CPOC The 10-Year Health Plan for England: CPOC submission

November 2024

1. **What does your organisation want to see included in the 10-Year Health Plan and why?**

Background

There is considerable scope to enhance the efficiency and productivity of the NHS and improve patient outcomes, through reforming and optimising the surgical pathway. This can be achieved through better "perioperative care" - essentially all care a patient receives both before, during, and after surgery, which is underpinned by multi-professional collaborative working, to ensure optimal outcomes.

Good perioperative care helps avoid cancellations, complications, lengthy hospital stays, and readmissions, and aids swift recovery. It also empowers patients in decision-making processes, enhances patient care, helps the NHS reduce the elective backlog, and delivers long-term cost savings that will outweigh necessary short-term investment.

We, the Centre for Perioperative Care (CPOC) https://www.cpoc.org.uk/guidelines-resources-resources/key-reducing-waiting-lists, are a partnership between health charities, patient groups, and several leading Royal Colleges- including the Royal College of Anaesthetists, Royal College of Surgeons of England, Faculty of Public Health, Royal College of Physicians and Royal College of Nursing- dedicated to the development and promotion of perioperative care. We have worked both to identify deficiencies in the way care is currently delivered and to develop realistic, practical solutions.

Inefficiencies

Currently, NHS productivity is hindered by entirely avoidable inefficiencies, within the surgical pathway, limiting its ability to deliver timely and effective patient care. Inefficiencies include:

- Each year around 80,000 on the day surgical cancellations take place, [1] estimated to cost the NHS £400 million annually in lost operating theatre time. [2]
- Complications occur in 12% of operations, resulting in extended stays in hospital. [3]
- Patients often spend one or two days longer than necessary in hospital after surgery. [4]
- 45% of hospital costs result from 3% of patients, often those with complications. [5]
- Over 11.5% of readmissions are preventable. [6]

- Care failures have driven NHS England compensation payments to record sums of £3 billion – 1.7% of the entire NHS budget. [7]

Causes of these inefficiencies include:

- Patients arrive on the day of surgery in an unfit state, which can be due to frailty; health behaviours such as smoking, physical inactivity, or excess drinking; or with one or more unaddressed co-morbidities such as anaemia or diabetes.
- Patients are often not actively included in decision-making around their own care, leading to surgical regret, the possibility of litigation, and the NHS performing operations when it doesn't need to.
- Missed opportunities to speed up patient recovery through promoting drinking, eating and mobilising after surgery.
- Inadequate discharge planning.

Solutions include:

Turning waiting lists into preparation lists

- The healthier patients are when going into surgery, the lower the risk of last-minute cancellations, surgical complications, and extended stays in hospital.
- The first step is to pre-screen patients as they are added to the surgical waiting list to assess their health status and behaviours. This should be tailored to be age appropriate, including paediatric pre-assessment for children and comprehensive geriatric assessment for older patients (46% of adults who have elective surgery are aged over 65 years). [1]
- Then, if patients are found to have addressable health issues, they should be offered help to tackle these, including optimisation of medical conditions and active preparation for surgery including 'prehabilitation' programmes where available. This could involve support for exercise, diet, and smoking cessation.
- Evidence shows that active preparation for surgery reduces complications by up to 30%-80% and length of hospital stay by 1-2 days. [4]

Enhanced recovery

- 'Enhanced recovery' programmes aim to ensure that patients can recover from surgery as quickly as possible.
- This can be done through simple interventions such as facilitating an early return to Drinking, Eating, and Mobilisation (DrEaMing) after surgery.
- This helps to prevent complications in the postoperative period and reduce the length of hospital stay. As a result, patients recover more quickly and are less likely to be readmitted to hospital after discharge.
- Estimates suggest this could lead to savings of more than £150 million. [1]

Discharge planning

- Discharge planning involves collaboration between healthcare staff and patients to plan their discharge process and organise any necessary support.
- Planning should be a requirement to take place as early as possible to identify a patient's needs and ensure they are properly supported and managed. Ideally, this should happen before the patient is even admitted to hospital.
- Better discharge planning has been shown to reduce re-admissions by 11.5%, which may translate to reduced waiting lists and lower costs for the health system. [6]

Shared decision making (SDM)

