Versus Arthritis' response to the Health & Social Care Committee Inquiry on 'Delivering Core NHS and Care Services during the Pandemic and Beyond.'

May 2020

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1. Versus Arthritis welcomes the opportunity to respond to the Health & Social Care Committee Inquiry on 'Delivering Core NHS and Care Services during the Pandemic and Beyond.'[1]

2. Versus Arthritis is the charity formed by Arthritis Research UK and Arthritis Care joining together. We work alongside volunteers, healthcare professionals, researchers and friends to do everything we can to push back against arthritis. Together, we develop breakthrough treatments, campaign for arthritis to be a priority and provide support. Our remit covers all musculoskeletal conditions which affect the joints, bones and muscles including osteoarthritis, rheumatoid arthritis, back pain and osteoporosis.[2]

3. Arthritis and related musculoskeletal conditions affect 18.8 million people in the UK and are the single biggest cause of pain and disability in the UK. Cumulatively, the healthcare costs of osteoarthritis and rheumatoid arthritis will reach £118.6 billion over the next decade.[3] Musculoskeletal conditions account for a fifth of all sickness absence and result in the loss of around 28.2 million working days to the UK economy each year.[4]

4. This submission responds to the follow questions from the Committee:
   - How to achieve an appropriate balance between coronavirus and 'ordinary' health and care demand;
   - Meeting the wave of pent-up demand for health and care services that have been delayed due to the coronavirus outbreak;
   - How to ensure that positive changes that have taken place in health and social care as a result of the pandemic are not lost as services normalise;

5. This submission focuses on the delivery of joint replacement surgery. Over 90% of hip and knee replacements are carried out on people with osteoarthritis.[5] Given the focus in the NHS Chief Executive and Chief Operating Officer's recent letter asking NHS providers to evaluate their capacity to re-start elective surgery, we believe this is an area where scrutiny by the Committee would be particularly helpful.[6]

6. People with musculoskeletal conditions access a range of health and care services provided through the NHS, private sector and voluntary sector (including Versus Arthritis). This submission also refers to some of those services, including the provision of information and advice, access to primary care and community services and rehabilitation services.

7. Summary points:
   - The postponement of elective surgery from 15th April 2020 will have a significant impact on people with osteoarthritis waiting for joint replacement surgery.
   - Even before the onset of the COVID-19 outbreak in the UK, there was a growing number of people waiting for hip and knee replacement surgery, with significant numbers waiting beyond the maximum waiting time of 18 weeks from referral to treatment.
   - It is welcome that providers are being asked to consider whether they have the capacity to re-start elective surgery. However, the request to prioritise the longest waiters needs to be balanced by ensuring those patients with the greatest clinical need (but who may have waited for a shorter period) can access treatment.

- NHS England should learn from evidence from other health systems to consider how the re-introduction of elective surgery in England could be managed.
- NHS England should explore how to scale up and expand access to digital physical activity interventions and shared decision making that can help people with arthritis to self-manage, including management of pain.

8. Versus Arthritis works together with several professional bodies and cross-sector groups. In relation to this inquiry:
   - We are member of the Arthritis and Musculoskeletal Alliance (ARMA) and support the elements of their submission focusing on recovery planning for joint replacements, rheumatology and the importance of rehabilitation services for people with MSK conditions.
   - We are a member of the Richmond Group of Charities and support their submission focusing on community and primary care services, and the role that health and care charities are providing to support people affected by COVID-19 during the pandemic.
   - We are a member of the Community Rehabilitation Alliance and support their submission focusing on the value of rehabilitation services for long-term conditions that will be vital in supporting patients and the NHS beyond the pandemic.

How to achieve an appropriate balance between coronavirus and 'ordinary' health and care demand

Meeting the wave of pent-up demand for health and care services that have been delayed due to the coronavirus outbreak

Impact of delays to elective surgery

9. Writing to NHS providers on 17 March 2020, NHS England asked that all routine surgery be postponed from 15th April for at least three months.[7] This will have a significant impact on the people with osteoarthritis waiting for joint replacement surgery.

