

Access all ages 2

Exploring variations in access to surgery among older people





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Forewords



Professor Norman Williams
President of The Royal College
of Surgeons of England

Patients have the right to expect that medical decisions are based on their overall health and clinical needs, not on assumptions about their age. Our first report, *Access all ages*, showed that there is a marked decline in rates of elective (non-urgent) surgery for the over-65s living with a range of common conditions. The report's recommendation was clear: chronological age should not be used instead of clinical factors to decide whether to allow a patient a particular form of treatment or procedure.

As this follow-up report shows, the problems are far from over. There is concerning, widespread variation in the rates of surgery for older patients, depending on where they live. Clinical commissioning groups (CCGs), whose job is to commission most of the hospital and NHS services in a local area, have a clear duty to provide treatments on the basis of need. As part of this, they must provide access to the right care, at the right time, to improve outcomes for every age. This report looks at the rates of treatment for those aged over 65 and those over 75 according to their CCG. The results of this work highlight variation that patients may experience in receiving treatment they need; we want to support commissioners to take steps to ensure patients can access surgical interventions on the basis of clinical need, regardless of age.

As individual doctors, we too have a duty to ensure all patients receive the most appropriate treatment for their individual needs. I urge colleagues across the medical professions to reflect honestly on their decisions and about whether decisions to treat are based solely on clinical need or whether they have been influenced by a patient's age.

The College is delighted to be partnering with Age UK for a second time to publish this report, which we hope will encourage commissioners to ask themselves whether they have referral policies in place that might unfairly restrict access for older patients and how they can support local clinicians to make the most objective assessment of patients' needs. We urge CCGs to consider the variations presented in this report, critically examine their figures and identify what action they can take to optimise access to treatment for older patients.



Caroline Abrahams
Charity Director,
Age UK

As we published the first *Access all ages* report, showing significant declines in access to surgery for older people, unfair discrimination on the basis of age became illegal in the NHS for the first time.

Making longlasting change to how health and care services respond to the professional and moral imperative for age-equal services and, since 2012, the legal imperative, is complex. Changing attitudes is certainly part of this equation. Older people frequently report to us that they are subject to negative stereotyping or assumptions about what they want and are capable of. Seeing the person, and that person's very individual needs, is often far from the minds of the people providing or planning a range of services or from those caring for these individuals.

However, this is just one part of the picture. Understanding what works for older people is another crucial element of achieving age-equal services. Guidance and practice based on evidence from younger age groups or people living with few or no additional health needs can contribute to health professionals being risk averse. Likewise, promoting and spreading approaches that improve outcomes in older people, such as comprehensive geriatric assessment, can make a huge difference to a person's experience of care.

With this follow-up report, which we are very pleased to publish in partnership with the Royal College of Surgeons, we want to prompt the NHS to ask some of the questions that will help it to address these issues: Why are you 37 times more likely in one part of the country to have surgery for your breast cancer compared with another? Why does access to hernia repair surgery fall in some areas by up to 75% between the over-65 and over-75 age groups compared with a national average that sees it increase?

Moving towards truly person-centred care that reflects the needs of an older and ageing society will mean asking such questions and committing to address what they reveal.

2

Key findings

Our analysis reveals significant variation in access to surgery according to both age and commissioner of responsibility across England in 2011–2012:

- » There is widespread variation in the rates of surgery for the over-65s and over-75s, depending on the CCG area in which people live. These variations are particularly acute for breast excisions, hip replacements and knee replacements.
- » The reasons for this variation are complex but can include clinical decisions made by doctors, patients' own preferences, local social and economic factors, financial pressures and referral practices in an area.
- » People living with breast cancer who are aged over 65 face the greatest inequity in access to surgery based on where they live, characterised by a 37-fold difference between the highest (37 people per 10,000) and lowest (1 person per 10,000) rates of treatment.
- » A number of CCGs have very few people in the over-75 age bracket who have received surgery for the procedures we analysed. For breast excision, cholecystectomy, inguinal hernia repair and knee replacement, a number of CCGs had a rate of 0 per 10,000 for the over-75s. This is despite the incidence rate for conditions that can be treated through these procedures peaking at around the age of 80.
- » Across four of the procedures we analysed (breast excision, cholecystectomy, colorectal excision and knee replacement), there was a decline in the procedure rates for the over-75s compared with the over-65s. Across the remaining two procedures (hip replacement and inguinal hernia repair) there was an increase in procedure rates for the over-75s compared with the over-65s. For hip replacements, this is likely to be affected by a higher number of emergency hip replacements for the over-75s.
- » Nearly a fifth (19.4%) of CCGs recorded a decline of more than 25% in at least three procedures between the over-65 and the over-75 age groups. Eight CCGs reported a decline in procedure rates of at least 25% in four or more of the procedures we examined.

