Centre for Perioperative Care

A blueprint for NHS efficiency

Executive summary

- NHS waiting lists are at crisis levels.
- The NHS has too many cancellations, complications, and lengthy hospital stays – often due to patients arriving for surgery in an unfit state.
- These can be avoided by concerted action to turn waiting lists into preparation lists, including screening and actively supporting patients to improve and maintain their health while they wait.
- Better procedures to help patients drink, eat and mobilise after surgery can improve patient outcomes and reduce length of hospital stay, and better discharge planning can reduce re-admission rates.
- National NHS bodies, including NHS England, should continue and expand efforts to mandate, encourage and facilitate adoption of these measures.
- Implementing these policies would save the NHS money, but set-up costs are a barrier. Hence, we propose a £100 million 'NHS efficiencies transformation fund'.
- Health regulators, including the Care Quality Commission (CQC), should incentivise implementation through modifying their assessment frameworks.

About CPOC

The Centre for Perioperative Care (CPOC) is a partnership between health charities, patient groups, and several leading Royal Colleges, including the Royal College of Anaesthetists, Royal College of Surgeons of England, and Royal College of Physicians. Our aim is to optimise the surgical pathway, moment surgery is contemplated all the way through to full recovery. This is for the benefit of patients, their loved ones, and the NHS as a whole.

NHS waiting lists

NHS waiting lists are at crisis levels. The latest data reveal that 7.6 million patients are waiting for hospital treatment in England, 574,315 in Wales,[1] 733,637 in Northern Ireland,[2] and 676,747 in Scotland.[3] Drivers include the COVID-19 pandemic and chronic workforce shortages. However, the situation is also exacerbated by avoidable inefficiencies in the surgical pathway.

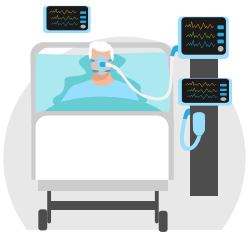
Avoidable inefficiencies

Each year around 135,000 on-the-day surgical cancellations take place,[4] estimated to cost the NHS £400 million annually in lost operating theatre time.[5] Additionally, complications occur in 10–15% of operations,[6] resulting in extended stays in hospital. 45% of hospital costs can be attributed to 3% of patients, often those with complications.[7] Patients often spend one or two days longer than necessary in hospital after surgery.[8]

Reasons behind these inefficiencies include patients arriving for surgery with modifiable issues such as frailty, unhealthy lifestyles, or unmanaged coexisting conditions. For example, patients may smoke, have poor diets, or do little exercise. They may also have unaddressed conditions, such as diabetes or anaemia, or be psychologically unprepared for surgery. All these factors increase the likelihood that:

- they will not be in a suitable state to have surgery on the day of their operation
- they are at increased risk of surgical complications and prolonged inpatient stay if they proceed
- they are more likely to develop other health problems that require NHS resources in the future.

Each year around 135,000 on the day surgical cancellations take place, estimated to cost the NHS £400 million annually in lost operating theatre time.



10–15% of operations have complications – which are often predictable and potentially preventable.

Within hospitals, 45% of costs can be attributed to 3% of patients – typically those experiencing complications.

Patients often spend one or two days longer than necessary in hospital after surgery due to surgical pathway inefficiencies.