- Patients are too often excluded from decisions regarding healthcare interventions. Sometimes this results in inadequate consideration of whether surgery is the right option.
- This has led to unnecessary operations, wasting valuable NHS resources, and surgical regret, with 14% of patients expressing regret at having an operation. [1]
- SDM involves actively involving patients in discussions of the Benefits, Risks, Alternatives, and possibility of No treatment (BRAN).
- It results in fewer regrets about treatment, better communication with healthcare professionals, and improved knowledge of their conditions and treatment options, with 10% of patients deciding against surgery. [8]
- Additionally, 'fail to warn informed consent' claims averaged £53 million per year between 2017-2022. However, patients experiencing good SDM are 80% less likely to sue, potentially saving the NHS £42 million per year in litigation costs. [9]
- There is a NICE guideline for SDM [NG197] but implementation is not comprehensive. [10]

Perioperative care for older people undergoing surgery

- 67% of patients over age 65 have multiple co-morbidities and are at greater risk of complications. [11]
- Therefore, they should be offered an individualised approach to optimise their care. This could include the Perioperative Care for Older People undergoing Surgery (POPS) model. This involves comprehensive geriatric assessment and optimisation and has already been implemented at over 30 hospitals across the UK.
- Clear benefits have been demonstrated in terms of improved SDM, reduced cancellations, reduced length of stay, and better patient and workforce satisfaction. 14% of patients decide against surgery after discussion with a geriatrician-led service. [12]
- Additionally, introducing comprehensive geriatric assessment and optimisation into the surgical pathway is estimated to reduce healthcare costs by £1,165 per patient overall – even when accounting for implementation costs. [13]

Enablers required for this to happen

The NHS is already trying to introduce these measures, such as including some perioperative care measures in its standard contract to trusts. However, widespread implementation remains inconsistent due to funding barriers. Many NHS trusts have claimed that they are unable to

establish services due to financial constraints, despite acknowledging the long-term cost savings they would bring. To overcome this issue, the NHS 10-Year Health Plan should provide a clear steer that trusts should implement these measures – and pledge funding for initial set-up costs. One way of introducing this could be the creation of an 'NHS Efficiencies Transformation Fund' made available to trusts.

Additionally, to enable this transformational change in the surgical pathway, the NHS requires skilled, motivated and highly performing staff working collaboratively in teams. Although the 'Delivery plan for tackling the COVID-19 backlog of elective care' and the 'NHS long-term workforce plan' included commitments to establish perioperative care teams, a fully-fledged perioperative care workforce strategy is lacking. CPOC has produced a new workforce position paper detailing how the workforce could be developed and upskilled to deliver effective perioperative care, which could provide a framework to do this. [14]

The NHS is short of key staff, such as anaesthetists, but the productivity of and retention of existing staff could also be improved, with attention to strategic detail in 10 key themes:

1. Efficiency
2. Working together
3. Activities to assist team-working
4. Culture and behaviours
5. Different staff groups
6. Education - levels of knowledge, skills and experience
7. Commitment to holistic health
8. I.T. systems set up to reduce workload
9. Patient-centred care
10. Leadership and workforce planning

We believe that the 10-Year Plan should acknowledge the importance of the perioperative workforce and include steps to ensure it is embedded.

Health regulators, including the Care Quality Commission (CQC), should also play a role in incentivising implementation by including perioperative care measures and outcomes in their assessment frameworks. Penny Dash's first and second reviews of the CQC recommends changes to the role of the myriad of regulators with a greater focus on effectiveness, outcomes, innovative models of care delivery and efficient use of resources.

CPOC can work with regulators to develop critical outcome metrics including cancellations, complications, length of stay, readmissions, and days at home, as well as the existence of more efficient practices that could promote change. Their inclusion would both help recognise good practice, and hold hospitals to account where there are omissions, failings, or inadequacies.

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2. **What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?**

Discharge planning

A critical challenge in shifting more care from hospitals to communities is inadequate discharge planning, once requirements for specialised care have passed. This creates two problems. Firstly, patients often remain in hospital for one or two days – and in some cases, even weeks – longer than medically necessary, straining NHS resources. As highlighted in Darzi's review, delayed discharges occupy 13% of all NHS beds.[1] Secondly, patients are too-often readmitted to hospital because sufficient planning has not taken place to allow themselves or their carers to recover at home or in other community settings or the safety netting processes have been poorly planned or coordinated.