Overall, our findings support the trends identified in *Access all ages* in that patients over the age of 75 living with breast and colorectal cancer, osteoarthritis of the knee and gallstones are less likely to receive surgical treatment for their condition than their over-65 counterparts.

3

Executive summary

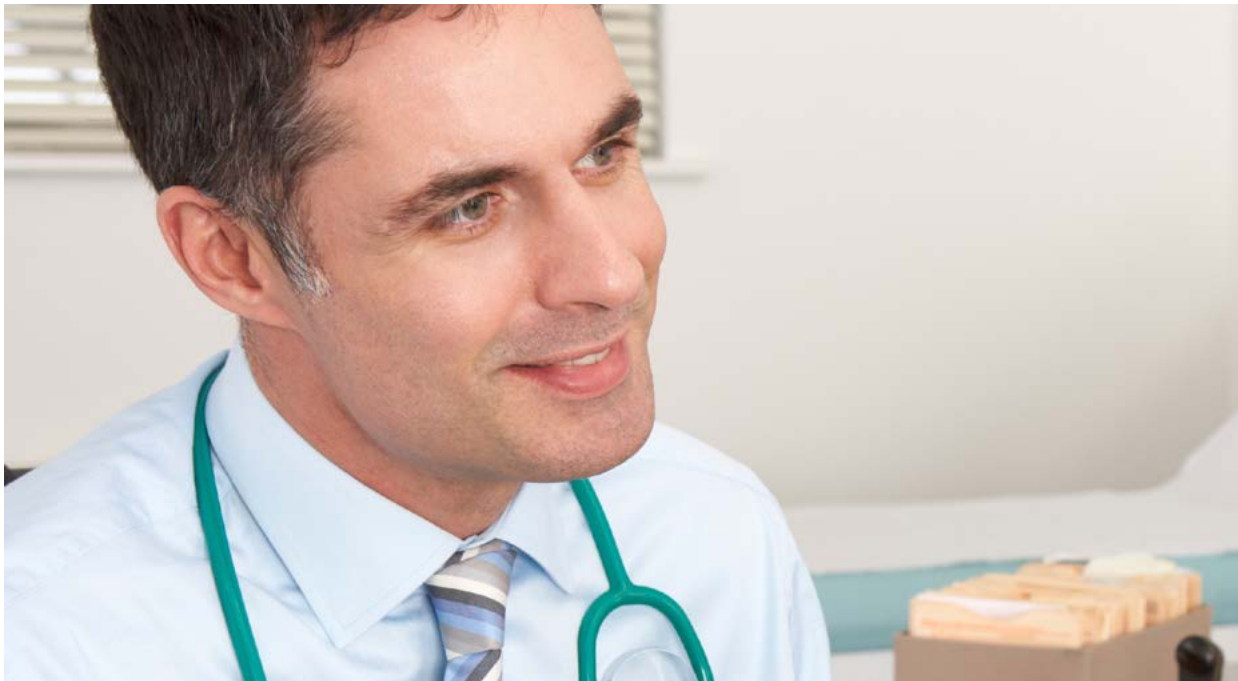
Longer lifespans have been described as ‘one of the greatest changes to affect humanity in the last 200 years’.¹ Today the over-65s are much healthier and more active than in previous generations but at the same time, advanced age, increasing frailty, chronic disease and co-morbidity are increasing our need for long-term care and support.² However, evidence suggests that the NHS is not keeping pace with these new norms; outcomes for major disease (including cancer, stroke and heart disease) are among the worst in Europe.^{3,4}

This report builds on our first report, *Access all ages*,⁵ which provided a detailed overview

of the impact of age on surgical treatment rates at a national level. Behind the national trends in access to surgical procedures, the picture is complex. A referral for surgery is shaped by different factors and decisions that take place over time, some of which are far removed from the decisions that are made by surgeons and their patients or carers. These can include clinical factors such as existing health conditions, clinical decisions made by doctors, patients’ own preferences, and the quality of care and information available to them along the treatment pathway. Local population factors (eg levels of deprivation) and financial pressures may also affect whether a patient is referred for surgery. The scope of these issues warrants our national attention – but they also depend on local leadership and scrutiny to get things right.

