Versus Arthritis position statement on the Clinically-led Review of NHS Access Standards
November 2019

National targets for elective care, cancer care, urgent & emergency care and mental health are currently being considered by NHS-England (NHS-E) through the Clinically-led Review of NHS Access Standards. Versus Arthritis believes that people should have access to joint replacement surgery within timeframes that are likely to be most effective.

The following recommendations apply to the standards being considered in the Review:

RECOMMENDATIONS:

- **Maximum waiting time**: The 18-week referral to treatment (RTT) target for elective joint replacement surgery should be retained. Academic evidence shows that delaying joint replacement surgery beyond six months reduces benefit in patient outcomes for people with osteoarthritis.

- **Alternative waiting time:** NHS-England should only consult on a replacement of the 18-week RTT target when they can present new and compelling evidence that an alternative would improve both individual and population level outcomes for people with osteoarthritis receiving joint replacement surgery.

- **Average waiting time:** The specific proposal for an average waiting time target for incomplete pathways should only be introduced when NHS-England can present new and compelling evidence that it would result in better individual and population level outcomes. Given current evidence, it should not be used as an alternative to a maximum waiting time in the final Review.

- **Alternative provision/patient choice offer:** The 26-week patient choice offer has the potential to complement the current maximum waiting time target for elective joint replacement surgery but sufficient time is required to pilot the effectiveness of this proposed standard to understand the overall impact on performance, including individual and population level outcomes for people with osteoarthritis. NHS-England should retain the current guarantee of access to an alternative provider if a patient is waiting for joint replacement surgery longer than 18 weeks.

- **52-week treatment guarantee:** The NHS Long Term Plan's commitment to levying fines for failure to deliver surgery within 52 weeks should be implemented fully to hold local health systems to account.

- **Accountability Framework:** Following the review, the NHS-England/NHS-Improvement (NHS-E/I) Accountability Framework for 2020/21 to 2023/24 should include indicators to hold the health and care system to account for delivering elective joint replacement surgery within a maximum waiting time, the proposed 26-week patient choice offer and 52-week treatment guarantee so that the impact of any changes can be monitored.

1. Background

It is estimated that 18.2% of people aged 45 years or over in England have osteoarthritis of the knee (4.11 million), and 10.9% of people aged over 45 in England have osteoarthritis of the hip (2.46 million).[1]

Given that the main modifiable risk factors for lower-limb osteoarthritis are obesity and physical inactivity, a public health approach is crucial to reducing the risk of developing osteoarthritis and preventing symptoms from worsening for those who are diagnosed. Regular physical activity and the provision of programmes such as ESCAPE-pain may help to reduce the risk of hip and knee osteoarthritis and improve physical function.[2]

In addition, increasing the use of shared decision making for people with osteoarthritis will help ensure that other treatment approaches can be explored before considering hip or knee replacement surgery.

Nonetheless, there are people with osteoarthritis whose condition is so severe that joint replacement surgery will be their only option to alleviate pain, improve mobility and the ability to self-manage. The musculoskeletal (MSK) calculator estimates 726,000 people have severe hip osteoarthritis and 1.4 million people have severe knee osteoarthritis in England, although not all of these people will require joint replacement surgery.[3]

Osteoarthritis was the primary cause of 90% and 98% of primary hip and knee replacements in the England, Wales and Northern Ireland in 2017.[4] The National Joint Registry's 15th Annual Report in 2018 showed that there were 105,306 hip replacement procedures and 112,836 knee replacement procedures in 2017.[5]

Evidence shows that hip and knee joint replacement surgery is clinically and cost effective[6, 7, 8, 9] and can help to restore mobility and reduce pain. Versus Arthritis believes that people should have access to joint replacement surgery within timeframes that are likely to be most effective and less likely to cause patient harm.

This statement is part of our wider policy work on access to joint replacement surgery and sets out our position on the Clinically-led Review of NHS Access Standards.

