

WELSH HEALTH CIRCULAR



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NATIONAL ENT IMPLEMENTATION PLAN

The planned care programme has developed an integrated national implementation plan for Ears, Nose and Throat (ENT).

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For Action by:

Local Health Boards
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Enclosure(s):

National ENT Implementation Plan

National ENT Framework and Reporting Template for Health Boards



Date: 8 February 2016

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

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

The Planned Care Programme Board identified Ears, Nose and Throat (ENT) as one of its top four priorities, where urgent action is needed to ensure the delivery of a sustainable service.

ENT is one of the key specialist services in Wales encompassing a high volume of children's surgery, cancer treatment as well as a range of adult services including patients with significant hearing disability.

The ENT implementation plan is based on prudent healthcare principles, focusing on endorsing existing policies as well as supporting health boards to understand demand and capacity issues and to develop sustainable solutions.

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

Regards

Peter Lewis
National Planned Care Clinical Lead

National Ears, Nose and Throat Implementation Plan



Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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Summary

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

The plan requires health boards to understand and measure demand, capacity and activity in ENT and establish a patient experience measure for ENT services in Wales.

The three primary drivers for service change will be:

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

The plan has been developed by the National Planned Care Programme Board after stakeholder consultation with advice and recommendations from the planned care reference groups that involves patients and the third sector. It contains thirteen key actions for health boards to implement.

A National Hearing Plan is being developed for people who are deaf or living with hearing loss (balance and tinnitus)

The plan is issued as a Welsh Health Circular (WHC/2016/006). Health boards' delivery against the plan will be reviewed at each meeting of the Welsh ENT Board.

A guidance framework for reporting The National ENT Implementation Plan has been developed.

2 Background

2.1 National Planned Care Programme

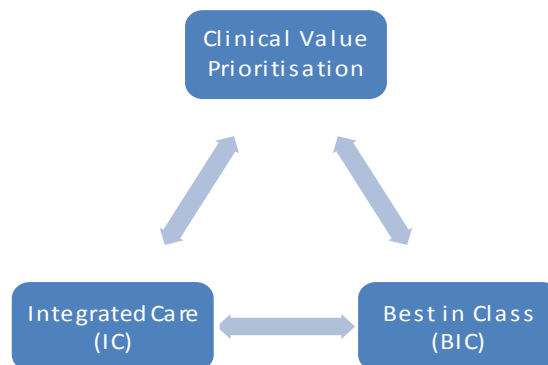
The purpose of the National Planned Care Programme is to apply a prudent approach to service change in order to:

- Provide “sustainable” planned care services
- Optimise patient outcomes and experience of planned care services

2.2 How will change be achieved

The programme requires measurement and management of demand, capacity and activity in each of the major subspecialties.

To achieve a match between demand, capacity and activity (“sustainability”) the programme will employ a balanced service change approach based on three primary drivers: Clinical Value Prioritisation, Integrated Care and Best In Class.



Clinical Value Prioritisation will include

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

Integrated Care will include:

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

Best in Class will include

- Establishing outcome measures for each planned care service
- Measuring the cost of providing services using pathway specific tools

