**Health Select Committee inquiry: public expenditure on health and social care**

**Royal College of Surgeons’ written evidence**

1. **Introduction**
	1. The Royal College of Surgeons exists to advance surgical standards and maintain the highest level of care for patients. In this evidence to the Health Select Committee we therefore focus our concerns on where financially-driven decisions are undermining access, patient safety, and quality of care.
2. **Summary**
	1. The NHS has performed well despite the extraordinary pressures that have been placed on the health service. In surgery, a rising trend in capacity means more operations than ever before are carried out on the NHS, with the Health Secretary quoting an extra 850,000 procedures being delivered every year since 2010.[[1]](#footnote-1) Surgical outcomes have also been improving thanks to extensive auditing and the adoption of rigorous surgical standards. However, some measures show that performance, especially in terms of access, is beginning to deteriorate.
	2. While we acknowledge difficult decisions will need to be made about how to spend finite resources, we are concerned about the number of financial pressures that will face hospitals over the next year. These include increased demand, unintended consequences of the Better Care Fund which will move money out of hospitals, and changes to NHS prices (the ‘tariff’). We particularly encourage the Committee to examine the potential effects of NHS England and Monitor’s proposed 3-5% reduction in prices to be paid for various treatments and services in 2015-16.
	3. The NHS is rationing access to surgical services according to recent evidence we have published[[2]](#footnote-2). For example, 44% of clinical commissioning groups (CCGs) require patients to be in various degrees of pain or immobility, or to lose weight, before accessing a hip replacement even though this contravenes NICE and other expert surgical guidance. While it is impossible to be certain the motivation is to save money, such measures are likely to increase not decrease in the present financial climate. We urge the Government to remind CCGs of the need for patient care to be delivered on the basis of clinical need, not compromised by financial considerations. The resource pressures in social care may be undermining the NHS’ ability to better co-ordinate the care of surgical patients, according to a recently published survey of surgeons.
	4. The RCS supports the NHS transitioning to a seven day services model of care. It is unacceptable that patients are not afforded the same quality of care at weekends and in the evenings. NHS England should initiate in-depth financial modelling to help anticipate the costs of implementing comprehensive seven day services.
3. **Current performance of the NHS**
	1. During the past few years the health service has been performing well on a number of indicators despite unprecedented financial pressures. Indeed, a recent Commonwealth Fund report[[3]](#footnote-3) placed the NHS first out of 11 countries’ health systems, rating it highest for quality, access and efficiency, despite the fact that many other governments spend considerably more on health.
	2. However, the sector faces significant financial challenges and there are signs that performance is beginning to deteriorate. For example, major A&E departments have breached their four-hour admission or discharge target for over a year. Similarly, people are reporting that it is harder to get a GP appointment and the waiting list now has more than 3 million patients. These measures are about access rather than quality but they have traditionally been used as proxy indicators of wider performance.
	3. We are particularly concerned that the important focus on initiatives in elective (planned) care such as hip and knee operations, has come at the expense of emergency surgery and emergency medicine more broadly. As a recent RCS briefing set out, there are wide variations in mortality rates in urgent and emergency surgery and poor readmission rates.[[4]](#footnote-4) Emergency surgery is at risk of becoming a Cinderella service in the NHS.
	4. The NHS has remained financially robust in the face of austerity related pressures but is now finding it increasingly harder to remain in balance. For example, in the last financial year NHS trusts posted a combined surplus of £383m. This year however, the Nuffield Trust is predicting a net deficit for the sector of just over £100m.[[5]](#footnote-5)
4. **Short and medium term risks to the acute sector**
	1. *Demographic changes*
		* A number of factors mean that acute trust finances are likely to come under particular strain over the next few years, including from rising demand driven by demographic change. With a growing older population, demand for surgical services will increase particularly for orthopaedic operations such as hip and knee replacement as well as surgery to treat conditions more common in the older people, such as cancer.