2. Overview of the Clinically-led Review of NHS Access Standards

The interim report of the Clinically-led Review of NHS Access Standards was published in March 2019 by NHS-England to outline proposals around current targets for elective, cancer, urgent and emergency and mental health care.[10]

The purpose of the review is to evaluate the core set of NHS access standards to reflect the service model described in the NHS Long Term Plan and recommend any required updates and improvements.

The maximum waiting time target from referral to treatment (RTT) for elective surgery has helped to hold healthcare providers to account for delivering treatment within 18 weeks for 92% of patients. In the interim report, NHS-England acknowledged that targets had helped reduce waiting times for elective surgery in England: *'Efforts to reduce waiting lists over the last decade have been supported by the national target of 18 weeks.'* [11]

The target also provides patients with assurance about when they can expect to access treatment for joint replacements, in a time period that evidence suggests will be most clinically effective.

3. Existing patient rights around elective surgery

Patients' rights around elective surgery are included in the Handbook to the NHS Constitution.[12] These rights have historically been embedded through targets to Hospital Trusts, with further accountability provided by the Mandates to NHS-England[13] and the Clinical Commissioning Group (CCG) Assurance Framework[14], holding health service commissioners and providers to account for delivering elective treatment in a timely manner.

The most recent Accountability Framework for NHS-England and NHS-Improvement (NHS-E/I)[15] , which replaced the Mandate to NHS-England, does not include these rights but instead focuses on reducing the longest waits for surgery (up to 52 weeks). However, the document does indicate proposals for field testing of potential future changes to elective care access standards that are outlined in the interim Clinically-led Review of NHS Access Standards.[16]

The twelve pilot sites for the proposed average waiting time target were recently announced.[1]

3.1 Rights in the NHS Constitution

The existing rights are:

- **Maximum waiting time:** The Handbook states that: *'You have the right to start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions.'*
- **Alternative provision (1):** Page 30 of the Handbook states**:** *'If it not possible to deliver surgery within 18 weeks, the CCG or NHS England must take all reasonable steps to offer a suitable alternative provider, or if there is more than one, a range of suitable alternative providers, that would be able to see or treat you more quickly than the provider to which the patient was referred. A suitable alternative provider is one that can provide clinically appropriate treatment and is commissioned by a CCG or NHS-E'.*
- **Alternative provision (2):** The current access standard highlighted on page 31 of the Handbook is that: *'All patients who have operations cancelled, on or after the day of the admission (including the day of surgery), for non-clinical reasons should be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.'*

3.2 Rights in the NHS England/Improvement Accountability Framework

Access standards – whether existing or proposed - will only be implemented if there is a strong accountability mechanism to ensure that Trusts prioritise their resources on meeting them.

[1] The trials trialling the new measure are: Barts Health Trust; Calderdale and Huddersfield Foundation Trust; East Lancashire Hospitals Trust; Great Ormond Street Hospital for Children FT; Harrogate and District FT; Milton Keynes University Hospital FT; Northampton General Hospital FT; Surrey and Sussex Healthcare Trust; Taunton and Somerset FT; The Walton Centre FT; University Hospitals Bristol Trust and University Hospitals Coventry and Warwickshire Trust.

In previous years, different Accountability Frameworks for CCGs[17] and NHS-E[18] have included indicators to meet the target to deliver 92% of elective surgery within 18-weeks from Referral to Treatment (RTT).

The first joint NHS-E/I Accountability Framework (published in May 2019) removed this objective pending the interim report of the Clinically-led Review of NHS Access Standards.[19] Instead, it has set the following objectives:

- NHS-E and NHS-I to test changes to access standards (waiting times) following publication of Clinical Standards Review.
- NHS-E/I should ensure there is an '*increase in elective activity and that the size of the elective waiting list is reduced*.'
- Expectation that waits of 52 weeks or more will be eliminated.