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

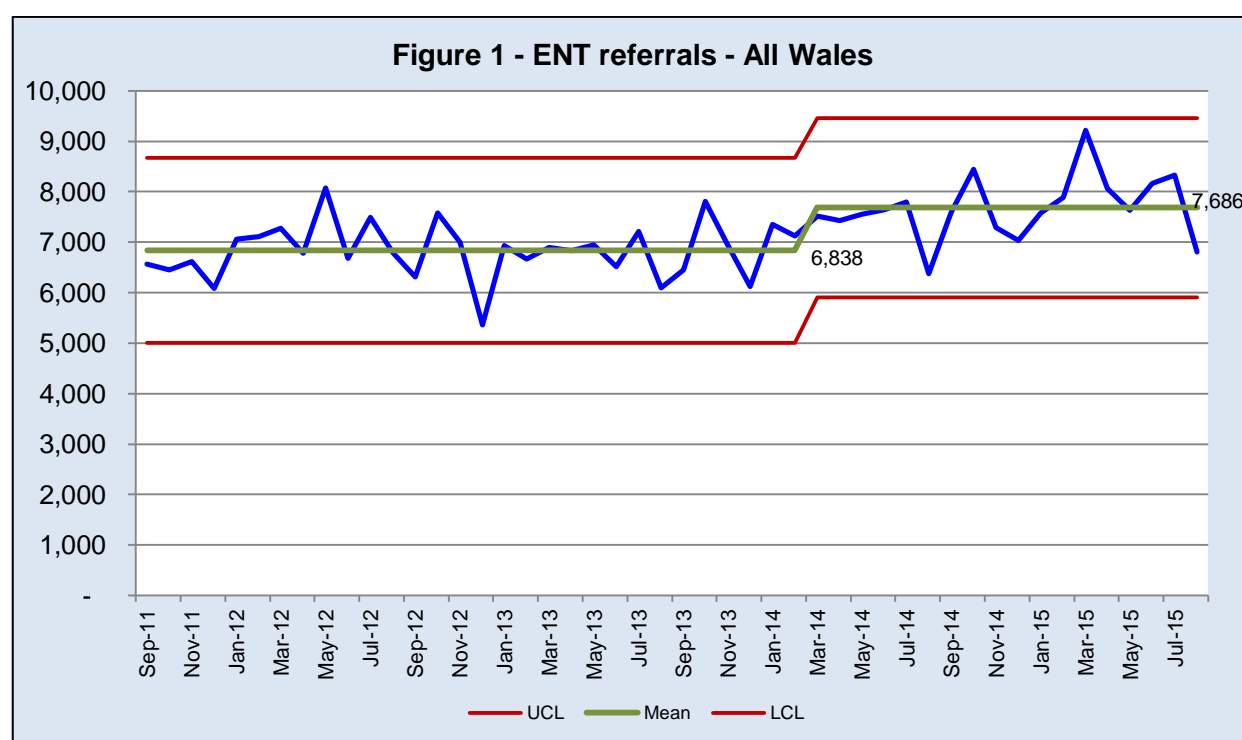
Each national service implementation plan will be delivered by individual health boards and reported through Welsh specialty boards. The programme will be supported by expert reference groups and will rely on patient involvement with contribution from third sector organisations.

2.3 Changes in ENT services

Our planned care system is facing challenges and there is a need for significant and urgent change¹.

ENT is one of the key specialist services in Wales encompassing a high volume of children's surgery, cancer treatment as well as a range of adult services including patients with significant hearing disability. There were over 84,000 new ENT outpatient consultations in Wales last year and approximately 15,000 treatments².

ENT services in most health boards are under considerable pressure to meet performance targets. The 'All Wales' monthly demand for ENT services shows an increase since October 2013 but this has been due to increases seen in two health boards³. The demand in the other health board's has remained relatively stable over the past 3 years (Figure 1⁴).