10. In the context of all elective surgery, hip and knee replacements are respectively the 2nd and 3rd most common operations taking place on the NHS.[8]

11. Osteoarthritis was the primary cause of 90% and 98% of primary hip and knee replacements respectively in England, Wales and Northern Ireland in 2018.[9] The National Joint Registry's 16th Annual Report in 2019 showed that there were 106,116 hip replacement procedures and 109,540 knee replacement procedures in 2018.[10]

12. Evidence shows that hip and knee replacement surgery is clinically and cost effective and can help to restore mobility and reduce pain.[11] [12] [13] [14] Versus Arthritis believes that people should have access to joint replacement surgery within timeframes that are likely to be most effective.

13. Even before the onset of the COVID-19 outbreak in the UK, there were a growing number of people waiting for hip and knee replacement surgery, with significant numbers waiting beyond the maximum waiting time of 18 weeks from referral to treatment in England.

14. At the end of January 2020, there were 521,408 people waiting for Trauma & Orthopaedic surgery (including hip and knee replacements) in England.[15] In addition, during this period an estimated 35,000-42,000 people were being added to the Trauma & Orthopaedics waiting list every week.[16]

15. In February 2020, Versus Arthritis published findings of a Freedom of Information (FOI) request on waiting times for joint replacement surgery in NHS Hospital Trusts across England, covering the period from April 2018 to March 2019. The findings showed that almost 30,000 people with

osteoarthritis had waited more than 18 weeks, 17,000 had waited more than six months, and 2,400 had waited more than a year for treatment.[17]

16. In May 2020, the standards for waiting times for elective care were under review by NHS England, with an expected timeline for issuing recommendations by April 2021.[18] The Clinically-led Review of NHS Access Standards was launched in 2018 to review the core set of NHS access standards, in the context of the service model described in the NHS Long Term Plan, and to recommend any required updates and improvements. Initial proposals for new elective care access standards were published in March 2019.[19] This included trialling the use of an average (mean) waiting time at 12 sites across England.

17. Versus Arthritis raised concerns that any new waiting time standard needs to demonstrate clear and compelling evidence of better patient outcomes than the current maximum waiting time of 18 weeks from referral to treatment (as enshrined in the NHS Constitution and the Health and Social Care Act 2012). NHS England should clarify how the proposed new standards for elective care will be evaluated during a period when elective surgery will be severely disrupted.[20]

18. There is a growing body of academic evidence about the health impact of delayed access to joint replacement surgery beyond six months. Evidence collated by Harry Burns for the review of targets and indicators in Scotland (the Burns Review) in 2017 highlighted a range of academic studies evaluating the impact of delays to surgery.[21]

19. The studies cited in the Burns Review suggested 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.

20. Last year, a survey carried out by YouGov (on behalf of Versus Arthritis) showed that of 1,009 English adults diagnosed with osteoarthritis, half (49%) said their physical health deteriorated and one third (33%) said their mental health deteriorated while they were waiting for joint replacement surgery.[22]

21. These findings have been reinforced in the results from a recent survey was launched by Versus Arthritis in April 2020. This had been completed by 4,500 people with arthritis by Friday 1 May. This included 1,284 people with osteoarthritis, and almost 300 people waiting for surgery.[23]

22. On 29th April 2020, NHS England sent a letter to providers outlining the second phase of the NHS response to COVID-19. This asked providers to evaluate in the following ten days whether they had the capacity to restart non COVID-19 routine surgery. In the annex, providers are asked to give priority to patients who have waited the longest period of time. While we can understand this rationale, NHS providers need to consider the impact on health outcomes from delays to surgery beyond six months and patients who have waited for a shorter period but with a greater level of clinical need.[24]

<u>Re-introducing elective surgery safely</u>

23. Planning around the restoration of elective surgery in local areas comes against the background of the NHS dealing with COVID-19, a new virus that we are still learning about at pace. Infection control systems for 'clean' hospital sites for non COVID-19 operations will be critical to ensure operations will take place safely, and national guidance from bodies like Public Health England will be required.

24. As stated in paragraph 22, whilst NHS providers have been asked to evaluate their capacity for re-introducing elective surgery, the guidance suggests that the emphasis will be on local

providers to decide when and how this happens, and there will be significant variation in access to joint replacement surgery.[25]

25. However, the most recent letter from NHS England suggests that local NHS providers will have the flexibility to re-introduce elective surgery where capacity is available to do so, with priority given to patients who have waited the longest amount of time.