The actions outlined above will set the foundations for further improvements in 2020/21 as part of the NHS Long Term Plan (LTP)'s commitment to improve urgent and emergency care performance and reduce waiting lists over five years.[20]

The need for interim measures of performance for elective surgery as the Clinically-led Review into NHS Access standards progresses is understandable. However, once the Review is completed, it is important the next NHS England/Improvement Accountability Framework includes indicators to hold the health and care system to account for delivering elective surgery within a maximum waiting time, as well as delivering the 26 week patient choice offer and 52 week treatment guarantee.

- **RECOMMENDATION: Following the review, the NHS-England/NHS-Improvement (NHS-E/I) Accountability Framework for 2020/21 to 2023/24 should include indicators to hold the health and care system to account for delivering elective surgery within a maximum waiting time, the proposed 26-week patient choice offer and 52-week treatment guarantee.**

4. Clinically-led Review of NHS Access Standards

Within the interim Clinically-led Review of NHS Access Standards, NHS-England highlights discrepancies within the existing waiting time standards for elective care that need to be addressed:

- No account is given currently to how long beyond 18 weeks someone has waited – performance is rated the same at 19 or 49 weeks;
- The current target can be 'misleading' to patients who may believe the majority of people wait as long as 18 weeks for treatment.

NHS-England has proposed exploring the following standards for elective care as part of the interim Review (the table below has been transcribed from the interim Review document)[21]:

Measure	**Clinical rationale**	**Implications for patient care**
Maximum wait of six weeks from referral to test, for diagnostic tests	Ensure that patients are accessing diagnostic tests quickly, so that a diagnosis can be reached and treatment can begin in a timely manner.	Need for consistent achievement in all places. Achieve opportunity for faster overall pathway to diagnosis and decision and create a clear plan for treatment earlier.

Defined number of maximum weeks wait for incomplete pathways, with a percentage threshold OR average wait target for incomplete pathways	Will test both approaches to consider the impact on prioritisation of care and reduction of long waits. Every week counts for all patients in achieving an average, hence keeps focus at all stages of their pathway.	Measure from the point of referral under treatment. Clock stops and starts will reflect new arrangements for outpatients.
Supporting Measures		
26-week patient choice offer (supporting measure)	Ensures that patients who have not accessed treatment within recommended timeframe, are able to choose whether to access faster treatment elsewhere in a managed way.	Faster care for many patients by re-directing to providers who can treat them more quickly.
52-week treatment guarantee (supporting measure)	This is too long and for any patient to wait and incentivising action to eliminate 52 week waits will focus on finding solutions to services that are unable to meet demand.	All patients must be treated within 52 weeks, with fines imposed on commissioners and providers who are jointly accountable if not.

5. Detailed comment on each of the proposed standards

5.1 Maximum waiting time: Defined number of maximum weeks wait for incomplete pathways

In June 2019, Versus Arthritis commissioned a poll by YouGov of 1,009 people diagnosed with osteoarthritis. The poll included a question about how important it would be to know various factors if they were waiting to get planned surgery such as a joint replacement on the NHS. An overwhelming majority of people with osteoarthritis (96%) said that knowing that there was a maximum waiting time set by the NHS that they should have to wait for treatment was ‘very important’ or ‘fairly important’.

The poll also highlighted the experience of people with osteoarthritis as they waited for joint replacement surgery. Almost half (49%) of those with experience of knee, hip or shoulder replacement surgery said their physical health deteriorated and one third (33%) said that their mental health deteriorated while they were waiting for their operation.

In addition, there is strong evidence drawing a link between poorer patient outcomes and waiting times beyond six months, as well as evidence that highlights how providers could deliver a greater number of hip and knee replacements:

The link between patient harm and waiting times beyond six months

Whilst the current targets for elective surgery allow the NHS to build some picture of how long a person is waiting from the point of referral, they do not capture the ‘hidden wait’ that occurs from when a patient first experiences pain in their joints to first presenting to a

healthcare professional. This means that for many people with arthritis, the time spent in pain before joint replacement will be far longer than the 18-week maximum standard wait (without taking into account possible delays for rehabilitation and surgery).

