover part of their contribution relating to Clinical Negligence Scheme for Trusts (CNST) incentive fund.[139] The standards are set to be useful for patient care but achievable by most units.

The pursuit of quality improvement must also be better recognised and rewarded. For example, the RCoA's Anaesthesia Clinical Services Accreditation (ACSA) provides minimum clinical standards in anaesthesia as they are generally regarded as entry-level requirements.

Though ACSA, like other accreditations such as 'JAG'[140], focus on clinical standards within a defined area, accreditations can provide a marker of an organisation's culture through it decision to pursue a higher quality of patient care.[i]

The RCoA supports proposals from the CQC for its inspection activity to be informed by a service having gained an appropriate and recognised accreditation, such as ACSA.[141]

We believe that the process of seeking a comprehensive and evidence based accreditation scheme provides the opportunity for a root and branch review of the quality of a particular service and demonstrate areas in need of quality improvement. Engagement with these schemes is evidence of a positive culture within a particular service and at Board level, a commitment to quality and improvement'.[142]

A well-constructed accreditation scheme will look at policies and processes in highly specialised areas of medicine. The scheme will be constructed by experts who understand the service best and know what constitutes an 'outstanding' service.

The RCoA has recently run pilot ACSA reviews within independent sector providers, looking at factors such as the capability of independent acute hospitals to deal with emergencies and the need for robust transfer arrangements to larger NHS facilities in the absence of in situ critical care units. This is particularly pertinent as the NHS looks to use capacity in the independent sector to manage increased patient demand.

Payment systems and incentives for improved patient outcomes

- Enablers – System Architecture
- Enablers – Clinical Review of Standards

As a Medical Royal College, our first priority is the development and maintenance of professional standards that enable the safest and highest quality patient care.

We believe that the current model for payments and targets needs revisiting, to support the new ways of working with greater integration of care that better incentivise the priority of clinicians to deliver the safest and highest quality patient care.

The payment by results (PbR) system – that covers the largest segment of NHS spend – was introduced to reduce waiting time for elective surgery, but the last 15 years have seen an evolution of priorities and processes in the NHS that makes the PbR sub-optimal to reflect contemporary practice.[143]

[i] NHS England National Medical Director, Professor Steve Powis, responding to the ACSA award at Dorset County Hospital said: "I am delighted to see the team at Dorset County Hospital being recognised for providing high quality care to patients. I would encourage medical directors to consider going through this accreditation process as it will help more hospitals provide even higher quality patient care."

For procedures where a general anaesthetic is standard the National Tariff accounts for it in the reference costs that are generated. However, colleagues in the area of radiology have raised an issue related to procedures are performed under local anaesthetic or with mild sedation. Increasingly these same procedures are done on patients with increased comorbidities including age or difficult positional issues.

There is an emerging resistance to involving anaesthesia as the costs of the anaesthetic largely nullify any profit available from the procedure. With the current system, in effect, anaesthetic support is having to be provided free, due to the lack of available remuneration.

This situation limits the development of effective models of care by creating a financial penalty for procedures that increasingly require anaesthetic support – such as in interventional radiology.

We believe that the NHS needs a payment system that enables three things:

- Patient care being delivered in a coordinated way in which services are seamlessly integrated along the care pathways[j]
- Optimal patient outcomes are achieved – that may or may not result from the delivery of a surgical intervention – by acknowledging that ongoing management of a condition is beneficial and should be incentivised
- Adherence to best practice can be properly recognised and rewarded. Research suggests that current Best Practice Tariffs (BPTs) are, in some areas, a catalyst for improved quality and outcomes.[144] However, BPTs must reflect the available resources in a hospital – including pressures on staff – and punitive measures for not meeting BPT criteria should not be in-place.

As the review of financial incentivisation of SDD demonstrates, payment models cannot be a substitute for the capacity, facilities and workforce to deliver high-quality patient care and treatment. However, the current payment system is not fit for the purpose of facilitating MDTs working within system delivering integrated care.

