West Midlands Regional Spine Network

Managing the Backlog in Spine Surgery

March 2023

Category	**Operational Delivery Network policy document West Midlands Regional Spine Network (WMRSN)**
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Introduction

The pandemic has resulted in a significant backlog for both outpatient and inpatient spine surgery patients.

There are also challenging NHS targets for services to achieve.

This is a list of considerations for trying to address the backlog.

Minimising Harm

Prioritise

Outpatients

All patients referred for urgent opinion should be triaged and appropriate time frames for clinic slots delivered. All clinics should have the capacity to see urgent patients as required.

Inpatients

All patients on an inpatient waiting list should be prioritised using the FSSA framework. Clinical priority must be considered ahead of long wait times. P1 and P2 patients should not be breaching their target time lines (72 hours and 4 weeks respectively). P3 patients breaching their 3 month target should be evaluated for harm and be considered for re-prioritisation.

Patients waiting more than 104 weeks should be prioritised ahead of P4 patients.

Harms assessment

Outpatients

All patients waiting >52 weeks for their outpatient appointment should be reviewed for harm.

Inpatients

All patients on a waiting list breaching their FSSA time targets should be reviewed for harm.

All patients on a waiting list >104 weeks should be reviewed for harm.

See the separate WMRSN harms assessment guideline.

Validation

Tiers of validation are required to reduce unnecessary work load and repetition. The validation can be applied to both outpatient and inpatient lists. A local decision should be made as to which groups are targeted for validation. Patients on either outpatient or inpatient back logs over 52 weeks should be considered for validation.

Validation	Description	Outpatient outcomes	Inpatient outcomes
Tier 1	Administrative cleanse of lists to ensure no inaccurate entries, duplications or previously completed or deceased patients remain on the list. Inpatients should be ready, fit and able to undergo surgery	Remaining patients to move to Tier 2	Remaining patients to move to Tier 2
Tier 2	Clinical validation by clinician in charge to review records and determine appropriate next steps	a. Needs F2F appt (cite time frame / clinic type) b. Needs remote appt (cite time frame / clinic type) c. Send validation letter (Tier 3) d. Discharge (GP and patient letter to be completed)	a. Continue on waiting list at same priority b. Continue on waiting list with new priority c. Send validation letter (Tier 3) d. Clinic review (remote or F2F to verify need for intervention)
Tier 3	Validation letter using a standard template letter outlining that the patient should contact if they still wish to be seen / have intervention. Patient's response must be possible via a clear reliable channel of communication (e.g. monitored phone or email address). Patient must respond within 6 weeks.	a. No response - discharge with notification to GP and patient that they have been discharged and to be referred back if required b. Response – see within 8 weeks	a. No response - discharge with notification to GP and patient that they have been discharged and to be referred back if required b. Response – continue on original prioritisation (unless stated otherwise)

Clinician validation must be resourced and should place as a booked validation clinic. The validation letter may be considered before Tier 2, but this risks patients who should be clinically monitored being discharged inappropriately. Having the clinical validation reduces this risk.

Capacity

Optimising capacity is a key part of managing the backlog. This needs Trust and managerial support to ensure ward and theatre capacity is maintained for spinal surgery; as is access to critical care beds as appropriate.

Prioritisation and validation techniques also improve capacity. Additionally consider the following.

Outpatient

- Remote consultations

  Use of remote consultations can improve capacity by allowing clinics outside of a dedicated clinic room. Appropriate resourcing for technology required and standard documentation of the clinic letter must happen.

- Practitioner led clinics

  These can improve multi-professional working across the team. These can be remote or F2F and for new patients or follow ups depending on competencies and requirements of the service.

- PIFU

  All HVLC type cases could be considered for PIFU clinics or blended PIFU clinics. PIFU clinics require the correct administrative support, clear channels of communication for patients and clinic slots for patients that request an appointment.

Inpatient

- Preassessment service

  The preassessment should be robust to improve efficiency and reduce last minute cancellations. The preassessment appointment should be far enough away from the TCI date to allow another patient to be made ready if postponement is required.