CCGs, who commission most of the hospital and NHS services in a local area, will need to rise to this challenge by establishing effective surgical pathways, developing the knowledge and skills of the workforce, and incentivising high quality care to improve outcomes for every age. Our second report aims to support this process by presenting, for the first time, a detailed picture of surgical intervention for older people, according to CCG. We sought to understand:





1. How do surgical intervention rates vary by CCG for the over-65 and over-75 populations for a number of common procedures? (These procedures were first explored in *Access all ages*.)
2. Based on these data, what action should commissioners take to understand whether their treatment rates are appropriate and what support do they need to carry this out?

The report uncovers the extent of variation among CCGs and highlights outliers. The health service data we used have allowed us to map CCGs and the levels of variance; however, the data were not adjusted for population factors such as deprivation. The data are therefore deliberately presented without adjustment for local differences, whether in relation to the burden of disease, the level of deprivation, the overall age profile and so on.

The findings should be read alongside the clinical commentary set out in the first report, *Access all ages*, to help inform local analysis (<http://www.rcseng.ac.uk/publications/docs/access-all-ages>). For instance, a relatively high rate of intervention for one procedure might be a reflection of high incidence among older people in the local population (which may in turn reflect specific features of the local health economy). This might be the case in cancer, for example, where surgical treatment may be seen as a proxy for incidence and signifies that the disease is at a stage where it is still operable.

Conversely, inflated rates of hip replacements for the over-75s are likely to be explained by an increase in emergency procedures, which might have been avoided through effective local approaches to reducing falls. In addition, a median rate among CCGs in England in any given procedure could appear



low or high when held up against international comparators.

For these reasons, we have not sought to draw conclusions about individual rates, nor to identify an optimum rate. Instead, we urge CCGs to consider the variations presented in this report and seek to explain whether, and if so why, their rates are appropriate.

We can no longer rely on outdated perceptions of fitness and old age. Patients have the right to expect that those making decisions about their care and treatment will base their decisions on an objective assessment of their health needs. Not everyone will benefit from surgery, and there are legitimate reasons why older people and their clinician may decide not to go ahead with a procedure. However, for many older patients, surgery can be life-enhancing,

reducing the debilitating impact of long-term conditions, maintaining their independence and helping them to live longer.

Fundamentally, patients should be able to ask questions about their care and treatment, and to raise concerns if they feel decisions about their treatment have not been taken objectively. Patients who are facing decisions about surgery should talk to their GP and their surgeon about the options available to them, the risks and benefits of surgery, and what it may mean in the longer term. Older people should also consider seeking out other local voluntary sector services that could help with non-clinical aspects of their care such as help at home or respite for carers. We would encourage health services to signpost these wherever possible and find ways to integrate them into an individual's care pathway.

4

Recommendations

The following five recommendations are intended to support the commissioning of high quality surgical care for older patients, based on need. They seek to consolidate a number of the recommendations set out in *Access all ages* in order to focus efforts and accelerate work in this important area.

- » **Recommendation 1:** CCGs should evaluate their treatment rates across each procedure and seek to explain whether, and if so why, their rates are appropriate. CCGs should look to benchmark their own rates against those of their peers, identify what action is required to improve access to treatment for older patients and improve their assurance process through changes across the commissioning cycle.
- » **Recommendation 2:** NHS England should endorse the commissioning checklist on page 36 of this report and ensure that CCGs are in a position to commission on the basis of quality by using the resources presented in this report.
- » **Recommendation 3:** The Health and Social Care Information Centre should routinely publish data on surgical procedures disaggregated by five-year age groups, by CCG, to support the analysis of trends in treatment rates over time.
- » **Recommendation 4:** NHS Right Care should publish an atlas of variation for common surgical procedures and other major interventions according to age and geography, including an exploration of the impact of the burden of disease, deprivation and age profile of the local population on access to surgical treatment.
- » **Recommendation 5:** The National Institute for Health and Care Excellence (NICE) should ensure that the next iteration of the CCG Outcomes Indicator Set includes outcomes indicators under each domain for the over-75 population.