The Chief Executive of NHS England, Simon Stevens, has indicated that the NHS payment system will be reformed, including the end of "sustainability funding"[145], echoing comments from the Chief Executive of NHS Improvement, Ian Dalton, who said: "We also need to have a look at the PSF as well. Clearly, it's positive that it's provider ring-fenced money but the distributional effects of that have again not necessarily been equal across the system".[146]

<u>Recommendation 15:</u> Payment systems should incentivise integrated care pathways, not isolated interventions, in order to deliver the best outcome for patients

<u>Recommendation 16:</u> The Tariff must be structured so to ensure that providers will not be financially worse-off for providing consultation and pre-admission that results in a shared-decision to not pursue a surgical treatment option

Service capacity and expectations for delivery through new care models

- Enablers – System Architecture

[j] The maternity pathway payment system provides a framework for how such pathway-based system could be developed, notwithstanding the problems that could be created by miscommunication between providers and commissioners about what is and is not included within the pathway payment. See https://improvement.nhs.uk/documents/2360/maternity_payment_pathway_system_supplementary_guidance.pdf

Over the period 1990/91 to 2015/16, the number of general and acute hospital beds has fallen from around 160,000 to 103,000. While the reasons for this reduction may in part reflect developments in the treatment of medical patients, including improvements in anaesthesia[147] and the associated advancement of day surgery – resulting in reduction in length of stay – in 2017 a number of trusts experienced sustained bed occupancy of over 99%.[148]

A July 2018 report from NHS Providers, concluded that last winter (2017-18) the NHS did not have enough hospital beds to cope safely with growing demand for care. Funding for the equivalent of an estimated additional 7,825 hospital beds (in England) needed to cope with these pressures safely, would cost almost £900 million.[149]

In advance of the Prime Minister's announcement of new funding for the NHS in England, the *HSJ* reported that NHS national leaders estimated that the service is "at least 4,000 beds short for next winter" and that a "funding plea" would be forthcoming. This "plea" came after the NHS England planning guidance, published in February 2018, had acknowledged that "there will be no additional winter funding in 2018-19."

We are concerned that the pursuit of reduced hospital activity and the associated financial savings, is being undertaken without a clear blueprint to improve the capacity in out-of-hospital care. In the medium-to-long-term, this will have a considerable negative impact on the ability to deliver high-quality secondary care services.

For example, in one London STP a 44% reduction in inpatient bed days is expected to be realised because of the new models of community care by 2020/21 (against baseline).[150] The Department of Health and Social Care has articulated the view that "[Sustainability and Transformation Partnerships (STPs)] are very simply about reducing hospital bed days per thousand population and reducing emergency admissions".[151]

Research from the Nuffield Trust notes that it is not likely that out-of-hospital care will be cheaper for the NHS in the short to medium term and certainly not within the tight timescales under which the STPs are expected to deliver change. Therefore the wider problem remains: more patient-centred, efficient and appropriate models of care require more investment.[152]

In December 2017, the RCoA published the results of a survey of 500 anaesthetists that revealed the impact that delayed transfers of care (DToCs) were having on vulnerable patients.[153] The survey, developed in collaboration with Alzheimer's Society, found that more than half of anaesthetists would be uncomfortable with a relative or close friend with dementia being admitted to an NHS hospital during the winter period. Overall 92% of respondents were 'very worried' (64.4%) or 'somewhat worried' (27.6%) that levels of bed occupancy resulting from DToCs will impact the ability to deliver safe care this winter.

The results of the survey demonstrate the impact that DToCs were having on the proper functioning of hospitals, stifling proper patient flow and creating anxiety among clinicians who see first-hand the combined impact of resource-pressures and limitations on capacity.

The King's Fund notes that delays in discharging patients also affects the flow of patients through a hospital… when a hospital is close to full capacity delayed transfers can mean there are no beds available for new admissions, with consequences for waiting times in A&E departments and for planned surgery.[154]

We welcomed the decision, in January 2018, to expand the remit of the now Secretary of State for Health and Social Care, which we believe should help to facilitate coherent decision-making that underpins a more integrated health and social care system.

With this broader portfolio, the Department for Health and Social Care must work with NHS England, NHS Improvement and professional bodies, including the Medical Royal Colleges, to re-evaluate any plans to reduce hospital activity that do provide fully-costed and clinically-supported plans for the provision of out-of-hospital care.

The Institute for Fiscal Studies (IFS) provides this cautionary assessment: '…although per-capita spending was at a historical high of £2,160 per head in 2015-16 (2016-17 prices), on average individuals will be older and therefore likely to require more health services than ever before.'[155]

<u>Recommendation 17:</u> No reconfiguration of services which result in reduced capacity of hospitals to diagnose, treat or provide perioperative management of patients should be approved without a fully-costed and clinically-supported plan for the provision of community-based care

Integrating Health and Social Care

- Life course programmes – Integrated and Personalised Care for People with Long Term Conditions and Older People
- Enablers – System Architecture

Providing care and treatment for an older patient population and growing prevalence of chronic conditions will be the biggest challenge to the health and social care system over the next 10 years. In England, the proportion of the population aged 65 years and over will increase by more than one-sixth (16.2%) over the period 2016 to 2026.[156] By comparison the proportion of the population aged 30-34[k] will increase just 0.74% over the same period and projections suggest will actually fall by 0.35% over the period 2016 to 2027.