(LCL: Lower Control Limits / UCL : Upper Control Limits)⁵

¹ <http://gov.wales/about/cabinet/cabinetstatements/2013/plannedcare/?lang=en>

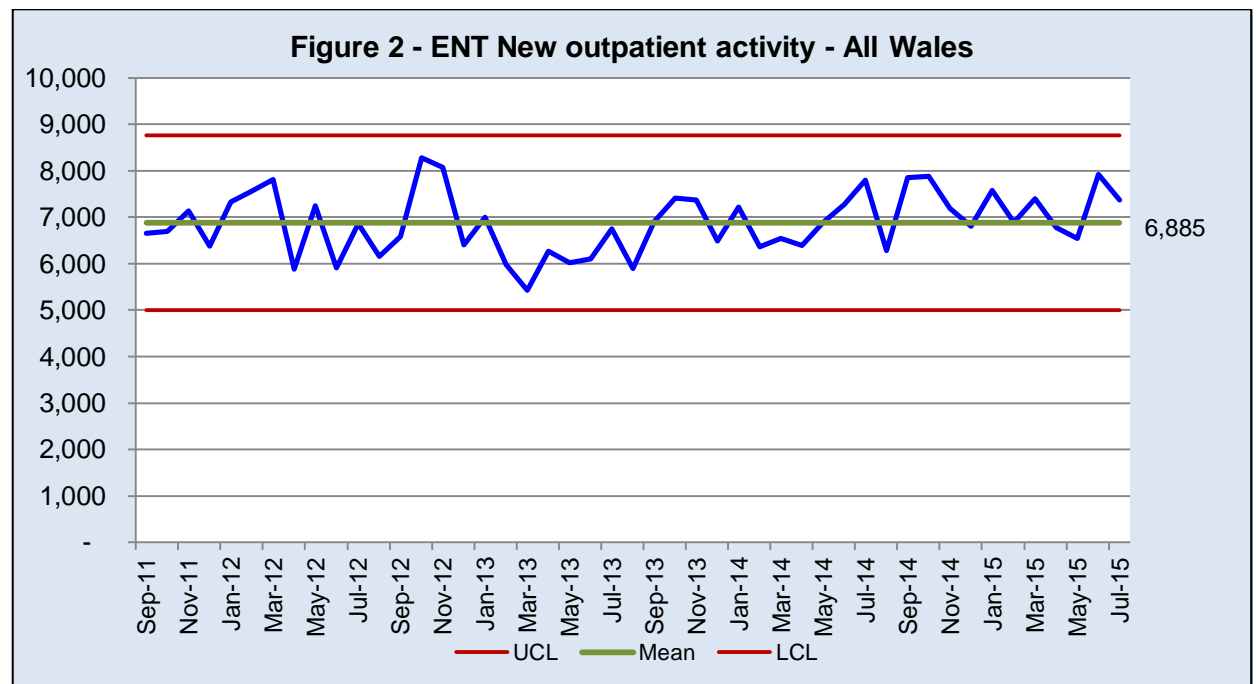
² NHS Wales Informatics Service Information Services