This was highlighted in a report published by Versus Arthritis in 2013, which explored the rights of patients with arthritis in accessing joint replacements.[22] We heard about the impact and burden of pain people experienced whilst waiting for an operation, especially those due for knee replacements. Consequently, the date of the operation, once fixed, became a day that people needing a joint replacement were planning their lives around.[23]

The Burns Review in Scotland

Evidence collated by Harry Burns for the review of targets and indicators for health and social care in Scotland (the Burns Review) [24] highlighted a range of academic studies that explored the relationship between the length of time waiting for joint replacement and clinical outcomes.

One study completed by Garbuz found that waiting for joint replacements for longer than six months 'was linked to a 50% decrease in functional outcome' and 'that delaying treatment may result in deterioration that may not be recoverable after surgery.'[25] Additional studies in the review showed that 'each additional month waiting for treatment was associated with an 8% decrease in the odds of better than expected functional outcome.'[26]

Furthermore, the Review found that functional capacity gain was poorer for patients who waited longer than six months for surgery, and that patients on extended waiting times had increased pain and disability compared to those with shorter waits.[27]

The studies cited in the Burns Review give us evidence on the likely timeframes that make surgery most effective, and an evidence base that demonstrates that outcomes deteriorate after this point.

Getting It Right First Time (GIRFT)[28]

Getting It Right First Time (GIRFT)'s review of adult elective orthopaedic services in England in 2015 noted in its Executive Summary that there were 'undesirable variations in practice' in relation to the delivery of joint replacement surgery.[29]

The review highlighted data collected from September 2013 to 2015 which showed that 23.7% of surgeons performing hip replacements, and 16.1% of surgeons performing knee replacements undertook 10 or fewer procedures per annum.[30]

GIRFT noted substantial evidence in the literature indicating that surgeons undertaking low volumes of specific activities may well result in less favourable outcomes as well as increased costs.[31] The review also indicated that surgeons who carry out at least 35 operations each year were maintaining their skills to a level that ensured better clinical results for patients.[32]

They also reported failure to follow the evidence of the National Joint Registry (NJR) and other registries in decision making around implant choice for patients, especially in those aged over 68 years.

A number of solutions (please see appendix) were identified by GIRFT for professionals, providers, managers and commissioners who all have a role in improving outcomes in adult elective orthopaedics. Learning from best practice is critical to ensuring that less patients

are waiting in pain for joint replacements that can improve their pain, mobility and independence.

Evidence from NHS-Improvement on NHS productivity

Evidence from NHS-I indicates there is significant room for higher productivity in the delivery of elective surgery.

Recent evidence from NHS-I suggests that greater efficiency within the NHS could allow more procedures to take place, reducing the amount of time that patients have to wait.[33]

NHS-I and Deloitte published a report in early 2019, which argued that greater productivity in the NHS would have allowed for 57,000 more orthopaedic procedures.[34] The report noted that of the 89 trusts that submitted orthopaedic data, 29% had an in-session productivity opportunity of more than 20% through the elective sessions that were delivered across the 12-month period. In the distribution of 'downtime' on operating lists that could have completed additional cases, early finish accounted for 50.5%, late start 20.1% and 'intercase downtime' 29.4%.

Recommended actions in the report included developing improvement plans, determining productivity measures at procedure level and sharing best practice at specialty and procedure level from Trusts that achieve consistently strong theatre productivity.

NHS-I's report highlights that despite the capacity and demand challenges faced by providers, greater efficiencies could ensure that more patients can access orthopaedic surgery, including hip and knee replacements, in a timeframe where the procedure is most likely to be clinically effective.[35]

Proposed changes to outpatient services in the NHS Long Term Plan

The proposed changes to the existing maximum waiting time target are strongly based around reforms to outpatient services that are outlined in the NHS LTP. This reform includes reducing outpatient appointments by one third, which NHS-England estimate will save patients an estimated 30 million visits to hospital and saving the NHS over £1 billion a year.[36]

However, as the House of Commons' Public Accounts Committee pointed out in their 2019 inquiry on NHS waiting times for elective and cancer treatment, such an ambition will require an expansion of capacity in primary care workforce for it to be delivered.[37] The NHS Long Term Plan and GP Contract Framework's proposals to develop primary care networks and encourage the recruitment of allied healthcare professionals to support GPs could help to reduce the demand for outpatient appointments.