26. The ability of NHS providers to provide that capacity for elective surgery will be highly dependent on a number of factors including the numbers of COVID-19 cases, availability of non-COVID and COVID beds and levels of hospitalisation[26]. This is likely to mean variations in access to joint replacement surgery (and other types of elective surgery) for patients across England. NHS England needs to work with charities like Versus Arthritis and professional bodies in the musculoskeletal sector to ensure that there is adequate information provision for people with arthritis on what to expect from services in their local area.

27. Where the NHS lacks capacity in local areas, the independent sector may need to perform a much greater proportion of NHS-funded hip and knee joint replacement surgery in the short term. Even before the pandemic, the National Joint Registry's latest report showed that around 40% of NHS-funded primary hip and knee procedures were being delivered by independent hospitals and Independent Sector Treatment Centres (ISTCs).[27]

28. Analysis from the Independent Healthcare Providers Network last year indicated that without capacity provided by the independent sector in Trauma & Orthopaedic care, the equivalent of 42 NHS Trusts would need to be built to make up for the lost capacity.[28]

29. Without additional capacity (whether in the NHS or independent sector), significant numbers of people with arthritis will be waiting for even longer to access treatment that could have a positive impact on their mobility, pain and quality of life.

30. In May, NHS England will be considering the extension of its current contract with the independent sector to provide additional capacity and the backlog of joint replacement surgery to be delivered needs to be a key consideration in this planning. In addition, we call on NHS England to work with the independent sector to ensure that there are good infection control processes in place to manage COVID-negative hospital sites to provide reassurance to people with arthritis about the safety of their treatment.

31. In February 2020, NHS England and Improvement's quality improvement agency, Getting It Right First Time (GIRFT), published a follow-up report[29] to review progress against the implementation of their best practice guidance around orthopaedics services in 2015.[30] NHS Trusts should consider how to integrate the recommendations in this report as part of their recovery planning, such as ringfencing bed space for orthopaedic surgery.

<u>Demand and Capacity Planning for elective surgery</u>

32. Imperial College London has created a Hospital Planning tool - J-IDEA – that is able to measure the impact of interventions designed to improve capacity, including suspending elective operations. Their tool estimated that cancelling elective operations would free 30% beds from critical care, and 41% from General & Acute in England.[31] This was based on analysis of Hospital Episodes Statistics (HES) data (January 2019) estimating the proportion of beds filled with non-emergency, non-maternity and non-cancer related elective patients in critical care and General & Acute beds respectively.

33. However, Imperial also highlighted that providers can use this tool to evaluate how re-introducing elective operations could affect capacity for other types of operations, including

"Under what circumstances can implemented healthcare provision interventions be scaled down (e.g. re-introduction of elective operations and closure of field hospitals)?"

34. In addition, we call on NHS England to consider how the capacity of Nightingale Hospitals might be maintained to support COVID-19 patients, easing pressure on other parts of the NHS and allow waiting lists for more routine surgery to be reduced.

Learning from International Experience – Australia

35. Learning from other health systems that are re-starting elective surgery may help to informing the same process in the NHS in England. On Tuesday 21st April, Australian Prime Minister Scott Morrison stated his Government's assessment[32] that there were sufficient levels of PPE and a rate of COVID related hospitalisation that provided grounds to re-commence some operations, including hip and knee replacements (from Monday 27th April).

36. It was acknowledged that continuing to delay elective surgery could create further harm to health outcomes and the economy.[33] Elective surgery will be reintroduced in stages in Australia: the intention was for 1 in 4 closed elective surgery operating lists to re-open on 27th April, with the flexibility for state governments to "determine the appropriate levels of elective surgery within this general framework." This approach will be reviewed on 11th May with a view to opening up more elective surgeries in Australia.