5

Background

In health, population ageing brings great opportunities, just as it does challenges. While it is recognised that the ageing trajectory is strongly influenced by social and behavioural factors throughout life, healthy ageing must be equally supported in older age itself if we are to realise the benefits to individuals, society and the economy of greater independence and participation in longer life.

Our analysis of access to surgery in England according to age (*Access all ages*) provides an instructive case in point. Surgery has the potential to transform patients' lives by alleviating pain, restoring mobility and independence, relieving emotional stress and giving more years of disease-free life. However, like all interventions, it comes with both benefits and risks, and the decision to treat (particularly where disability, frailty or co-morbidity is a factor) is often based on finely balanced clinical judgements, requiring multidisciplinary input before and during treatment, and throughout recovery.



Access all ages showed a marked decline in rates of elective surgery for the over-65s living with a range of common conditions (including cancer, arthritis and heart disease) and exposed a stark disparity between increasing health need and an apparent decline in access to treatment among older patients (Box 1).⁶

Our analysis focused on the point at which a patient is referred to a consultant surgeon and factors that may affect decisions at this point in the pathway. However, a referral for surgery is shaped by actions, decisions and behaviours at different milestones along the patient pathway, as can be seen in Figure 1. These may be broadly summarised as:

1. **Clinical factors** – Existing health conditions or co-morbidities may mean that the risk of treatment outweighs the clinical benefits.
2. **Clinical decision making** – Decisions may be based on an assumption about a patient’s fitness due to his or her age rather than a

comprehensive, objective assessment of need. This may be exacerbated by a shortage of evidence of the effects of treatment among older patients, particularly those living with frailty, or a lack of specialist input.

3. **Patient preference** – Patients may themselves opt not to undergo surgery. This decision may be based on knowledge of different options (including opting out of treatment) or it may be taken in the absence of information/advice or the lack of other kinds of support such as respite for carers.
4. **Pathway-related factors** – The provision of high quality care at every stage of the pathway means that patients are more likely to be in a position to be referred to and benefit from surgery, for example through early management of co-morbidity or risk factors. This may include early identification of needs in primary care, good information and shared decision making, high quality social care and support following treatment.