The Committee also raised questions about how access to care would be maintained if the target of reducing a third of outpatient appointments cannot be delivered.[38]

Even if the target around the removal of outpatient appointments can be achieved, there is still a need to maintain the existing maximum waiting time target, given the inadequacies of the proposal for average waiting times that are discussed further in section 5.3.

- **RECOMMENDATION: The 18-week referral to treatment (RTT) target for elective joint replacement surgery should be retained. Academic evidence shows that delaying joint replacement surgery beyond six months reduces benefit in patient outcomes for people with osteoarthritis.**

- **RECOMMENDATION: NHS-England should only consult on a replacement of the 18-week RTT target when they can present new and compelling evidence that an alternative would improve both individual and population level outcomes for people with osteoarthritis receiving joint replacement surgery.**

5.2 Average waiting time: Average wait target for incomplete pathways

The proposal in the interim review to introduce an average waiting time for incomplete pathways for elective surgery requires a significant level of evidence to justify being included as a future access standard for elective care.

Versus Arthritis is concerned that the proposal to pilot the average wait and other proposed elective care standards for just four months (a 17 week period) with the potential backdrop of winter pressures does not give sufficient time to evaluate the impact on patient outcomes and make a firm decision on changes to access standards.

If the current broad categories of data collection (i.e. Trauma & Orthopaedics) are retained, there are questions about whether an average waiting time would provide sufficient clarity around waiting times for individuals and procedures like joint replacements that are not published in the current dataset. Whilst the pilots will be exploring the impact on the behavior of providers, it is also important to evaluate the experience of patients under this standard.

The Nuffield Trust has argued that the introduction of an average waiting time could incentivise Trusts to tackle the longest waits for surgery between 18 and 52 weeks.[39]

However, they suggest that an average waiting time could also have unintended consequences, because hospitals reducing the number of planned outpatient visits 'could make their average waiting time performance worse by removing some of the shorter waits (like the number of planned patients waiting for an outpatient visit).'[40]

It is important not just to focus on the experience of average patient waiting times but also consider patients who are waiting longer than they should and experiencing an impact on their quality of life (even before they reach 52-week limit). Proposed changes for elective care access standards also need to take into account what matters most to people with osteoarthritis, whose access to care will depend on the nature of future standards.

In June 2019, Versus Arthritis commissioned a YouGov poll of people diagnosed with osteoarthritis (see also section 5.1 above). The poll included a question about how important it would be to know various factors if they were waiting to get planned surgery such as a joint replacement on the NHS. Whilst 65% of respondents said that knowing the NHS target for the average waiting time was 'very important', a higher proportion of people with osteoarthritis (77%) said that knowing that there is a maximum amount of waiting time set by the NHS was 'very important'.

- **RECOMMENDATION: The specific proposal for an average waiting time target for incomplete pathways should only be introduced when NHS-England can present new and compelling evidence that it would result in better individual and population level outcomes. Given current evidence, it should not be used as an alternative to a maximum waiting time in the final Review.**

5.3 Alternative provision/patient choice offer: 26-week patient choice offer

The Clinically-led Review of NHS Access Standards is also considering people's rights to access treatment through alternative providers.

The proposal in the interim Clinically-led Review of NHS Access Standards is to allow for patient choice of an alternative provider if treatment is not delivered within 26 weeks. This would suggest a change, compared the current access standard in the Handbook, which states: '*You have the right to start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions… If this is not possible, the CCG or NHSE… must take all reasonable steps to offer a suitable alternative provider, or if there is more than one, a range of suitable alternative providers, that would be able to see or treat you more quickly than the provider to which you were referred.'* [41]

It is unclear what the rationale is behind selecting 26 weeks as the cut-off point when patients will be able to request/access an alternative provider if the NHS cannot deliver surgery within the recommended time-frame. Therefore, building understanding of how the patient choice offer would work through field testing across a sufficient period of time is particularly important.