Other areas of musculoskeletal health care

Services to support physical activity

37. During the pandemic, many people with arthritis will need support to manage their pain and prevent the onset of symptoms. Guidance from NHS England in March 2020 asked community health providers to prioritise services like rehabilitation on patients who have had recent elective surgery, and advises that services for all other patients should be stopped altogether with patients helped to self-manage.[34]

38. Physical activity interventions can play an important role in maintaining fitness while surgery is postponed (including aspects of pre-habilitation). Programmes like ESCAPE-Pain (which provides self-management support to help people manage arthritis pain) have been traditionally delivered face to face in community settings but have now shifted exclusively to online platforms.

39. We call on NHS England to consider how to build on this innovation and scale up rehabilitation programmes like ESCAPE-Pain[1] that have a strong evidence base in identifying the needs and supporting people affected by arthritis to manage pain.[35] At the same time, there will be a need to consider how to re-commence face to face services.

40. In the NHS Long Term Plan, NHS England pledged to expand access to the online version of ESCAPE-Pain as part of its work to reduce the impact of musculoskeletal conditions. The current circumstances provide an opportunity for NHS England to work with the Health Information Network (HIN) to explore ways of expanding access and developing evidence on the effectiveness of the online version of ESCAPE-Pain.[36]

41. Local commissioners should make use of the checklist that was developed by Versus Arthritis (in partnership with Public Health England, the Department of Health and NHS England) to

[1] ESCAPE-Pain = Enabling Self-Management and Coping with Arthritic Pain through Exercise

support them to map out and highlight any potential gaps in local physical activity provision for people with arthritis and musculoskeletal conditions.[37]

Shared decision making and care and support planning

42. In recent years, Versus Arthritis has published the findings of research around the benefits of shared decision making and care and support planning[38] for people with arthritis.

43. This is supported by evidence from our commissioned "Living Well with Arthritis" (LWwA) services in the CCG areas of Berkshire West, Frimley, South Tees, Surrey Heartlands and Northumberland. The LWwA service aims to assist patients to work through the shared decision-making process to help them determine whether hip or knee replacement surgery are appropriate. It involves them in care planning to build understanding of their condition, increase confidence in self-manage symptoms and be able to make informed choices about their care.

44. Once commissioned by CCGs, this service is available for GPs and healthcare professionals to refer into and can be provided in a number of formats including telephone.

45. Whilst waiting lists for surgery are being reduced over the coming months, services provided by the voluntary sector like LWwA will be vital for the management of arthritis and musculoskeletal conditions. The face to face services delivered by Versus Arthritis have been suspended, but like many charities we have adapted the information and support we provide to support people affected by arthritis during the pandemic:

    - Our Helpline operating hours have been increased as demand has risen;
    - We have introduced a new chatbot "COVA" to help people with arthritis with specific questions about COVID-19 and managing their condition;[39]
    - We have launched an Arthritis Tracker app for teenagers and young adults to help them record their arthritis symptoms and track pain, medication side effects and emotional wellbeing.[40]

46. A personalised, co-produced approach to long term conditions is important and we encourage NHS England to consider prioritising the expansion of shared decision making and care and support planning for people with long-term conditions as they implement their Universal Personalised Care plan in the aftermath of COVID-19.[41]

How to ensure that positive changes that have taken place in health and social care as a result of the pandemic are not lost as services normalise.

47. The transformation of primary care during the COVID-19 pandemic – where an estimated 95% of consultations are taking place remotely[42] – provides opportunities for improving the experience of people with arthritis. Remote appointments, whether by phone or video, allows for some degree of triaging that will help primary care professionals to better signpost people with arthritis to a service that can address their needs, such as physiotherapy.

48. By shifting consultations to digital by default, this may free up capacity for primary and secondary care professionals to implement elements of personalised care that can provide great benefits to people with arthritis. This includes increased use of shared decision making and

care and support planning; both of these elements support people to make decisions about their care, including decisions relating to COVID-19.

49. However, for new, acute MSK symptoms, a person may require a face to face consultation with a qualified MSK healthcare professional to establish what the nature of the issue is. Guidance is needed in primary care to outline best practice for GPs on which issues should be undertaken face to face and which issues can be dealt with online.

50. Feedback from our MSK Clinical Champions suggests that the shift in delivering support groups online is engaging people with arthritis and MSK conditions who previously did not have the ability to travel to face-to-face support groups when delivered in that format. This could help to address unmet need among people with arthritis who have the capability to access these groups online.

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