

White papers and financial challenges

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PRESIDENT

'You're all whingeing about SHAs [strategic health authorities] and we're scrapping them; you're all whingeing about PCTs [primary care trusts] and we're scrapping them; you're all whingeing about quangos and we're abolishing most of them; and you're still whingeing. Please will you go away and get on with it!' I heard these words from a senior government figure and it is a good point. NHS bureaucracy is legendary and any radical measure to reduce it will be welcomed by the front line and by surgeons in particular, so in that context at least, the reforms in the Health and Social Care Bill should be welcome.

A great deal of the negative reaction to the government's plans has in my view been excessive. It is plain silly to talk of dismantling or privatisation of the NHS. It is not the most radical reform the NHS

has ever undergone. Anyone who has spent significant time actually working in the NHS rather than commenting on it knows that there have been many 'radical' reforms without changing the essential purpose of the organisation, which is to provide universal healthcare, free at the point of use.

If the Secretary of State wants change he is right to do it immediately and with urgency; otherwise the inertia in the system will ensure that nothing happens. Life at the coalface changes only very slowly, oblivious of which management hierarchies are nominally managing it. After all, the basic purpose of the acute sector is simple. As a surgeon my job on the first day of my career was the same as on the last – go to work, see patients, sort them out and operate on those who will benefit.

It is not a role of the College to tell the government and the population of Britain

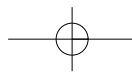
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how health services should be paid for and delivered. This is for national political debate and no doubt within the surgical community there will be a full range of views. Our role as the professional body for surgeons is to set the highest possible standards for the care of surgical patients, for whatever system is decided by Parliament.

To this end we have raised concerns about certain parts of the proposed legislation. We welcomed the greater role for clinicians promised in the white paper, so are greatly concerned that there is no provision for clinician involvement on the National Commissioning Board. We do not comment on the concept of 'any willing provider' but would like to flesh this out into 'any willing competent provider able to achieve the highest standards of care including audit, research and training'. We are alarmed that surgical care might be commissioned on price alone, without input from clinicians. There must be minimum clearly set-out standards of care produced by practising clinicians. There is nothing wrong with competition provided that it is used to obtain the best care, not necessarily the cheapest.

This leads me on to an issue very topical at the moment, so-called 'procedures of limited clinical value'. Although this has

come up at the same time as the government's reforms it is a separate issue. It is brought about by the 'Nicholson challenge', introduced by the last government in 2009 well before the election, to save £20 billion by making 'efficiency' savings of 4% per annum from health budgets. Some doubt if this is possible but I remember 3% being



attempted and sometimes achieved in the past. Plus ça change!

Hard-pressed managers and commissioners have to save money and save it fast. Elective surgery is a soft target as it can be switched off quickly if patients can be kept out of the system. Referrals have to be stopped at source so general practitioners are asked not to refer patients with certain conditions. If they do, the referrals are screened by professionals such as physiotherapists or non-clinical staff, with the aim of making sure that a significant number never get to a consultant, never mind a named one, and do not enter the system. This assumes of course that general practitioners know enough about the various conditions to make an accurate diagnosis of which patients need surgical procedures. Of course they do not and having trained to practise a different kind of medicine entirely how can they have the knowledge and experience of a surgical consultant?

Nevertheless, lists of procedures to be curtailed have crept into existence, without noticeable intelligent clinical input. Their existence may be denied but a division of the Department of Health has produced a list given to the specialty associations that the College has seen. In the regions, SHAs and PCTs are doing likewise. Sometimes there has been clinical advice of a sort but often there has been none. Are there such things as procedures of no clinical value at all? Of course there are but surgeons are hardly likely to do anything that will not benefit the patient. That is the whole point of our training and ethos.

The difficulty with the concept of 'procedures of limited clinical value' is

that much elective surgery is done not just to alleviate current symptoms but also to prevent long-term risks to health, with the major benefit coming later. For example, operating on some hernias may safely be delayed for a while but eventually the chickens will come home to roost and who wants to see

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strangulated hernia returning as a common emergency procedure? If surgery to remove tonsils and adenoids were to be stopped, some children with recurrent symptoms would continue to suffer but of even greater importance, we would see the resurgence of chronic middle-ear and mastoid infections, with eventually extra-dural and cerebral abscesses making a comeback. Another problem with stopping operations is that after delay the outcome of surgery may be inferior. There is an optimum time for, say, joint replacement beyond which the deterioration in mobility and muscle power prevents the best result.

A further fundamental economic argument is that the patients who are not dealt with will not disappear. They will have to have their operation some time, by which time they will be joined on the waiting lists by a new generation who have developed the same problems. Inappropriate reductions in elective surgery will plant a social and economic time bomb. Clinical input from those with insight is needed urgently.

What can surgeons do if this starts to happen in their area? The specialty associations have been involved by the

Department of Health, which is encouraging. The College regional networks of directors of professional affairs (DPAs) and their committees of specialty advisors, who are the regional representatives of the specialty associations, are collecting intelligence. Additionally, some of the more

enlightened commissioning groups have asked for College advice by this route. Giving such advice is one of the main purposes for the College regional networks.

Please pass on incidences of inappropriate restrictions to your regional specialty professional advisor or DPA or contact the College directly on policy@rcseng.ac.uk. The media is very interested and the issue has been prominent in the national press recently, with College views prominently displayed. Harnessing public opinion in this way applies pressure on commissioners to behave rationally and sensibly. As I said before, however, please do not confuse this back-door rationing with the NHS reforms. The particular problem supposedly being solved by limiting elective operations is the need to save money at the moment; changing the way the NHS is organised and funded is something different. If the country cannot afford elective surgery for those who need it, there should be an open debate on the options, not stealth rationing that only stores up trouble for the future.

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