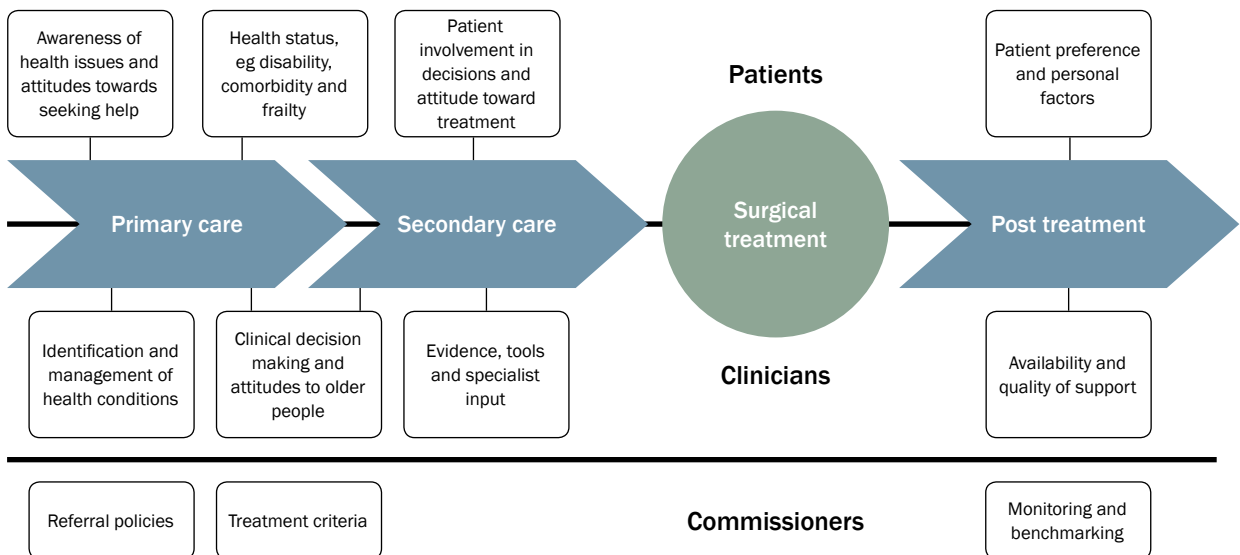


Figure 1 Factors affecting access to surgery


5. Local population factors – The characteristics of the local community (including the burden of disease, deprivation and age profile) may have an impact on surgical rates. For example, commissioners in areas with older populations who tend to be treated locally may have comparatively high rates of intervention because local services have more experience of addressing need among the over-65s. Similarly, in deprived areas, late diagnosis due to lower awareness of cancer may limit treatment options, including surgery.⁷ The data we used have not been adjusted for population factors; however, these issues are explored in more detail in Box 2 and should be considered by CCGs.

6. Financial pressures – In the current budgetary climate, some procedures that are predominantly performed on patients aged over 65 (such as hip and knee replacements and cataract surgery) have been subject to additional criteria that may undermine access for older patients.⁸



Box 1 Older people's health and care⁶

- » Life expectancy at 75 is 11 years for men and 13 years for women
- » Longer waiting times in A&E
- » Lower rates of referral to specialists
- » Poorer access to treatment for common conditions



Social deprivation

Box 2

There are a number of population factors that may impact on the procedure rate in a given area, such as the age profile of the local population, the level of social deprivation and whether it is a predominantly rural or urban area. There is evidence that deprived groups are less likely to receive surgery to treat cancer^{9,10} and have worse outcomes.¹¹ There is also evidence that social deprivation is linked to lower rates of hernia repairs¹² and hip and knee replacements.¹³ These factors must also be built into any response to lower rates of access, incorporating age in the wider context of health inequalities.

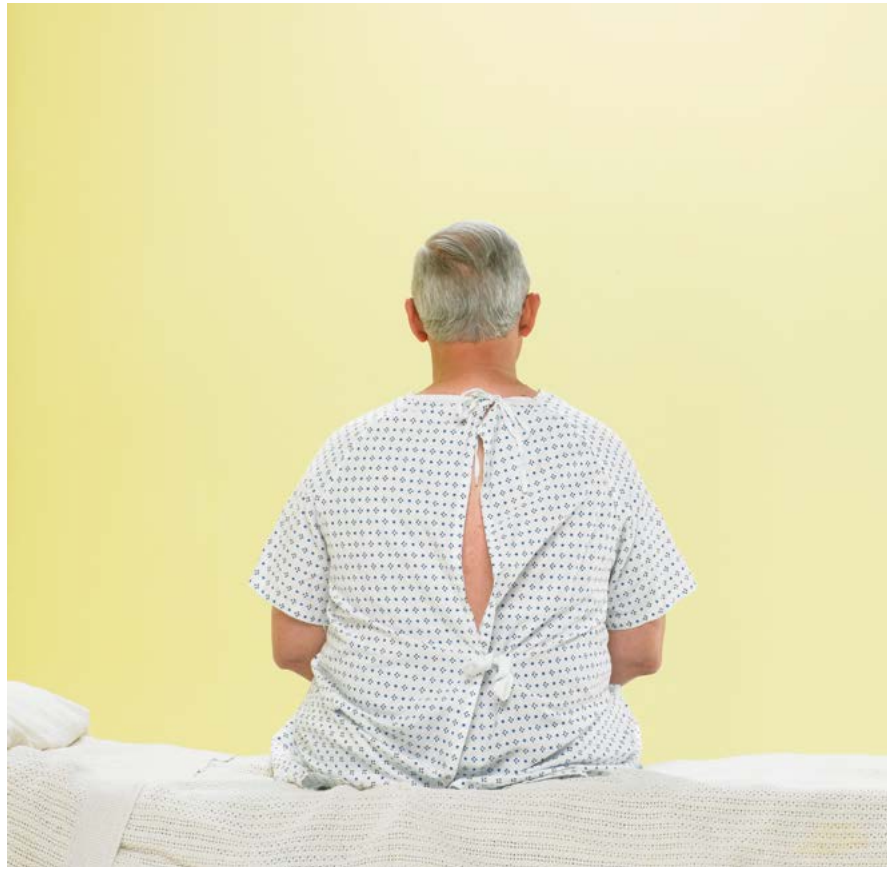
Commissioning surgery for older people in the new NHS

Under the Health and Social Care Act 2012, CCGs are responsible for commissioning services that meet the needs of their local population, including surgical treatment and care. In doing so, they should consider the breadth of issues and characteristics that define the local health economy and influence the patient journey.