³ Cardiff & Vale and Cwm Taf Health Board

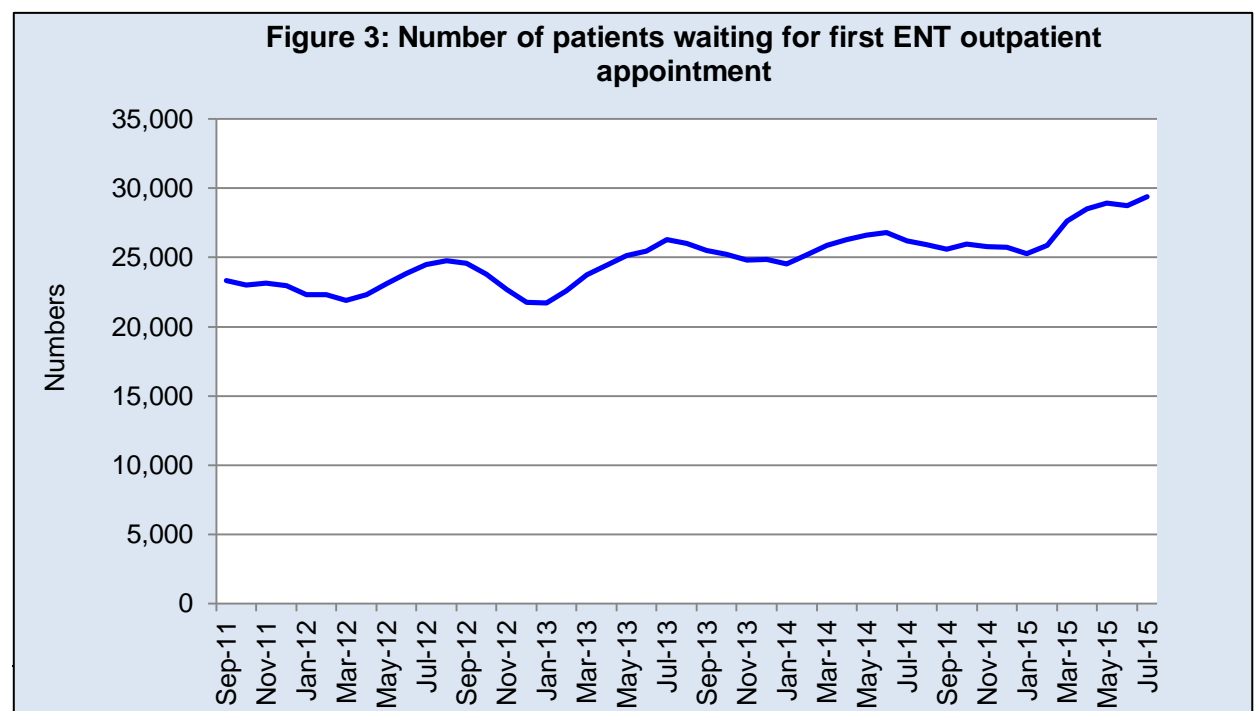
⁴ NHS Stats Wales

⁵ The Upper and Lower Control Limits show the expected boundaries of variation in the number of referrals per month.

During this time, new ENT outpatient activity (attendances) has remained relatively stable (figure 2).

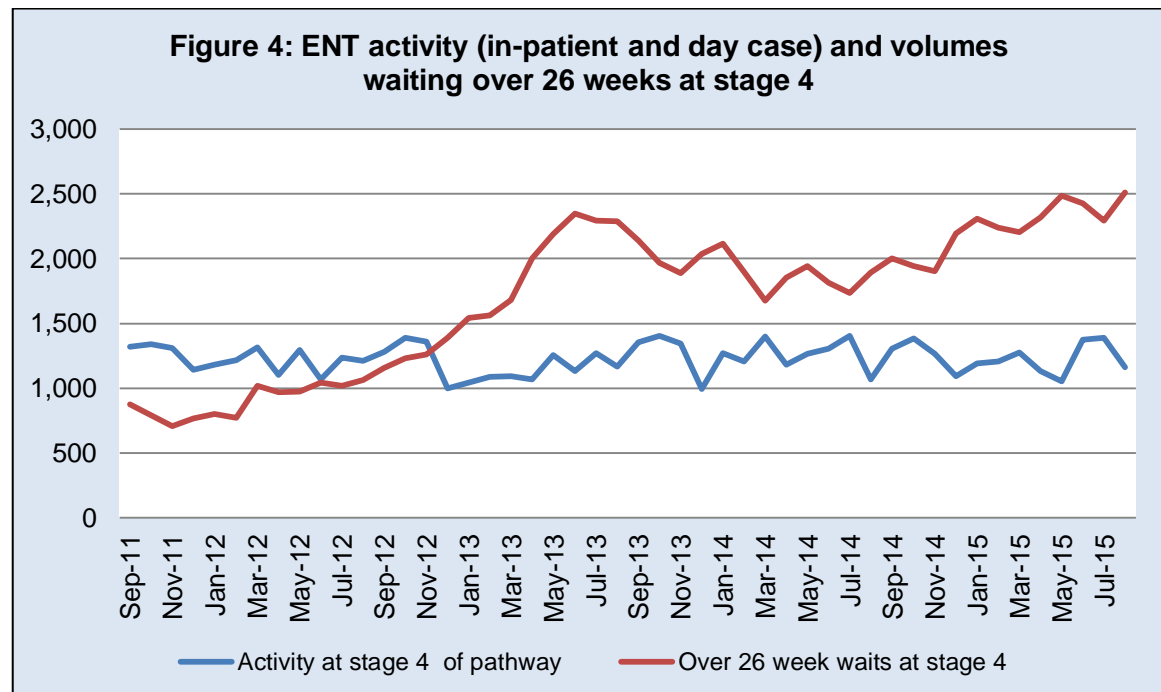


It appears that, despite the use of “variable capacity” in the form of backfill and waiting list initiatives by most health boards, there has been an imbalance between demand and activity. This has resulted in increasing numbers of patients waiting for new outpatient appointments (figure 3⁶).