Currently, there is insufficient coordination between hospital staff and patients, carers, GPs, and other health and care services in the community to plan the discharge process and arrange necessary post-discharge support. For example, according to Carers UK's 'State of Caring 2023' report, 60% of carers reported being excluded from discharge planning, signalling a breakdown in communications.[2] . Consequently, many patients- particularly elderly individuals- remain in hospital wards, despite their needs being better served in a community-based setting. This exacerbates NHS capacity issues, incurs higher costs, and leads to poorer patient outcomes and experiences.

Research also shows that effective discharge planning can reduce re-admissions by 11.5%.[3]

Discharge planning can start pre-operatively for elective and semi-urgent pathways, but this requires a joined-up perioperative pathway approach so pre-assessment staff are educated and empowered to be proactive. In addition, this area is ripe for re-design using digital technology and innovation.

Turning waiting lists into preparation lists

Another challenge is the lack of patient preparation before surgery. As mentioned in the previous section, too often patients arrive on the day of surgery in an unfit state, which can be due to frailty; health behaviours such as smoking, physical inactivity, or excess drinking; or with one or more unaddressed co-morbidities such as anaemia or diabetes. These factors increase the risk of complications, causing extended stays in hospital and readmissions, thereby delaying the shift of care to community settings.

Perioperative interventions can address these issues. Measures such as pre-screening, prehabilitation, medical optimisation, and comprehensive geriatric assessment help to turn waiting lists into 'preparation lists'. Ideally, these should occur in a local, accessible location for patients, supporting the shift of care closer to home.

These initiatives also promote long-term health improvements. By utilising the waiting period to deliver targeted health messages, long-term behavioural changes can be embedded. For example, prehabilitation programmes have resulted in 48% - 75% of participants increasing physical activity, 43% stopping smoking, and 40% reducing alcohol consumption after surgery. [4] This increases patients' ability to live healthier lives in their communities.

Medication management during the transition of care

Patient safety relating to medication is a critical concern when transferring care from hospitals to communities, as recognised by the World Health Organisation. Poor communication during the referral or discharge of patients risks the inappropriate continuation or cessation of medication.

Robust communication between secondary care, primary care, and patients is essential. For example, initiatives like opioid stewardship guide patients on how and when to reduce analgesia and how to safely dispose of unused medication. This will reduce the risk of persistent opioid use or the misdirection of medications.

Technology

Technology plays an important role in addressing the aforementioned challenges. Improved data sharing between hospitals and community care providers will support initiatives like discharge planning and pre-assessment.

Additionally, the expansion of virtual wards could support the shift of care to communities. Virtual wards allow post-operative patients to recover at home using an app that provides clinical teams with real time health data. These teams monitor the results from virtual hubs and community nurses provide support to patients on the ground. This reduces hospital stays and allows patients to recover safely and conveniently at home. The West Hertfordshire Teaching Hospitals NHS Trust has successfully delivered virtual wards, demonstrating their potential for wider adoption across the UK.[5]

Perception of hospital care rationing

An unspoken barrier to moving care into community settings is that many of the public perceive that this equates to rationing hospital care, which they believe they need for themselves or their loved ones. However, if the reforms proposed by CPOC are clearly identified as being from CPOC, which is multi-professional and patient-centred, this will be more acceptable to patients and the public. Historically, local campaigns to preserve services have stalled many NHS reconfiguration plans. Including professional leadership redefines the perception of these major changes from a portrayal of hospital care rationing to a well-supported, professionally-led, joined-up system to improve care and empower patients. This highlights the importance of the Government working with trusted professional organisations to reassure both patients and healthcare staff during the shift of care to communities.

Overall, to enable the safe and efficient transfer of care from hospitals to communities, the 10-year plan should prioritise the following:

- Formal, mandatory discharge planning that begins as early as possible in the patient pathway, ideally before admission to hospital.
- Medication management should be embedded at every transition of care to ensure patient safety.
- Waiting lists should be transformed into ‘preparation lists’.

- Technology should be utilised to connect hospital and community care, including integrated patient records and virtual wards.
- The Government should work with trusted professional organisations to help implement change.