	2. *Better Care Fund*
		* The Government’s Better Care Fund is an important step towards improving integration between health and social care. However, the approximately £5bn that is to be pooled between the NHS and local government is not new or additional spending. Much of this money will need to be found from within existing acute budgets. NHS England believes the investment could reduce pressures on hospital, such as reducing emergency admissions by 15%.[[6]](#footnote-6) However, polling of trust finance directors by the King’s Fund earlier this year found that not a single director thought such a cut was likely.[[7]](#footnote-7)
		* Further integration of health and social care is widely regarded as a key solution in meeting future health challenges. However, recent research from the University of York suggests that previous schemes have not always succeeded in their aims. For example, their study found that rather than reducing demand, integrated care initiatives often revealed unmet need that instead acted to increase rather than reduce total costs.[[8]](#footnote-8) Addressing clinical need is of course important but there is a risk that the Better Care Fund could put new pressures on acute care by reducing funding and increasing demand – especially if patients do not utilise new community-based services.
		* We are therefore pleased that the Government have indicated there needs to be ‘risk sharing’ in all better care fund plans to protect acute hospital finances. We encourage the Committee to scrutinise these plans and to assess whether they are sufficient to cover the risks to hospitals.
	3. *Tariff changes*
		* The RCS recognises that payment systems, including the national tariff, have incentivised access to treatment and helped to drive down waiting times.
		* We recently responded to Monitor and NHS England’s consultation on the tariff system for 2015/16 in which we set out our views on proposals for changes to the payment system[[9]](#footnote-9). In our submission we outlined our support for the way in which encouraging local variation in the pricing system can help local service transformation, including by incentivising enhanced integration between health and social care. We are also pleased to see Monitor and NHS England continue to propose new best practice tariffs.
		* However, we are concerned about the proposed 3-5% across the board price reduction for different services. We question the evidence base behind this proposal and such an efficiency saving, coming after additional years of savings, is unlikely to be applicable across all branches of surgery. Some surgical services are already underpriced and these prices may simply encourage the use of inferior but cheaper techniques or treatments, reducing the quality of the service.
		* We also remain concerned that the tariff for urgent and emergency care currently penalises acute hospitals. We are disappointed that the marginal tariff for emergency care will remain unchanged until the wider review of urgent and emergency care for 2016/17 prices. The Committee has previously commented on this issue and we remain adamant that the marginal tariff simply needs to be abolished.
		* There has been insufficient public scrutiny of NHS England and Monitor’s proposals to date. We encourage the Health Committee to probe the pricing proposals for 2015/16 and better understand the effects this will have on patient care.
5. **Evidence of rationing decisions**
	1. In the past the NHS has sometimes sought to overcome financial pressures through short-term measures such as restricting access to medical care. We firmly believe that access to surgery should be based on clinical need only and should not be compromised by financial constraints.
	2. Restricting access to treatment can impact on the outcomes of surgery, with evidence that patients are less mobile and suffer more pain if operations are delayed or denied. In some cases, such as in the case of groin hernia repair, delays in operating can lead in rare circumstances to a strangulated hernia, which is a medical emergency.
	3. Under Primary Care Trusts the Committee previously commented on such actions, saying there was ‘disturbing evidence that the measures currently being used to control the financial situation could fairly be described as “short-term expedients” or “salami slicing”’.[[10]](#footnote-10)
	4. In July we published *Is Access to Surgery a Postcode lottery?.[[11]](#footnote-11)*  This study used information obtained through Freedom of Information requests to compare CCG commissioning policies with expert commissioning guidance published by the RCS/surgical specialty associations (SSAs) and, where available, NICE. The research is the first major report to review whether new commissioners are ignoring clinical advice about acceptable commissioning thresholds. The study found:
		* 73% of CCGs reviewed were not following NICE and clinical guidance on referral for hip replacement.
		* 44% of CCGs required patients to be in various degrees of pain and immobility (with no consistency applied the country) or to lose weight prior to hip replacement surgery. This is considered unacceptable by NICE, the RCS and the British Orthopaedic Association.
		* Only 27% of CCGs from our sample have policies that comply with NICE or surgical guidance on inguinal hernia repair. 15% required evidence of a hernia increasing in size or a history of the hernia not being able to return to the abdominal cavity (incarceration) even if a patient is suffering from debilitating pain.