⁶ NHS Wales Informatics Service Information Services
OP WL volumes are the numbers of patients on a RTT pathway waiting for a first outpatient appointment

Similarly, treatment activity has remained relatively constant throughout this period but the combined effects of the imbalances at both the stage 1 (new outpatient) and stage 4 (treatment) phases of the patient pathway has resulted in an increase of patients starting treatment after 26 weeks of their referral, as shown in figure four.⁷



Although ENT services, with its current ways of working, appears not to have sufficient capacity to meet demand, the scale of the deficit is such that changes to the delivery model applied to a reasonably productive service may be sufficient to provide a balanced position of demand and capacity without the need for a major investment in increased capacity.

The National ENT Implementation Plan addresses the need for service change building on previous developments including the National Focus on Programme and the more recent successful Prudent Health Care workshop commissioned by the Minister for Health and Social Services that took place in Abertawe Bro Morgannwg University Health Board in 2014⁸.

⁷ NHS Wales Informatics Service Information Services

⁸ www.1000livesplus.wales.nhs.uk/prudent-healthcare

Clinical Value Prioritisation is based on the prudent health care principles of:

- Do only what is needed, no more, no less; and do no harm
- Reduce inappropriate variation using evidence based practices consistently and transparently

This involves ensuring the correct criteria for referral and treatment in secondary care, optimising the use of all health care professionals and ensuring urgent needs are met.

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

Finally, “Best in Class” reflects the principle of caring for those with the greatest health needs first, making the most effective use of all skills and resources and involves the measurement of service quality and cost to ensure the concept of value for money is real and transparent. This will enable health boards to develop actions to match top performing services and organisations.

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

3. The National ENT Implementation Plan

3.1 Measuring patient experience

The National ENT Implementation Plan aims to optimise patient experience by

- adopting a standard measure
- agreeing actions to improve levels of performance by health boards.

The Patient Reported Experience Measure (PREM) for ENT will be developed in collaboration with Aneurin Bevan Community Health Council based on the hearing loss pathway.

Health boards will report on the “*you said, we did*” principle.

Action 1 - Health boards will put in place systems to collect patient reported experience measures (PREMS).

3.2 Achieving a “sustainable” service

The purpose of the plan is also to achieve a sustainable service by matching demand and capacity for each of the following patient streams:

- Urgent suspected cancer (USC)
- Routine paediatrics
- Hearing loss, tinnitus and vertigo (“audiology stream”)
- Other routine adult including Audiovestibular Medicine (Hearing loss, tinnitus and vertigo)

Demand, capacity and activity will be measured at the high-level pathway points:

- New outpatient
- Diagnostic
- Treatment
- Follow up outpatient

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

3.3 Clinical Value Prioritisation

3.3.1 Do not do

Prudent healthcare principles encourage clinicians to “*do no harm*”. The list of procedures that clinicians should avoid includes NICE “do not dos”, “interventions not normally undertaken” (INNU) and health board decisions on procedures that should not be undertaken. In ENT this list will include;

- Pinnaplasty
- Surgery to remodel the external ear
- Rhinoplasty for cosmetic surgery
- Surgery or laser treatment for rhinophyma
- Nasal surgery for snoring

There may also be patients on waiting lists that, for administrative or good clinical reasons, do not need to be seen. A process of “validation” can remove such waiting list entries by either administrative or clinical staff.

Action 3 - Welsh ENT Board to review and where necessary amend the list of do not dos and review responses from each health board’s Medical Director.

Action 4 - Health boards will undertake a waiting list validation to remove patients who do not require either outpatient appointments or surgery.

3.3.2 Thresholds

Tonsillectomy in the UK was the first procedure, world wide, that was subject to a study of variation in provision. Scottish Intercollegiate Guidelines Network (SIGN) guidelines⁹ on thresholds for tonsillectomy have been accepted by most organisations in the UK. Much work in Wales has been done on the Focus On Pathways which in ENT include tonsillectomy.

The National ENT Implementation Plan involves data collection that will assure health boards that tonsillectomy is being performed at the correct threshold based on at least six episodes of tonsillitis in a period of a year.

