# Elective Care: What needs to happen now?

## October 2020

Covid-19 has ruthlessly exposed flaws in our society, from social care funding to democracy itself. Trust is fundamental to a functioning society and it is eroding in many areas. One of these areas is elective care which we happen to know quite a lot about. An exploding waiting list and an inability to restart elective services for a variety of reasons are an under-appreciated societal risk in national debate.

**The key element of a functioning elective care system is the relationship between primary and secondary care. Increasingly we note higher than usual tension in the system around how elective patients are being managed.**

Philosophical arguments on this subject are fascinating: the transactional nature of secondary care versus the whole-health risk management approach of primary care. Fascinating though it may be, patients are at increasing clinical risk due to secondary care's challenges in treating them right now. Now is not the time for philosophical argument. Now is the time for action to reduce risk.

The key question clinicians need to work together on is clinical responsibility. When a GP refers to secondary care, they are effectively handing clinical responsibility for the referring condition to secondary care. And when a hospital discharges a patient, they are handing clinical responsibility back to primary care.

The challenge Covid has exposed is what happens when the patient isn't being seen in secondary care? Who is responsible for the management of that condition? Primary care would say secondary care. Secondary care would say that where they cannot see the patient due to Covid or the patient doesn't want to be seen then responsibility should go back to the GP. Meanwhile patients are at risk of slipping through the net.

It is important to note that we don't claim to have all the answers to this but there are some basic steps that we can see that both primary and secondary care can take individually and more importantly collectively to improve the levels of care to patients.

## So, what can be done today?

To understand what can be done today, it's important to understand what went wrong during the first wave. Already we are beginning to see the worst affected hospitals cancel elective procedures again and it's likely this will only increase. To a certain degree, the shortages of staff in secondary care to manage beds is something that little can be done about in the short term. So, expect to see more inpatient procedures cancelled over the coming months.

**However, outpatients and diagnostics in particular should have never been curtailed to the levels they were. It is imperative to protect these services moving forward.**

Interestingly, we have been surprised at how hospitals have struggled to restart these services.

Two big issues exist:

- Firstly communication (yes, that again) between the hospital and it's clinicians. Development of new clinic and diagnostic templates has been poor. How many new appointments, follow-ups and whether face-to-face or virtual has been very difficult to pin down. There isn't even a standard system in place for virtual appointments.

- Secondly, even if we have figured out new templates, the administration systems required to make the changes and reschedule patients have really struggled.

Changing every clinic template on a hospital EPR isn't easy - depending on the system. Then you have all the patients that were already booked in the old templates that need to be unbooked and moved to the new templates. It's a huge task frankly and it means that hospital administrators are doing that at the expense of booking patients who are on the waiting list to be seen.

**It all adds up to half-empty clinics and chaos with everyone confused. It's simply not satisfactory for anyone - the clinicians, patients and administrators are all frustrated.**

But back to risk and what to do. Unfortunately, in our line of work the biggest thing to do isn't sexy. It's about the basics of how to manage a waiting list. And it's harder now than ever. How to run a waiting list meeting covering thousands of patients (and growing) on Zoom or Skype or whatever, when half the people you need can't log in or are isolating at home. **Tricky, but not impossible. Basics.**

There simply isn't a silver bullet. It's hard work.

And primary care needs to be in the game. At present most GPs have no idea what's happening to their patients in secondary care. We have heard examples where 50% of calls to GP practices are from patients wondering why they haven't heard from the hospital. And the GPs don't know what's happening either.

Primary care hasn't closed - it's busier than ever. But a lot of what it is having to do is manage patients that aren't being seen in secondary care, blindly.

We can argue about secondary care getting its act together and to a degree it needs to but, in our experience, they are genuinely struggling. In the meantime, patients need primary care to assess risk after they've been referred and not been seen.

GPs say they don’t have time and we agree. Primary Care Networks need to advocate for their patients to get access to their information and more importantly, the resources and time to manage them if secondary care can’t. It is not acceptable to let patients decline on waiting lists with primary care unaware of what’s happening.

Technology to do this quickly exists and isn’t being used. It’s even possible to have algorithms flag particular risk groups to Primary Care. The harder question of resourcing it is an urgent discussion to be had between clinicians and NHS leadership for the sake of their patients.

**Basics.**

---

**020 3600 0451 // info@mbihealthcaretechnologies.com // @mbihealthcaretechnologies**

MBI Healthcare. Technologies.