On average, a 65-year-old costs the NHS more than three times that of a 30-year-old. This increases to five times as much for an 85-year-old.[157]

Evidence presents the implications of these changes as something of a mixed picture. While it seems clear that spending on chronic conditions – associated with shorter life expectancy – is proportionally high, the rise is healthcare expenditure toward end-of-life is more gradual.[158]

A review of available evidence from the Institute of Public Policy Research (IPPR) concluded the following:

[A] significant shift in the location of end of life care will require substantial investment to develop and support capacity in the community…This should include greater resourcing for care models that enable people to spend their final days and weeks at home where possible and appropriate.[159]

Over just a decade, the average age of hospital admitted patients has risen from 49 to 53 years old.[160] Coupling this increase in the average age of patients, the nature of hospital admissions are changing as patients increasingly present with age-related co-morbidities;

[k] *The ONS data groups age by five-year cohorts*

most significantly dementia. At least 25% of hospital beds are occupied by people with dementia.[161] In 2015, 24.4% of people over the age of 65 who experienced a delayed discharge had dementia.[162] This was as high as 65.4% in one hospital (from those trusts who responded to a Freedom of Information request).

The Mandate to NHS England (2017/18) set a target to reduce delayed transfers of care (DToCs) to 3.5% by September 2017.[163] Analysis from NHS Providers[164] shows that in Q4 2016/17 the DToC rate hit 5.6%. The DToC rate has not been within the 3.5% target since Q1 2014/15. The target to reduce the proportion of beds occupied due to DToCS to 3.5% was re-affirmed in the February 2018 joint-planning guidance, as an in-year target.[165]

The proportion of total DToCs attributable to a social care issue has increased from less than one-quarter (24.6%) to nearly four in 10 (38%) in just three years (June 2014-15 to June 2017-18).[166] DToCs that are the result of inadequate social care provision are contributing to the frequent cancellation of elective surgery that is distressing and potentially harmful for patients. It also compromises the ability to train the next generation of anaesthetists and has a financial cost for the healthcare system.

The Carter review identified that 'on any given day as many as 8,500 beds in acute trusts are occupied by a patient who is medically fit to be transferred' and the cost of the associated delays could be around £900m per year.[167] However, this is based on a £300 per bed day model that is likely to underestimate the cost by around £300m per year.[168]

Reform of care and support services for older people were first announced in November 2017 with a green paper on social care to be published in summer 2018.[169] Delays to the publication of the paper led the Local Government Association (LGA) to launch its own green paper on adult social care in July 2018.[170] The LGA presents a series of options for raising additional funding for social care services – including possible increases in basic rate income tax, national insurance or council tax.

Funding for the NHS continues to be a political battleground and this is arguably worse for social care, where the government of the day is making decisions that will have a greater impact on future governments.

The House of Lords' Select Committee report on the long-term sustainability of the NHS[171] published in April 2017 recommended the establishment of a new Office for Health and Care Sustainability (OHSC). The experience of the Better Care Funding planning process underlines the difficulty in finding consensus between the component parts of the health and social care system in addressing long-term challenges such as the operability of the interface between secondary, community and social care.[172]

<u>Recommendation 18:</u> We support the recommendation of the House of Lords' Select Committee report on the long-term sustainability of the NHS for the establishment of an independent body with a similar operating model to the Office for Budget Responsibility

Measuring success and embedding accountability

- Enablers – System Architecture
- Enablers – Clinical Review of Standards

With the ongoing development and rollout of new care models in England, the appropriateness of the current NHS outcomes frameworks for health[173], public health[174] and adult social care[175], has come under scrutiny. Writing in the British Medical Journal (BMJ), authors from the King's Fund noted:

> *The models of care emerging are almost without exception predicated on greater integration of public health, health and care services, making the three discrete outcomes frameworks increasingly anomalous*[176]

The current NHS Outcomes Framework (NHSOF) is intended to provide national level accountability for the outcomes the NHS delivers and is the framework by which the Secretary of State monitors the progress of NHS England against the national outcome goals.[177]

However, the current NHSOF captures both inputs (including certain emergency admissions), system cohesion (such as the proportion of patients offered rehabilitation after a procedure) and quality of life outcomes (such as mobility after hip fracture repair).

None of the three frameworks – for health, public health and adult social care – provide a consistent measure of outcomes. Taken together, the data captured in the three frameworks do not provide a useful measure of outcomes for patients on an exemplar care pathway, but rather re-inforce how compartmentalised the delivery of patient care can be.