  All patients that are prioritised as P2 and all patients over 104 weeks should be pre-assessed before a TCI date to allow last minute adjustments.

- Pooled lists

HVLC cases should be considered for pooled waiting lists on listing. The patient should be ready, fit and able for surgery. They should be notified that their surgery may not be by the index surgeon and that they will meet the surgeon at preoperative consent clinics.

This will reduce inequity of access related to individual surgeon's capacity, job plan and backlog.

- Flexible backfill of sessions

  All theatre sessions should be backfilled by spine surgery to avoid loss of capacity and reduced activity. This should be resourced.

- Day case procedures and ERAS

  Some HVLC are suitable for day case surgery in addition to injections (e.g. discectomies). Day case pathways should be clear and actioned to encourage day cases and improve inpatient bed capacity.

  Similarly enhanced recovery pathways should be resourced to improve patient outcomes and where possible reduce length of stay.

  Anaesthetic techniques should support the day case pathway.

  Consider whether physiotherapy led mobilisation is required as this can be a limiting factor to early mobilisation. Nurse led or preoperative instruction may reduce operation to mobilisation time and improve the chance of same day discharge.

- AQP

  The use of the independent sector for HVLC cases should be explored where bed or theatre capacity is limited.

- Low volume high complexity (LVHC) cases

  These have their own issues. Using 2 consultant operating where required may improve theatre efficiency and allow more cases per theatre session. However,

indiscriminate use of 2 consultant operating may paradoxically compromise capacity and this should be taken into consideration.

Critical care dependency for LVHC cases can be a barrier to efficient theatre usage, can result in same day cancellations and can limit the number of cases completed in a theatre session. Trusts should ensure where possible that systems to allow safe return to ward for selected patients exist. In addition early step down from level 2 / 3 to ward based level 1 beds may improve overall critical care capacity. Trust management must be involved in securing critical care beds for spine surgical cases where required.

Regional options

The WMRSN is supportive to strategies to improve backlogs in spine surgery.

Mutual Aid

In addition the WMRSN will look at regional solutions such as mutual aid requests.

In considering mutual aid the following should be in place:

1. Units with capacity to provide mutual aid should self-report to the network along with an indication of cases they could take.

2. Units requesting mutual aid should do so to the network as well as the usual ICS / NHSE channels

3. Units requesting mutual aid should have a clear break down of cases that they require support on – this includes:

- Type of burden (P2 / 104 week etc)
- Type of case load (HVLC type, paed deformity, adult deformity etc)
- Clear indication of numbers of cases involved
- An indication of critical care requirements for the case load
- An option of transferring LCHV without critical care demand to increase capacity

Referral diversion

Due to the known issue of capacity across units in the WMRSN and the general reluctance of patients already on a waiting list to transfer, there should be consideration given to diverting first non-urgent referrals to neighbouring units. This allows patients to build relationships with other units and allows a reduction in burden to the unit struggling with workload.

Outpatients

Strategy	Benefit	Risk
Remote consultations	Reduce need for clinic space Flexible clinic sessions	Technology required Need for F2F appt
Practitioner clinics	Increased clinician capacity for complex patients Reduced risk of delayed appointment	Education and protocols required Need for consultant appointment
PIFU / blended PIFU	Patient engagement Increased clinic capacity	Delayed appt on request Lost to follow up

Inpatients

Strategy	Benefit	Risk
Robust preassessment services	Reduce late cancellations. Optimise preoperatively. Initiate planned discharge date from preams (e.g. day case)	Resource intensive Not completed in time to prepare another patient
Pooled waiting lists	Reduce individual consultant burden Reduce wait times Ensure clinical priorities are managed in correct time frames	Patient declines Differing consultant opinion Consultant reluctance
Flexible backfill of theatre sessions	Optimise spine surgery theatre capacity	Needs resourcing (job plan or extracontractual)
Day case procedures	Optimise bed capacity	Needs overnight stay Needs clear pathway

ERAS	Improve outcomes May reduce LOS	Resource required May not reduce LOS
AQP	Improve capacity Reduce wait times	Cherry picking of “easy cases” Patient declines