Recent work in Abertawe Bro Morgannwg University Health Board, commissioned by the Minister for Health and Social Services as part of the prudent healthcare initiative, has demonstrated that many patients with hearing loss are best referred directly to audiology services according to agreed criteria¹⁰. The National Implementation Plan involves translating that local initiative into standard practice nationally to include patients with tinnitus and vertigo.

It is up to individual health boards to decide on the most appropriate local venue for this audiology service. However, similar work in Cardiff and Vale University Health Board has suggested that when such services are provided in a community setting, patient experience appears enhanced.

In alignment with prudent healthcare principles, follow-up appointments should only be given where absolutely necessary. Increasingly, “virtual” out patient appointments are being used (throughout Medicine) to avoid outpatient appointments when it is safe to give advice using different portals of communication. The Welsh ENT Board has decided that health boards should be encouraged to use virtual outpatient appointment where appropriate and to report experiences at the regular Welsh ENT Board meetings. This is applicable in both ENT and Audiology services.

Action 5 - Health boards will measure and report the proportion of patients who fit the threshold for tonsillectomy based on the number of episodes of tonsillitis prior to surgery.

⁹ <http://www.sign.ac.uk/>

¹⁰ www.1000livesplus.wales.nhs.uk/prudent-healthcare

Action 6 - Health boards will establish audiology services capable of managing direct referrals from primary care for hearing loss, tinnitus and dizziness (the “audiology” stream). Health boards will report the proportion of patients in the audiology stream who are directly referred to audiology.

Action 7 - Health boards will report the nature of the virtual system being employed and the number of patients who were suitable for a virtual out patient appointment.

3.3.3 Urgent and priority groups

ENT includes services for certain head and neck cancers. Patients with suspected cancer will continue to be managed within existing Welsh Government targets.

Prioritising patients who are referred to ENT for reasons other than cancer can result in a significant increase in overall waiting times for all. All patients who are not suspected as having cancer will be designated “routine”. When there is a compelling clinical reason for a patient to be seen within a shorter time frame, the patient may be designated as “urgent”.

The Welsh ENT Board has decided that “urgent” patients should be seen within 10 weeks.

Action 8 Health boards will report the number of new patient referrals, where there is no suspicion of cancer, who are designated "urgent" and the proportion of this "urgent" cohort who are seen in outpatients within 10 weeks.

3.3.4 Holistic care

Lifestyle factors such as smoking and obesity are associated with reduced life expectancy and poor health. There is also a body of evidence that lifestyle factors may also be associated with higher rates of postoperative complications and length of stay¹¹.

All patients will have a smoking and weight assessment as part of their referral pathway for a routine ENT outpatient appointment. Smokers and those patients with a BMI>35 will be referred to the appropriate local service for antismoking and weight reduction management respectively as part of their active treatment.

In order to enable this health boards should:

- ensure that there are a suitable range of antismoking and weight reduction support services available to local communities
- appropriate referral mechanisms exist.

Action 9 - Health boards will report the number of patients referred to secondary care who smoke or have a BMI>35 and the percentage who have completed either an antismoking or weight reduction programme.

¹¹Ash.org.uk

3.4 Integrated Care

3.4.1 Interface collaboratives

New structures “care collaborative groups” (CCG) will be established in each health board to manage the flow of patients between primary and secondary care. There is currently no such formal structure in ENT but similar groups exist in other specialties such as the musculoskeletal referral service (MSK) in Betsi Cadwaladr University Health Board and eye care groups which have been established in most health boards.

It will be the responsibility of each health board to establish their own care collaborative groups based on national Terms of Reference (ToR). The collaboratives will have the following principles:

- Include local professionals, patients and service managers
- Oversee appropriate patient streams and referral thresholds and where necessary to triage referrals before submission to secondary care
- Provide life style services for all patients identified with a BMI over 35 and patients who smoke
- Establish services to improve patient activation and decision making
- Monitor progress against the National ENT Implementation Plan.

Action 10 - Each health board will establish an ENT care collaborative group in accordance with national ToR based on the above principles.

