



Archwilydd Cyffredinol Cymru
Auditor General for Wales

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Meeting demand for orthopaedic services: Key questions for NHS board members



Introduction

Orthopaedic services is the largest clinical specialty in the NHS, accounting for fifteen per cent of all GP referrals and NHS outpatient activity. With fifty per cent of the population likely to require orthopaedic surgery at some point in their life, the ability of health boards to meet demand is becoming increasingly important.

In June 2015, the Auditor General concluded in his report on [Orthopaedic Services in Wales](#) that:

- Orthopaedic services are more efficient and waits are shorter than a decade ago but performance against waiting time targets has deteriorated recently and demand is continuing to rise.
- At a national level, there has been a clear commitment to improving musculoskeletal services with matching investment but the approach has had less impact than expected.
- Health boards have started implementing the national vision but not on the required scale and there is not yet enough information on outcomes to say whether change is benefiting patients.

Comparative reports were also produced for each health board¹ to supplement the national report. To support ongoing scrutiny of orthopaedic services we have now produced the following questions with the aim of supporting NHS board members to obtain assurance that their health board is effectively, safely and economically meeting demand for orthopaedic services.

¹ which can be found on the [Wales Audit Office website](#).

Understanding demand for orthopaedic services, and preventative services to help manage that demand

1

Does the Health Board know its demand for orthopaedic services?

How does demand compare nationally? For example, what are referral rates per 10,000 population?

Within the Health Board, are there unexplained variations in referrals? For example, are some GP practices sending a significantly higher or lower number of orthopaedic referrals?

2

Does the Health Board use its knowledge of orthopaedic demand to target population groups proactively?

Does the Health Board have unexpected patterns of demand, and if so, can it target its actions to specific groups of patients to help meet the population need for orthopaedic services?

Is the Health Board ensuring that those who are most deprived, hard to reach or fall within the protected characteristic categories of the Equalities Act (2010) have equal access to services and, if required, targeted intervention?

3

Is the Health Board taking appropriate action to reduce inappropriate referrals?

Is the Health Board recording and analysing inappropriate referrals and conversion rates (from outpatients to inpatient lists)?

Is the Health Board working with GP practices to reduce the number of inappropriate referrals?

Has the Health Board implemented specialty/service advice lines to provide advice to GPs to reduce inappropriate referrals?

4

Is the Health Board using prudent approaches to help manage demand by providing alternative treatment and reducing over-treatment?

Are there effective triage processes to route patients to the most appropriate care setting?

Is the community musculoskeletal assessment and triage service (CMATS) effectively deployed and accessible to patients?

Are there effective approaches to educate patients on their condition, and the options that are available to help manage or improve it?

Are there accessible and effective exercise and weight management programmes to help with weight related musculoskeletal pain and functional mobility?

Are pain management arrangements accessible and effective?

Strengthening strategic orthopaedic commissioning, internal service design and operational performance

5

Is there a clear orthopaedic plan which sets out who provides the service?

Does the orthopaedic plan describe the sources of orthopaedic supply to address population level demand (i.e. internally provided services, services provided by another health board or Trust, primary care based services, external private or internal privately provided services)?

Do we fully understand the differences between routine capacity and additional waiting list initiative capacity?

Does the plan attempt to match its demand and capacity at an annual and monthly cycle?

Is the plan demonstrating good value?

Does the plan define the process for receiving quality assurances, no matter who provides the service?

Does the plan articulate the contracting and commissioning arrangements?



6

For orthopaedic services provided in-house, is there a clear service delivery plan?

Does the orthopaedic service delivery plan demonstrate logical service model design? For example, orthopaedic sub-specialisation, defining centres of excellence by clinical condition and hospital site level.

Does the internal delivery plan show how it will match the demand for procedures with supply of sessions?

Has the Health Board created options to 'step-up' internal supply? For example, weekend sessions, 3 session days, exploiting underutilised theatre capacity.

Is the mix/proportion of scheduled and unscheduled care provision by month allowing for peaks in unscheduled care demand?

Is the mix/proportion of outpatient to operating session time appropriate, and in outpatients is the planned mix of new to follow up appointments right?

Does the service delivery plan ensure that, where appropriate, there is a pooling of consultant lists to smooth individual peaks and troughs?

Does the service delivery plan seek to address staff capacity and capability?

Does the service delivery plan ensure that clinical procedure volumes are high enough to enable healthcare professionals to maintain safe and effective practice?



7

Does the Health Board know how its locally provided services are performing?

Are efficiency measures improving? For example, length of stay by clinical condition/procedure, day of surgery admission, Did Not Attend and cancellations, outpatient appointments per episode, discharges vs. new referrals, bed availability, and operating theatre efficiency and productivity.

Is the Health Board managing its costs for internally provided orthopaedic services? For example, cost of labour, cost of theatre use, cost per inpatient episode, cost of loan equipment, and is it reducing the cost of and, minimising unnecessary variation in, the use of prosthesis.

Is the Health Board improving orthopaedic performance on Tier 1 waiting list targets for Referral to Treatment?

Is the Health Board improving orthopaedic performance on delays and backlog on its follow-up waiting list?

Where performance is not matching target levels, are there sound and sustainable plans in place to achieve the required improvements?

Achieving public and patient outcomes as well as assurance on the safety of services

8

Are orthopaedic services safe, regardless of who provides them?

Are orthopaedic incidents effectively recorded and analysed. If so, what is this telling us, and is the health Board learning lessons and implementing improvement actions?

What is orthopaedic quality and safety data telling us (How do we compare on orthopaedic inpatient mortality, 90 day mortality, surgical site infection, implant revision rates)?

Is the Health Board appropriately demonstrating corporate responsibility and candour in its approach when things go wrong?

9

Are primary, community and therapeutic orthopaedic services making any difference?

Does the Health Board have systems in place to determine the impact of preventative and restorative therapeutic orthopaedic services such as CMATS, weight management, pain management, exercise programmes and physiotherapy?

Is the service compliant with NICE, specialty advisory committee and national guidance, for example in clinical management of hip fractures, knee replacements, back pain, hand surgery?

Are these services improving the quality of life for patients (reduced pain, improved mobility and function)

Are these services having a longer-term effect that alleviates patients' symptoms to reduce the need for intensive intervention?

10

Are acute orthopaedic care services providing a good experience and delivering effective outcomes for patients?

Does the Health Board have arrangements to systematically collect and analyse patient experience and outcomes?

Do patients have a good experience in outpatient services?

Is the Health Board providing a good patient experience in advance of an inpatient episode, and before, during and after surgery?

Are patients' outcomes good? Is their pain reduced, do they have improved function, mobility and quality of life?

If there are areas where patient outcomes are poor, or intervention is ineffective, is this informing clinical governance and supporting clinical decision making processes?

