Royal College of Surgeons: Response to Evidence Based Interventions consultation

The Royal College of Surgeons (RCS) welcomes the opportunity to provide a response to NHS England's consultation on proposals developed as part of the Evidence Based Interventions programme. The RCS and a number of surgical specialty associations have worked closely with NHS England on a number of the treatments included in this consultation, and we are keen to contribute to this work as the Evidence Based Interventions programme continues.

Executive summary

- The RCS supports the aims of the Evidence Based Interventions programme. NHS resource should be used wisely and proportionately, with only effective, evidence-based treatments routinely funded.

- The RCS has concerns around the requirement for GPs to seek prior approval from the relevant Clinical Commissioning Groups (CCGs) to refer patients for Category 2 interventions. For patients who have already exhausted a range of treatment options prior to applying for prior approval, this is another delay that could leave patients in unnecessary pain and distress. Clinicians should be able to use their judgement to refer patients for treatment without recourse to unnecessary administrative hurdles.

- In order to ensure equitable access to the treatments proposed in this consultation, we believe NHS England must introduce clear national guidance for CCGs' Individual Funding Request (IFR) policies, possibly including a template IFR for CCGs to vary according to locally relevant criteria. This will ensure that IFRs are fit for purpose if they are included as part of the rollout of the Evidence Based Interventions programme.

- The RCS shares the concerns raised by the British Society for Surgery of the Hand (BSSH) over recommendations for the treatment of carpal tunnel syndrome, Dupuytren's contracture, trigger finger, and wrist ganglion. We recommend that NHS England should remove the current conditions from the proposed list, engaging with relevant clinicians to ensure any alternative recommendations relating to these conditions take full account of the clinical evidence available.

- We would encourage NHS England to ensure clinicians front any future communications work to provide assurance to the public and ensure the aims and intentions of the Evidence Based Interventions programme are conveyed accurately and effectively.

- We recommend that NHS England should look to undertake a qualitative analysis of the treatments in question, engaging with patients who have received these treatments to gain an understanding of their benefits and drawbacks. Such engagement with relevant patients is vital to shaping the future of the Evidence Based Interventions programme, and will help secure greater buy-in from patients and the public. It would also be appropriate for NHS England to commission an academic health research department to conduct this work, with a view to producing valid findings.

- To ensure the right treatments are included in the Evidence Based Interventions list, NHS England should seek to monitor patient outcomes from the commissioning of Category 1 and Category 2 treatments. This will ensure that the list of treatments identified continues to align with clinical evidence, and will help ensure that the programme's messaging is not being misinterpreted by some CCGs to mean a procedure is entirely banned.

Interventions covered by the consultation

The RCS supports the inclusion of the majority of the surgical interventions covered in this first phase of the Evidence Based Interventions programme. However, we share the concerns of the British Society for Surgery of the Hand over the recommendations for the treatment of carpal tunnel syndrome, Dupuytren's contracture, trigger finger and wrist ganglion.

These common conditions can have a significant detrimental effect on quality of life. Although mild cases may resolve with non-operative treatment, timely surgical treatment is effective in relieving symptoms and preventing irreversible loss of function that can occur in neglected cases.

The RCS is concerned that the evidence base for limiting access to treatments for these conditions has not been appropriately considered. To take the case of carpal tunnel syndrome, the British Society for Surgery of the Hand (BSSH) states that surgery is an effective treatment for patients with severe persistent symptoms and provides a permanent and complete cure in 80-90% of patients.[1] Evidence, including that from randomised controlled trials, has shown that surgery is more clinically effective than non-operative treatment for moderate and severe disease.[2] A related study showed that surgery is also more cost effective.[3]

The RCS is also concerned that alternatives to surgery set out for some of these procedures do not align with clinical evidence. For instance, the programme recommends physiotherapy and splinting as an alternative to surgery for Dupuytren's contracture. However, the RCS and the BSSH are not aware of any published evidence indicating that physiotherapy or splinting are of any benefit in correcting or preventing progression of contracture.

Instead, surgery should be avoided in cases where there is no contracture, and in patients with a mild contracture that is not progressing and does not impair function. Overall, the choice of treatment should be guided by the severity of the contracture, the age of the patient and rate of progression. Surgery is the only effective treatment for severe contracture. It is also important to consider the background of an individual patient; for example a medical professional with Dupuytren's contracture may find it difficult to operate or treat patients, so earlier intervention may be necessitated in their case.

The RCS therefore believes NHS England should remove the current conditions from the proposed list, engaging with relevant clinicians to ensure any alternative recommendations relating to these conditions take full account of the clinical evidence available.

The RCS has written very clear evidence-based commissioning guidance on many of the procedures involved. The RCS has also been very supportive of the Getting It Right First Time initiatives, which use data and best practice and may include supporting patients to avoid surgery.

A multi-disciplinary team approach is required to give clear consistent messages about the alternatives to surgery to manage these conditions. For example, patients with orthopaedic conditions

[1] https://www.bmj.com/content/362/bmj.k2903/rapid-responses
[2] Gerritsen AA1, de Vet HC, Scholten RJ, Bertelsmann FW, de Krom MC, Bouter LM. Splinting vs surgery in the treatment of carpal tunnel syndrome: a randomized controlled trial. JAMA. 2002 Sep 11;288(10):1245-51.
[3] Korthals-de Bos IB1, Gerritsen AA, van Tulder MW, Rutten-van Mölken MP, Adèr HJ, de Vet HC, Bouter LM. Surgery is more cost-effective than splinting for carpal tunnel syndrome in the Netherlands: results of an economic evaluation alongside a randomized controlled trial. BMC Musculoskelet Disord. 2006 Nov 16;7:86.

who are considered for arthroscopy for knee arthritis or injections for back pain (in Category 1), or shoulder decompression (in Category 2) need clear accessible information; the GPs, physiotherapists, exercise professionals and others supporting them may need additional resources.

