



PAC evidence session on progress in making NHS efficiency savings – 14 Jan 2013
Briefing from the Royal College of Surgeons

Introduction

The Royal College of Surgeons' prime responsibility is the maintenance and improvement of surgical standards to deliver high quality patient care. While it is not our role to decide how savings are best made in the NHS we have concerns that some cost-saving measures are undermining patient safety and quality of care and may, in fact, increase expenditure in the long-term. This is happening on several levels including reductions on professional time which is essential for education and training, rationing of available treatments and services, and financially-driven redesign of services. This briefing to members of the Public Accounts Committee sets out our concerns primarily around rationing decisions, and addresses how we believe service redesign – which the National Audit Office report says is necessary for larger savings – can be supported without undermining patient care.

Evidence of rationing decisions

The RCS agrees with the National Audit Office report that despite the significant financial pressures facing the NHS it continues to perform well against *certain* measurable 'headline indicators of quality'. For example, referral to treatment waiting times as of October 2012 are historically low¹.

Despite such successes, the College is aware of factual evidence and anecdotal information from our members which indicates many NHS commissioners are rationing clinically necessary services. For example, a 2012 study by *GP magazine*² said that over 90% of Primary Care Trusts (PCTs) were rationing care in some form for cataract surgery, joint replacement, tonsillectomies, or bariatric surgery. Restrictions on access to surgery can affect the outcomes of surgery and patient safety, with evidence that patients are less mobile and suffer more pain if their operation is delayed or denied.

This is despite the fact that the Government has repeatedly said restrictions should be based on clinical and not financial criteria:

- At Prime Minister's Questions Time Foreign Secretary Rt Hon William Hague MP said: 'It is totally unacceptable if trusts are rationing on the basis of financial considerations'³.
- On 21 September 2011 the NHS medical director Sir Bruce Keogh wrote to Strategic Health Authorities⁴ to say that 'Any decision to restrict access to a treatment or intervention must be justified in relation to a patient's individual circumstances' and that 'decisions should not be made solely on the basis of cost, and any refusal to offer the intervention in question must be fair and consistent.'

¹ <http://transparency.dh.gov.uk/2012/06/29/rtt-waiting-times/>

² <http://www.gponline.com/News/article/1136671/Exclusive-90-PCTs-rationing-care/>

³ HC Deb, 20 June 2012, c855

⁴ The letter is available here: <http://www.hsj.co.uk/Journals/2011/10/10/k/d/d/Keogh-letter.pdf>



- In November 2011 the Department of Health announced that it was requiring PCTs to cease imposing minimum waits, activity caps, and inappropriate constraints on elective activity by no later than 31 March 2012⁵.

Case study: access to bariatric surgery

A high profile example of where access to surgery has been restricted is bariatric surgery. In 2010 the College surveyed bariatric surgeons about access to weight-loss surgery. NICE clinical guidance (CG43) on obesity recommends – but does not legally require – that bariatric surgery is offered as a first-line option for different groups of patients dependent on Body Mass Index (BMI). A study published by the College in 2011 highlighted the many clinical benefits of bariatric surgery⁶; twelve months after surgery, for instance, the number of patients with type 2 diabetes and/or high cholesterol had halved.

However, our survey found that while some Primary Care Trusts adhered to the guidelines, others were raising the bar so that only the most extremely ill patients – those with a BMI of 50 or 60 with obesity related illness – are being referred for surgery even though there is no clinical evidence to support this practice. Our members also told us that some PCTs were refusing to commission *any* obesity surgery.

There is compelling evidence that weight-loss surgery (bariatric surgery) is one of the most cost-effective treatments in acute health care which cannot be ignored. Restricting patients' access to surgery to save money in the short term by raising the threshold on BMI over and above NICE recommendations is irrational and not in patients' best interests. In the long term restriction are likely to cost the NHS more money since obesity associated healthcare costs are estimated at £7.2billion per annum.

The College's view

The NAO report notes that NHS savings so far have been primarily generated through contractual levers applied by the Department. £520m of the reported savings for 2011-12 were also non-recurrent. While we appreciate the unprecedented scale of the financial challenge facing the NHS, there is therefore a danger that further rationing of clinically necessary services and treatment will take place in the future as commissioners look for other short-term ways of saving money.

Patients' access to treatment should be driven by need based on clinical assessment, and must not be compromised by financial pressure. Most methods to restrict access to surgery use unproven and arbitrary thresholds which unfairly deny patients some of the most successful operations which vastly improve quality of life. Efficiency must not lead to shortcuts on quality and patient safety.