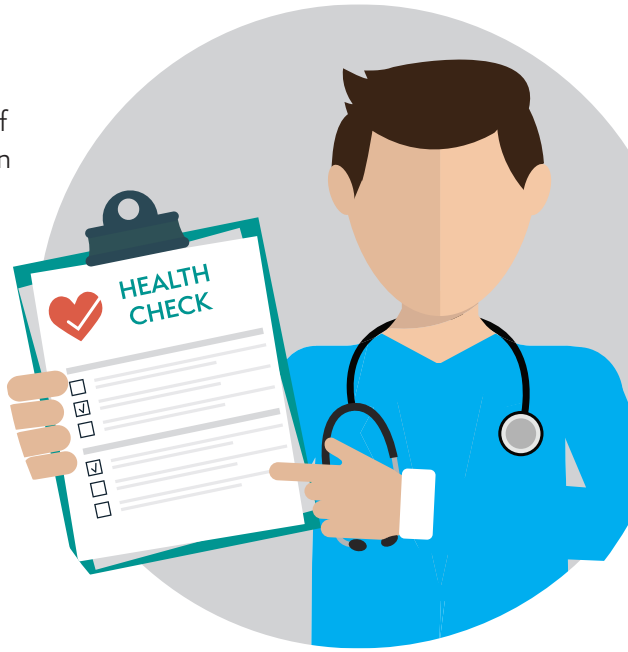
Solutions

We believe the surgical pathway can be optimised to address issues like these, including implementing interventions both before and after surgery.

Example 1: turning waiting lists into preparation lists

The healthier someone is when going into surgery, the lower the risk of last-minute cancellations, surgical complications, and extended stays in hospital.

This can be achieved by pre-screening patients as they enter the surgical waiting list, including for elderly patients a comprehensive geriatric assessment (it must be noted that 46% of adults who have elective surgery are aged over 65 years).[4] If patients have addressable health issues they should be offered help to tackle these, including through 'prehabilitation' programmes, which could involve support for exercise, smoking cessation and much else.



Our 2020 research review found that preparation for surgery reduces complications by 30%–80% and length of stay by 1–2 days.[8]

This is not, and should not be, about erecting barriers to surgery: it is about giving patients the support they need to prepare themselves as best they can.

Example 2: enhanced recovery

'Enhanced recovery' programmes aim to ensure that patients are able to 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 reduces 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.[4]

Example 3: discharge planning

Discharge planning involves collaboration between medical staff and patients to plan their discharge process and organise any necessary support. Planning should be a requirement and 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.[9]

The current situation

There is a recognition in the NHS of the value of these interventions, and there are plans to facilitate implementation through the introduction of 'perioperative care† teams'.[10] NHS England has also stipulated that during 2024 its providers must introduce measures to screen and optimise patients this year.[11]

However, it remains unclear what the level of implementation actually is or how comprehensive the services being offered are. 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.[12]

We are aware that set-up costs are a barrier, and some NHS trusts have claimed they are unable to establish services due to financial constraints, despite acknowledging the long-term cost savings they would bring.

†'Perioperative care' refers to all the care practices around an operation, both before and after.

What needs to happen

National NHS bodies, including NHS England and devolved nation equivalents, should maintain and expand their efforts to push local NHS trusts, integrated care systems (ISCs), and healthcare boards to adopt the aforementioned practices, both through mandates (such as contracts), encouragement, and facilitation.

In order to overcome issues with set-up costs, we believe that the Government should invest in an 'NHS efficiencies transformation fund' that trusts could access to fund the implementation of new programmes. We suggest £100 million, which could provide around £600,000 to each of the 160 relevant hospital trusts in England. It would also leave around £4 million for NHS England to use centrally for assistance, impact measurement, and implementation of digital systems.

The fund should be backed with new money from the Government, not taken from the existing NHS budget, which is already hugely overstretched. The fund should also be proportionately matched with funding for the health systems in Scotland, Wales, and Northern Ireland via the Barnett Formula.

Health regulators, including the CQC, should also play a role in incentivising implementation by including efficiencies practices (such as prehabilitation), and outcomes (such as complications and re-admissions) in their inspection frameworks.

Summary of recommendations

All political parties should –

- ensure national NHS bodies, such as NHS England, continue to mandate, encourage, and facilitate the adoptions of efficiencies;
- provide new money for a £100 million NHS efficiencies transformation fund for initiatives such as turning waiting lists into preparation lists, integration of enhanced recovery, and adoption of procedures for better discharge planning.
- ensure that health regulators, such as the CQC, incentivise the implementation of efficiencies through their assessment frameworks.

References

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