These measures should be centrally driven and prioritised immediately to ensure adoption by all NHS trusts.

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3. **What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?**

Improve data sharing

The NHS needs improved data sharing capabilities- ideally through shared IT systems- between primary and secondary care. An integrated patient record, such as the 'patient passports' recently announced by Wes Streeting, would be one way to achieve this. Currently, GPs and clinical staff in secondary care use separate platforms to record patient data that don't speak to each other. This has significant impacts on patient care and hampers overall productivity.

However, improved data sharing would support the implementation of practices that will give rise to efficiencies. For example, an integrated patient record would help transform waiting lists into preparation lists by allowing clinicians in secondary care to swiftly access patient data recorded by GPs, facilitating the identification of health issues and supporting faster, more targeted patient care. Additionally, it would enhance discharge planning, as GPs would have access to complete discharge notes for patients coming out of secondary care.

NHS England is already working to improve data sharing. Work has been underway to roll out the Federated Data Platform across NHS trusts and integrated care systems. However, GP data is excluded from the scope. Any future initiatives should attempt to build in data sharing at the outset and be common with, or include designed-in integration with, primary care systems. Information Governance needs to be carefully considered. Concerns remain around the safety of patient data and there is a need for appropriate safeguards to ensure it is protected.

Comprehensive data collection and analysis

The NHS also requires improved digital systems to record patient data and generate meaningful analytics. Comprehensive data should be collected for all patients on the surgical pathway, including information on co-morbidities, health behaviours, time of pre-screening, decision to offer prehabilitation, and time of discharge. Additionally, data on cancellations, complications, hospital bed days, and readmissions is critical. Collecting this data systematically will support the identification of best practices and target areas for improvement, allowing the NHS to address problems and allocate resources more effectively.

Promisingly, HQIP (which is funded by NHSE) has started the process of commissioning a perioperative care audit. This is an important step forward but should be underpinned by the routine collection of relevant data as standard by NHS providers.

Wider use of Robotic Process Automation

The NHS has begun using Robotic Process Automatic (RPA) but its application remains limited and it could be utilised more widely in pre and post-operative settings. Currently, doctors spend a significant amount of time on paperwork, taking them away from other clinical duties, learning opportunities, and often causing delays. However, RPA could be used to generate patient records such as discharge letters. It could also be used to introduce digital screening to triage patients on the waiting list to the appropriate preoperative assessment pathways. This would optimise the use of medical staff, improving efficiency and freeing up staff for more complex tasks.

Overall, in order to make better use of technology in health and social care the 10-year health plan should prioritise the following:

- Improved data sharing between primary and secondary care.
- Comprehensive data collection and analytics.
- Wider use of robotic process automation.

However, new technology must only be viewed as a complement to getting the basic processes right within the surgical pathway, not a replacement for it.

4. **What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?**

One huge opportunity to spot illness early and tackle the causes of ill health occurs when patients get referred for surgery. Unfortunately, this opportunity is often missed.

The surgical pathway is a time when groups that are sometimes hard to reach are a) in contact with health professionals; and b) highly motivated to make behavioural changes. We believe the NHS could take far greater advantage of that important co-occurrence to detect co-morbidities and poor health behaviours, address them, and embed long-term positive change.

As stated above, many patients awaiting treatment have one or more unaddressed co-morbidities, unhealthy lifestyles, or are elderly. Common issues include poor diet, lack of exercise, smoking, frailty, and untreated conditions like anaemia, diabetes, or mental health issues. In the UK, 45% of adults who have elective surgery are over 65, [1] and two-thirds of these patients have multiple co-morbidities. [2] These increase the risk of cancellations, complications, extended hospital stays, and readmissions, but also increase the likelihood of future health problems.

A solution is to transform waiting lists into 'preparation lists'. All patients referred for surgery should be pre-screened to identify their health status and behaviours. This should be tailored to be age-appropriate, with paediatric pre-assessment for children and comprehensive geriatric assessment for older patients. Where health issues are identified, patients should receive tailored support through medical optimisation, comprehensive geriatric optimisation, or active preparation for surgery including 'prehabilitation' programmes. This could involve support for exercise, diet, smoking cessation, alcohol moderation, or psychological support.