An exemplar perioperative care pathway that incorporates public health interventions in advance of surgery, a clinically effective procedure and aftercare in the community or a social care setting should be measured against a single set of outcomes. By doing so, the cumulative outcome of an integrated package of perioperative care can be measured.

The establishment of an NHS Assembly (we understand that this is a provisional name) provides an opportunity to reinvigorate the existing Clinical Senates and Strategic Clinical Networks (SCNs). We believe that an NHS Assembly, working with Senates and SCNs, could be developed as a model for collaboration across boundaries that facilitates the scaling-up and national rollout of local and regional pilots with proven outcomes (such as perioperative initiatives).

Improving the speed with which initiatives in care processes and pathway design can be delivered at a national scale, could offer significant improvements to the care that patients receive. This is particularly important as local systems evolve their respective STPs at different speeds, with the second-wave integrated care systems already in development.

Though we support the development of new care models that facilitate patient-centred integrated care, we are concerned that a lack of alignment between STPs, CCGs, NHS England regions, Local Workforce Action Boards (coordinated by Health Education England) and Clinical Senates, might undermine the delivery of consistent and coordinated patient care.

The former long-time Chair of the All Party Parliamentary Group on Cancer has suggested that the development of the long-term NHS plan provides a "golden opportunity" to move away from time-based targets and move to one that focuses on outcomes.[178]

Moving from time-based to outcomes-based targets will require careful consideration with respect to patient expectations – and not just in the area of cancer care. The public engagement report that accompanied the Mental Health Taskforce report noted that, in

discussions with public and patient stakeholders, access and waiting times were understood interchangeably: 'better access meant reduced waiting times and more timely access to support'.[179]

As discussed on numerous occasions within this response, we believe that the NHS is not well equipped to take pilot programmes that demonstrate positive results and impact and bringing them to scale.

NHS leaders and healthcare professionals need to better understand whether patients interpret access to a service as 'how long they wait' because that service is the most effective and likely to deliver the best outcome; or simply because it is the only option.

The Vanguard programme has delivered some success in this approach, but the scalability from 'test' phase in a Vanguard to national rollout seems sluggish and availability of recurrent funding is unclear.

If we can develop some of the pilot programmes and innovative approaches that have a proven positive impact, we may find that factors such as consistency of the service, the environment in which it is delivered and the engagement of a broader church of skills within a MDT have a bigger role in an individual's decisions about their own health.

<u>Recommendation 19:</u> The NHS Outcomes Framework, NHS Adult Social Care Framework and Public Health Outcomes Framework should be replaced with a single framework that captures integrated care outcomes

Getting It Right First Time

- Enablers – System Architecture
- Enablers – Clinical Review of Standards

Getting It Right First Time (GIRFT) is a clinician-led initiative that incorporates a range of surgical and medical specialties in order to identify ways to improve hospital efficiency and patient care. GIRFT began as a pilot in the area of orthopaedic surgery which was subsequently scaled across a total of 32 specialties, following a £60 million investment provided by Government in November 2016.[180]

Two Leads for Anaesthesia and Perioperative Medicine have been appointed to the GIRFT programme, reflecting the evolution of the anaesthetist as the 'perioperative physician' who manages a patient before, during and after surgery. A Lead has also been appointed for Intensive Care Medicine.

GIRFT is most likely to be the vehicle to address the disproportionate use of NHS resources by a given patient cohort. For example, research from consultancy, Capgemini – analysed in the *Health Service Journal* – found that just 5% of the population consume up to half of resources for emergency activity and up to 40% of associated cost. This includes taking 40% of bed capacity taken up by emergency admissions.[181]

A number of GIRFT reports have been published to date, with implications for our membership. However, we will await the report of the Anaesthesia and Perioperative Medicine Leads before developing recommendations that are specific to the GIRFT programme. Six of the STPs published in 2016 proposed using the GIRFT methodology to

identify performance improvements in hospital clinical acute care[182] indicating that the conclusions of the GIRFT Leads for Anaesthesia and Perioperative Medicine will be applicable to the current operating environments.

However, it should be acknowledged that NHS productivity has been rising far faster than the economy as a whole[183], and the opportunities for further efficiencies may be more limited over the next decade, than has been the case over the five years since the establishment of NHS England.

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*28 September 2018**

If you have any questions regarding our submission, please contact Chris Woodhall, Head of Policy & Public Affairs, at cwoodhall@rcoa.ac.uk or on 020 7092 169

** Please note that a number of edits were made to this document in December 2018, to correct typographical errors and to provide clarity some of the analysis. However, no new evidence or information published since the original publication of this document on 28 September 2018 has been included.*

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