The RCS and the surgical specialty associations are also playing their part to help reduce unwarranted variations in services by developing evidence-based guidance on surgical service

⁵ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131089.pdf

⁶ <http://www.rcseng.ac.uk/news/obese-patients-suffering-avoidable-disease-and-disability-reveals-first-ever-uk-bariatric-surgery-audit>



commissioning. This aims to improve the health and wellbeing of patients and reduce differences in commissioning standards across the NHS.

Commissioners should, however, additionally look at reducing access to clinically unnecessary procedures. The 'Clinical responses to the Downturn'⁷ report in 2010, which brought together NHS managers and clinicians, set out some areas for potential savings.

Monitoring rationing decisions

The Health and Social Care Act 2012 requires clinical commissioning groups (CCGs) and the NHS Commissioning Board 'to have regard to' NICE's quality standards. These will set out aspirational but achievable areas for quality improvement in a defined care or service area, including for obesity. However, they will not be mandatory and it remains to be seen how the legal duty to 'have regard to' will be interpreted locally.

The RCS welcomes the recent announcement from the Department of Health that will require CCGs from April 2012 to publish their level of compliance with NICE technology appraisals⁸. However, it is important to note that NICE technology appraisals only cover a small proportion of the services provided by the NHS so rationing of clinically necessary services may still occur. NICE guidance on bariatric surgery is not classified as a technology appraisal so there is therefore no legal requirement on the NHS to fund bariatric surgery.

Recently published secondary legislation⁹ will also require CCGs to comply with relevant NICE technology appraisals (although not all advice NICE provides), and to publish on their websites policies on providing medicines, medical devices, diagnostic techniques, surgical procedures, or other therapeutic interventions. This will improve transparency around rationing decisions.

We encourage PAC members to ask the witnesses:

- In the new NHS system how will the Department of Health and/or the NHS Commissioning Board monitor access to clinically necessary services and monitor performance against NICE quality standards?
- Has the Department of Health analysed the impact of Sir Bruce Keogh's letter to strategic health authorities on 21 September 2011?
- Do they agree that more needs to be done to ensure commissioners are following NICE guidance on bariatric surgery?

Redesigning services

The NAO report argued that 'Service transformation is key to making future savings, but only limited action has been taken to date'. We agree that service transformation has been slow. To an extent, health service staff must take some responsibility for slow progress on reshaping services. Too many reconfigurations have failed to win the support of doctors, nurses or the public. Consultations have sometimes been a loaded tick-box exercise designed to secure token

⁷ http://www.aomrc.org.uk/publications/statements/doc_details/9319-clinical-responses-to-the-downturn.html

⁸ <http://www.dh.gov.uk/health/2012/12/ihw-creating-change/>

⁹ <http://www.legislation.gov.uk/ukxi/2012/2996/part/7/made>



support, rather than engage in a genuine conversation with the public. We must ensure the public understands the substantial clinical benefits that can be achieved, while addressing natural concerns regarding the availability of emergency care and transportation issues. We also agree with the report's recommendation that the DH and the NHS Commissioning Board should work with the NHS to reduce barriers to transforming services.

However, as the College made clear in '[Reshaping surgical services](#)',¹⁰ – published at the start of January 2013 – **it is essential that any service change is based on clinical evidence, not purely financial motives** especially where that may lead to a reduction in available services.

The College strongly supports service change where there is evidence that this will lead to improvements in the outcomes of surgery. The focus when reshaping services must be delivering improvements in patient care, and patients and their families must be fully involved in this process.

There is a strong clinical case for reshaping some surgical services. Scientific and medical advancements mean it is no longer necessary or appropriate to deliver certain operations or procedures in acute hospital settings. At the same time we know from the comprehensive evidence currently available that for many procedures and conditions concentrating specialist surgical services into fewer, larger centres of excellence can improve outcomes, and often save lives.

2013 is an important year for service redesign

Our President, Professor Norman Williams, recently addressed NHS managers¹¹ noting that 2013 has to be the year when politicians, clinicians, and managers come together to support historic change in the NHS and create a long-lasting legacy for all of our population. As we get closer to an election in 2015 there is a danger that some service changes will be swept up in election campaigning. It is important for politicians to engage with the clinical case for reshaping services as much as public concerns and support solutions that improve patient treatment and care. Once a decision has been made, it should be implemented quickly as delays can affect future planning of services.

We encourage PAC members to ask the witnesses:

- How many service changes over the next twelve months are likely to be driven by primarily financial motives?
- What support will the NHS Commissioning Board provide to all commissioners to back clinically necessary service change?
- Whether more needs to be done to win the support of national and local politicians to back clinically necessary changes?

¹⁰ <http://www.rcseng.ac.uk/publications/docs/reshaping-surgical-services/>

¹¹ <http://nhsvoices.nhsconfed.org/2013/01/07/2013-its-now-or-never-for-service-change-jeremy-hunt-must-deliver-says-norman-williams/>