		* Two CCGs had minimum ‘watchful waiting’ periods, meaning some patients may not access tonsillectomies for a year and a half
		* 77% of CCGs do follow clinical evidence on the commissioning of treatment for glue ear. However, six CCGs require minimum waits to watch for additional symptoms, contrary to clinical guidance.
	5. Further data, published on the RCS website[[12]](#footnote-12), demonstrates wide variations in age- and population-standardised rates of access to key surgical services, indicating a number of procedures are likely being restricted by CCGs or providers.
	6. These findings are despite the fact that the Government has continually said that rationing of health services is unacceptable and that any restrictions should be based on clinical criteria only.
	7. It is clear that the financial challenges in the acute sector may encourage more commissioners to ration surgical services as they seek short-term ways of saving money.
	8. Nevertheless, the College position is clear: efficiency must not lead to shortcuts on quality and patient safety. The RCS and surgical specialty associations (SSAs) are therefore working alongside commissioners to reduce unexplained variations in service provision. RCS and SSA commissioning guides – published through a NICE accredited process – offer broad commissioning support with the aim of improving the health and wellbeing of patients and reducing unexplained variation in surgical services. We urge the Government and NHS England to review what further action is required to ensure the NHS is providing equitable access to high-quality surgical care.
	9. However, we remain concerned that despite the availability of high quality guidance and advice from NICE and professional associations, as our research shows, many CCGs continue to ignore such resources with regards to their commissioning behaviour. We encourage the Government to remind CCGs of the need to ensure their commissioning policies are in line with the clinical evidence base.
	10. Government legislation also requires CCGs to publish policies on providing medicines, medical devices, diagnostic techniques, surgical procedures, or other therapeutic interventions. This should help to improve transparency around rationing decisions. However, while this is a legal requirement, our research shows that many CCGs have still not published this information. For example, we found that 58% of CCGs in our *Is Access to Surgery a Postcode Lottery?* report sample group did not hold a commissioning policy for inguinal hernia repair. We would like the Government and NHS England to remind CCGs that this is a legal requirement.
6. **Financial pressures undermining co-ordinated care**
	1. A recent RCS survey of over 200 surgeons suggests the financial pressure experienced in social care might affect the co-ordination of care for surgical patients.[[13]](#footnote-13) Respondents highlighted a number of concerns regarding patient transfer from hospital (discharge):
		* Only a quarter of surgeons felt there is a thorough transfer planning process in place for patients leaving hospital. Many surgeons felt this had to happen much earlier, potentially at pre-assessment stage before surgery.
		* Respondents said social care services are not getting involved in transfer planning until after the operation. This may not be due to a lack of willingness but an effect of resource constraints.
		* Surgeons felt that communication between medical professionals and community care organisations was very dependent on local arrangements and information sharing between the two needed to improve. For example, just 41% thought that carers were given enough information about the needs of patients on discharge.
		* Respondents to our survey highlighted a need for better access to primary, social and community care when patients leave hospital.
	2. The Better Care Fund has the potential to reduce these problems but we encourage the Committee to acknowledge the problems at the interface of primary, secondary and community healthcare and urge Government to consider how to better align the entire care system. Our survey shows improvement will not only arise from substantial structural changes or huge financial investments but can in some cases be implemented through influencing culture and practice.
7. **Seven day services**
	1. The RCS strongly supports the need for seven-day consultant-led services. We firmly believe that it is unacceptable that mortality and complication rates are significantly higher for patients admitted at the weekend.
	2. An Academy of Medical Royal Colleges’ report, chaired by ex-RCS President Norman Williams, set three clear standards for the service in delivering seven day care to hospital inpatients. These include a patient review by an on-site consultant at least once every 24 hours, seven days a week.
	3. Many consultant surgeons already work at weekends in order to visit patients on whom they have operated during the week, but they cannot work effectively when other services such as diagnostics, pharmacy, radiology and physiotherapy are unavailable. This should also extend to the community, where there is a need to ensure full weekend access to social care services so patients can be transferred when there is no longer a need for them to remain in hospital.