Versus Arthritis is also concerned about whether the proposed access standards for an average waiting time and 26 week patient choice offer will be tested alongside each other.

In particular, there is an issue about how the average waiting time would be calculated in a situation where a patient exercised their right to access another provider after 26 weeks. Clarity is needed about whether the waiting time clock from the first provider will be added to the other provider, or whether it would start again.

The timescale of the pilots will coincide with increased pressures on capacity in elective care during winter 2019/20 – with possible impact on patients who are being treated according to the existing access standards.

Versus Arthritis also questions whether four months is a sufficient period of time to test the effectiveness of proposed supporting measures of the patient choice offer - which would cover a six-month period – and the 52-week treatment guarantee.

- **RECOMMENDATION: The 26-week patient choice offer has the potential to complement the current maximum waiting time target for elective joint replacement surgery but sufficient time is required to pilot the effectiveness of this proposed standard to understand the overall impact on performance, including individual and population level outcomes for people with osteoarthritis. NHS-England should retain the current guarantee of access to an alternative provider if a patient is waiting for joint replacement surgery longer than 18 weeks.**

5.4 52-week treatment guarantee

NHS-E's intention to better understand the performance of providers who deliver surgery between 18–52 weeks through the 26 week patient choice offer and the 52 week treatment guarantee is welcome.

Evidence from the studies in the Burns Review suggests that patient outcomes gradually worsen the longer they have to wait for treatment, so it is important that this is reflected in

the way performance is measured after 18 weeks. The current focus on 52-week waits should not be at expense of delivering surgery within maximum waiting time.

We welcome the use of penalties for commissioners and providers if they do not deliver elective surgery within 52 weeks within the NHS Long Term Plan, but it is important that accountability is strengthened as existing waiting times targets are reviewed.

- **RECOMMENDATION: The NHS Long Term Plan's commitment to levying fines for failure to deliver surgery under 52 weeks should be implemented fully to hold providers to account.**

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Jonathan Canty, Policy Officer, November 2019

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APPENDIX 1 – GIRFT AT A GLANCE

Problem: Costly (quality of life and ££). Variation in Outcome in Adult Elective Orthopaedics.

Caused by	Solutions	Case study of best practice
VARIATION IN PRACTICE BY PRACTITIONERS • Not following evidence on implants • Low volumes of specialist work • Ownership of collecting outcome data and coding • Different approaches to networking, multidisciplinary team (MDT), joint working and trauma	PROFESSIONALS • Clinical leadership • Follow guidance • Sub-specialise to deliver minimum numbers • Mentoring etc. • Appraisal • Revalidation	• Royal Devon and Exeter • Princess Alexandra, Harlow • Leicester • The specialist units
VARIATION IN PATHWAY AT PROVIDERS • Ring-fenced beds, theatre and staff • Governance • Support for data quality and accuracy of outcome data and coding	PROVIDERS • Reconfiguration to facilitate critical mass and minimum volumes in networks • Ring-fenced beds, theatres and staff • Litigation – pre-emptive planning	• Northumberland • Bolton • South West London Elective Orthopaedic Centre • Bournemouth • The specialist units
VARIATION IN MANAGEMENT MODEL • Top-down management combined with poor clinical engagement • Loss of clinicians morale	MANAGERS • Management model – shoulder to shoulder with clinicians	• Wirral University Hospitals • Royal Devon and Exeter • Guy's and St Thomas' • Mid Yorkshire Hospitals
VARIATION IN COMMISSIONING • Lack of focus on minimum critical volumes across a region/potential network • Inconsistent and unregulated relationships with AQPs (Any Qualified Providers)	COMMISSIONERS • Commission collaboration to achieve critical mass • Total collaboration across providers to encourage critical mass and healthy collaboration/competition with focus on sustainability and quality	• London

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