The RCS also supports the consultation's recommendation for haemorrhoid surgery, but would advise that references to injections be removed from the 'proposal' and 'rationale for recommendation' section of the consultation. The use of injections as part of non-surgical outpatient treatment is no longer supported by the colorectal community.

Prior approval for Category 2 interventions

The RCS also has concerns around the requirement for GPs to seek prior approval from the relevant CCGs to refer patients for Category 2 interventions.

Although we recognise NHS England's intention to outline best practice for prior approval alongside NHS Clinical Commissioners, we are concerned that, overall, this process will introduce unnecessary delay for patients accessing treatment. For patients who have already exhausted a range of treatment options prior to applying for prior approval, this is another delay that could leave patients in unnecessary pain and distress. Furthermore, such delay could increase patients' reliance on interim treatments such as antibiotics and painkillers, with ramifications for efforts to tackle antimicrobial resistance and opioid dependency.

In instances where patients have exhausted other treatments options, the RCS sees it as unnecessary for clinicians to apply for prior approval. Clinicians should be able to use their judgement to refer patients for treatment without recourse to unnecessary administrative hurdles.

We would also recommend that NHS England and Health Education England (HEE) take into account the potential impact on training opportunities if limiting access to these treatments. In instances when these procedures are deemed appropriate for patients, it is important to ensure that trainees have the requisite experience to undertake them.

Use of Individual Funding Requests (IFRs) for Category 1 interventions

Although the RCS recognises the need to introduce mechanisms to limit the appropriate use of Category 1 interventions, we nevertheless have concerns about the reliance on Individual Funding Requests (IFRs) to serve this purpose.

Following discussions with NHS England, we understand that there is no central guidance or template for CCG-level Individual Funding Requests. This therefore means that CCGs can introduce IFR policies with a wide variety of criteria and timescales, thereby increasing regional variation for patient access to treatment. The shortcomings of the current IFR model have recently been highlighted in a study undertaken by the *British Medical Journal* (BMJ), which found IFRs were being widely misused to restrict patient access to routine treatments.[4]

In order to ensure equitable access to the treatments proposed in this consultation, we believe NHS England must introduce clear national guidance for CCGs' IFR policies, possibly including a template IFR for CCGs to vary according to locally relevant criteria. This will ensure that IFRs are fit for purpose if they are included as part of the rollout of the Evidence Based Interventions programme.

Possible elements to include within the centralised IFR policy include a guaranteed review period by which the applications are approved or denied; an opportunity to appeal negative IFR decisions; and mechanisms to enable patients to keep track of progress of their IFRs.

Enabling effective communications and engagement to support implementation

The RCS is pleased to have been able to work closely with NHS England during the development of these proposals. We believe that the collaborative approach taken by NHS England during the preparatory stages of this consultation has helped secure buy-in from relevant clinicians, and we would encourage NHS England to continue with this approach going forward.

The RCS is keen to ensure that both the aims and the detail of the Evidence Based Interventions programme are properly communicated to patients, clinicians, and the general public. In particular, we have been concerned that the intentions of the programme may have been miscommunicated as part of the launch of this consultation. Media coverage has suggested that these treatments have been 'banned' by the NHS, and that patients would not be able to access these treatments in times of clinical need.

Although we recognise that NHS England cannot be held entirely responsible for any media coverage that does not accurately convey the intentions of its activity, we would encourage NHS England to ensure clinicians are front and centre of any future communications work.

[4] British Medical Journal (2018); 362:k3002

Having senior clinicians and representatives from the Royal Colleges presenting the programme's recommendations could enhance patient buy-in, thereby preventing any miscommunication that could see patients not receiving appropriate treatment for their condition. For instance, there is a danger of patients incorrectly seeing these interventions as wholly ineffective, thereby reducing the uptake of such treatments in appropriate instances.

Building on its work with the Evidence Based Interventions programme to date, the RCS would be happy to help NHS England in communicating the next tranche of proposals to patients, clinicians and the general public. We would also recommend that information for patients is presented in an easily digestible format.

The RCS also believes that NHS England should look to undertake a qualitative analysis of the treatments in question, engaging with patients who have received these treatments to gain an understanding of their benefits and drawbacks. Such engagement with relevant patients is vital to shaping the future of the Evidence Based Interventions programme, and will help secure greater buy-in from patients and the public. It would also be appropriate for NHS England to commission an academic health research department to conduct this work, with a view to producing valid findings.

Monitoring of treatment activity

The RCS is keen to ensure that the Evidence Based Interventions programme continues to identify and reduce spend on treatments of limited clinical effectiveness. In order to enhance this process, NHS England should seek to monitor patient outcomes from the commissioning of Category 1 and Category 2 treatments. This will ensure that the list of treatments identified continues to align with clinical evidence, and will help ensure that the programme's messaging is not being misinterpreted by some CCGs to mean a procedure is entirely banned.

A centralised audit of these treatments would equip NHS England with the necessary information, and would thereby allow certain treatments to be phased out more quickly or slowly on the basis of the patient outcomes data collected. Without this collection of outcomes data, we do not believe 'conservative', 'moderate' and 'ambitious' reduction targets can be appropriately set for the treatments listed.

September 2018