	4. There will be resource implications for providing seven day services. While, in the long-term, money might be saved through a potential reduction in fixed-costs (e.g. if inpatients can be treated across the week we may be able to reduce the number of beds), there are likely to be short-term costs. In the current financial environment there may also be a need to centralise some services onto fewer sites to ensure there is sufficient consultant cover and availability of services.
	5. To aid NHS planning we believe it is imperative that the Government or NHS England should commission in-depth financial modelling of the anticipated costs of seven-day services and set out how they expect these to be funded.
8. **Independent sector involvement in the NHS**
	1. The present inquiry’s terms of reference indicate the Committee will explore the use of the independent sector in the NHS. The RCS supports provision of the highest quality service wherever it is provided for the benefit of patients.
	2. The independent sector is playing an increasing role in providing NHS elective surgery. Although the independent sector only provides roughly 3% of all elective NHS care, 19% of all hip replacements and 22% of all knee replacements are now conducted by such organisations.[[14]](#footnote-14) Surveys suggest many independent sector centres are highly regarded by patients.[[15]](#footnote-15) [[16]](#footnote-16)
	3. However, the RCS is concerned that in the independent sector education and training of the workforce is extremely patchy.The sector should play a larger role in providing, delivering and funding education and training opportunities, since many independent providers currently benefit from staff trained at the public expense. Moreover, as an increasing number of surgical procedures move into the independent sector, this will increasingly become the most appropriate place for some specialty training to take place.
	4. We also urge commissioners to think carefully about the effect of commissioning independent sector providers on existing provision of surgical services. For example, taking surgeons and other staff from current providers and moving them to another site may destabilise existing services such as emergency care and create further fragmentation of the local health system. This may further undermine coordination of care. It is important that tenders consider and avoid such negative consequences.

1. <http://www.conservativehome.com/platform/2014/08/jeremy-hunt-mp-no-one-should-have-to-wait-more-than-a-year-for-an-operation.html> [↑](#footnote-ref-1)
2. See our report *Is Access to Surgery a Postcode Lottery?* (July 2014) [↑](#footnote-ref-2)
3. http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror [↑](#footnote-ref-3)
4. https://www.rcseng.ac.uk/policy/documents/RCS%20Emergency%20surgery%20policy%20briefing.pdf [↑](#footnote-ref-4)
5. http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/into-the-red-report.pdf [↑](#footnote-ref-5)
6. NHS England, 2013: <http://www.england.nhs.uk/wp-content/uploads/2013/12/bm-item6.pdf> (see page 5) [↑](#footnote-ref-6)
7. http://www.kingsfund.org.uk/sites/files/kf/field/field\_publication\_file/quarterly-monitoring-report-april2014.pdf [↑](#footnote-ref-7)
8. http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP97\_Financial\_mechanisms\_integrating\_funds\_healtthcare\_social\_care\_.pdf [↑](#footnote-ref-8)
9. <https://www.rcseng.ac.uk/policy/documents/RCSresponsetoNHSEnglandandMonitorconsultationonNHSTariff2015.pdf> [↑](#footnote-ref-9)
10. House of Commons Health Committee. Public Expenditure: Thirteenth Report of Session 2010–12.

London: TSO; 2012. [↑](#footnote-ref-10)
11. Royal College of Surgeons: <http://www.rcseng.ac.uk/news/docs/Is%20access%20to%20surgery%20a%20postcode%20lottery.pdf> [↑](#footnote-ref-11)
12. Royal College of Surgeons: <https://www.rcseng.ac.uk/healthcare-bodies/nscc/data-tools> [↑](#footnote-ref-12)
13. <http://www.rcseng.ac.uk/news/docs/coordinated-care-survey> [↑](#footnote-ref-13)
14. National Joint Registry Annual Report 2013 [↑](#footnote-ref-14)
15. NHS Confederation: <http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/A-positive-partnership_121011.pdf> [↑](#footnote-ref-15)
16. What patients think. An analysis of user ratings and comments on NHS Choices. NHS Choices (February 2011). [↑](#footnote-ref-16)