3.4.2 Patient empowerment

Co-production Wales is clear about enabling citizens and professionals to share power and work together in equal partnerships.

Audiology services in Wales already provide group sessions for patients with hearing loss and tinnitus enabling “*peer support*” these actions are included in quality assurance reports.

Patients should also be clear about their treatment options and risks. Therefore, each health board will provide option grids¹² to patients who are being considered for tonsillectomy. The precise environment and support for patients to use option grids will be left to individual health boards. However, each health board will follow the principle that option and risk appraisal above, should take place at a point in the pathway before a decision has been made to proceed with preparation for surgery or other treatment.

Action 11 - Health boards will establish processes to enable patients to use option grids in a supportive environment.

¹² <http://optiongrid.org/>

3.5 Best In Class

It is self evident that in order to demonstrate that they are making most effective use of resources, individual services should be able to measure “value for money” in a way that allows comparison with recognised high performing services or ‘Best In Class’ .

There are many potential measures of quality in ENT services. In order to provide a simple measure of value, the quality of the tonsillectomy service will be assessed by recording age adjusted readmission rates after tonsillectomy with costing of the tonsillectomy pathway from GP to discharge.

The national reference group for Best In Class has advised the Planned Care Programme Board to use Time – Driven Activity -Based Costing (TDABC) to measure cost. This will be applied to the tonsillectomy pathway when Directors of Finance (DoF) Wales have completed their assessment on the first use of TDABC¹³.

In addition, health boards will continue to report on outcomes for cancer surgery to include 30-day survival after surgery and 2-year survival for all head and neck cancer patients.

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

Action 12 - Health boards will put in place systems to record value for money for their tonsillectomy pathway (re-admission rates / pathway cost).

Action 13 - Health boards will continue to report cancer treatment outcomes (30-day postoperative mortality, 2-year survival).

¹³ Cataract pathway

4. Reporting and collaboration

Health board's performance against the National ENT Implementation Plan will be reported to a Welsh ENT Board scheduled to meet bi-monthly.

The chairman of the Welsh ENT Board will report to the Planned Care Programme Board shared with the Wales Executive Board (Programme sponsors).

The planned care programme team will work with a health board to model the impact of the high-level service changes, and determine the indicative cost for a new sustainable ENT service. The health board will also assist in the communications and outcome of the Welsh ENT board meetings.

Appendix A: List of Actions

Action 1 - Health boards will put in place systems to collect patient reported experience measures (PREMS).

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

Clinical Value Prioritisation

Action 3 - Welsh ENT Board to review and where necessary amend the list of do not dos and review responses from each health board Medical Director.

Action 4 - Health boards will undertake a waiting list “validation” to remove patients who don’t require either outpatient appointments or surgery.

Action 5 - Health boards will measure and report the proportion of patients who fit the threshold for tonsillectomy based on the number of episodes of tonsillitis prior to surgery.

Action 6 - Health boards will establish audiology services capable of managing direct referrals from primary care for hearing loss, tinnitus and dizziness (the audiology stream). Health boards will report the proportion of patients in the audiology stream who are directly referred to audiology.

Action 7 - Health boards will report the nature of the virtual system being employed and the number of patients who were suitable for a virtual out patient appointment.

Action 8 - Health boards will report the number of new patient referrals, where there is no suspicion of cancer, who are designated "urgent" and the proportion of this "urgent" cohort who are seen in outpatients within 10 weeks.

Action 9 - Health boards will report the number of patients who smoke or who have a BMI>35 who are referred to secondary care and the percentage who have completed either an antismoking or weight reduction programme.

Integrated Care

Action 10 - Each health board will establish an ENT care collaborative group in accordance with national ToR.

Action 11 - Health boards will establish processes to enable patients to use option grids in a supportive environment.

Best In Class

Action 12 - Health boards will put in place systems to record value for money for their tonsillectomy pathway (re-admission rates / pathway cost).

Action 13 - Health boards will continue to report cancer treatment outcomes (30-day postoperative mortality, 2-year survival).