This proactive approach would allow early identification of health concerns, enabling timely interventions to improve patient outcomes. Evidence shows that preparation for surgery can reduce complications by 30-80% and length of hospital stay by 1-2 days. [3] Prepwell run by South Tees Hospitals, is just one example of a prehabilitation scheme that has successfully improved patients' health before surgery. [4]

Using the waiting period as a 'teachable moment' for healthcare professionals to deliver individualised health messages has also been shown to embed long-term behavioural change. Research shows that 46% - 75% of patients in prehabilitation programmes report positive lifestyle behaviour changes, with 48% - 75% increasing physical activity, 43% stopping smoking, and 40% reducing alcohol consumption after surgery. [5] These changes will have profound positive impacts on people's future risk of disease.

For example, University Hospital Southampton NHS Foundation Trust runs a preoperative 'Fit 4 Surgery' school which provides a 2-hour classroom-based session covering the benefits of exercise, nutrition, the enhanced recovery approach, and lifestyle modification advice regarding smoking and alcohol intake. [6] Over two years, patient feedback collected by CPOC revealed that 63% of school patients intended to make lifestyle changes as a result of attending, with 46% reporting increased physical activity compared to only 25% among those who didn't attend the school. [7]

NHS England has already committed to rolling out pre-screening and medical optimisation by stipulating that providers must introduce measures to screen and optimise patients in the 2024/2025 standard contract. However, the level of implementation remains unclear. A recently published study suggests that only around half of NHS trusts and health boards have implemented some kind of prehabilitation programme, and that these do not necessarily support all patients, nor are they set up to optimise all health conditions. As stated above, set-up costs are a significant barrier.

At a time when the NHS is in crisis, we cannot afford to miss the opportunity to utilise perioperative care to identify health issues, address them, and embed long-term behavioural change. At the local level, there are examples where prehabilitation schemes are embedded. However, the implementation of such schemes is not centrally driven, and they are not available across the country. Therefore, government support and funding are essential for the implementation of these schemes.

We must also emphasise that supporting patients to improve their health should not begin only when they join the waiting list. To enhance population health and address inequalities in health outcomes, proactive measures must focus on helping the entire population to lead healthier lives, emphasising the importance of diet and exercise. Efforts by governments to address this have, to date, been largely unsuccessful. However, the right strategy, taking a system-wide approach across all aspects of people's lives, will enable everyone to improve their health.

References

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5. **Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivering in.**

- NHS England to mandate, encourage, and facilitate the adoption of surgical pathway efficiencies.
- Develop a national joined up perioperative care workforce strategy using the Centre for Perioperative Care's knowledge, skills and experience as a multi-professional organisation to help facilitate this.
- Provide new funding for interventions to optimise the surgical pathway, such as prehabilitation schemes, comprehensive geriatric assessment, better discharge planning, shared decision-making, and enhanced recovery programmes.
- Ensure that health regulators, such as the Care Quality Commission, include efficiencies practices (such as prehabilitation) and outcomes (such as cancellations) in their assessment frameworks.
- The collection, sharing, and analysis of data to measure improvement, boost efficiencies and promote better patient outcomes.

We believe these policies should be implemented immediately. The foundation for rolling out perioperative care across the NHS is already in place, with numerous successful initiatives demonstrating their effectiveness. To support these efforts, CPOC has developed resources, including guidelines, interactive pathways, blogs and patient information materials. Additionally, NHS England has commissioned CPOC to write a medical perioperative curriculum, further reinforcing this framework.

Timelines for implementing these interventions vary by type. Initiatives such as shared decision-making could be implemented within the next year. Other interventions, like prehabilitation programmes, could also start within the next year or so but the speed of adoption may be dependent on the resources made available to implement them. The NHS Standard Contract published in March 2023, mandated that providers must establish a system of screening and health optimisation by no later than 31 March 2024, giving providers just over a year to implement such interventions. Despite this, as stated above, the extent of implementation remains unclear, and we know that funding has been a significant barrier. As such, we believe many providers are not fulfilling the 2024/25 Standard Contract to implement and maintain a system of early screening and health optimisation. However, with targeted support from the Government, these initiatives could be rapidly scaled up to a national level, delivering both immediate and long-term benefits.