Since October 2012, the NHS has been under additional duties under the Equality Act 2010 to promote age equality and eliminate age discrimination in the provision of services. These changes were intended to help address the disadvantage that many patients experience when they are in need of care and support because of their age.¹⁴

Although decisions about treatment, and efforts to improve patient involvement in their care, fall instinctively in the domain of providers and clinical teams, high quality commissioning should exert leadership and influence that helps to:

- » produce and work to an accurate picture of need
- » improve patient outcomes, for people of all ages
- » reduce unwarranted differences in access to treatment
- » support effective use of limited resources and secure greater value across the pathway
- » reduce inequalities and promote access to high quality care based on need.



[The NHS has a duty] to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population

NHS Constitution

The Health and Social Care Act 2012 includes a number of core duties in relation to delivering services that pose important questions for commissioners wishing to improve surgical care for older patients.¹⁵ These duties include securing continuous improvements in the quality of services and individual outcomes, protecting and promoting the right of patients to make choices with respect to treatment, and promoting the involvement of patients in their treatment and care.

In order to improve outcomes for older people, CCGs will need support to commission services on the basis of quality. CCGs should work in close collaboration with local partners (including patients, carers, health and wellbeing boards, providers and local Healthwatch) across the commissioning cycle. This process is outlined in more detail later in this report under *What does this mean for commissioners?*

Strong and supported clinical leadership will be critical to engage all parties with the commissioning cycle, if it is to succeed in increasing value, improving quality and delivering a safe and effective NHS

Director of NHS Right Care, 2012



Methodology used to examine treatment rates

6

The report examines six different surgical procedures and seeks to answer the following:

1. How do surgical intervention rates vary by CCG for the over-65 and over-75 populations?
2. What are the possible explanations for the trends identified?
3. What action should CCGs take to be assured that treatment rates are appropriate and what support do they need to do so?

The following procedures are analysed in the report:

- » **Breast excision** – used primarily in the treatment of breast cancer
- » **Colorectal excision** – used primarily in the treatment of colorectal cancer as well as for Crohn’s disease and diverticular disease
- » **Cholecystectomy** – used primarily in the treatment of gallstones
- » **Inguinal hernia repair** – used to treat weaknesses and tears in the abdominal wall
- » **Hip replacement** – used to replace all or part of a damaged or diseased hip joint caused by osteoarthritis or a fall (Please note that the data presented in this report include both emergency and elective procedures. For further explanation see Box 3)
- » **Knee replacement** – used to replace all or part of a damaged or diseased knee joint caused by osteoarthritis

These procedures were analysed in *Access all ages* and have been selected to allow continuity of analysis and to support both national and local investigation of trends. Each procedure has been proven effective among older patients, typically addressing health needs that are common in later life. *Access all ages* included an analysis of radical prostatectomy and coronary artery bypass graft surgery but owing to the very low intervention rates, it has not been possible to analyse these procedures at CCG level.

Data on treatment numbers for each procedure were elicited for the over-65 and over-75 populations for 2011–2012. Hospital Episode Statistics data were linked to GP practices and these data were then matched with boundary

information for CCGs in order to estimate the number of procedures carried out in each CCG.

We analysed data from both the over-65s and the over-75s so we could track the impact of ageing on access to surgery.

Two surgical rates were produced for every CCG based on population data from the Office for National Statistics. This is expressed as the number of patients aged over 65 and the number of patients over 75 who underwent surgical treatment per 10,000 of the population in the relevant age brackets in 2011–2012. Where the number of people who underwent a certain procedure in a CCG was less than five, it was not included so that patient confidentiality can be maintained.

At the time of writing, these data were not available publicly by CCG, only by primary care trust. The CCG data have therefore been modelled retrospectively to allow us to explore trends in the context of today’s NHS structures. This means that there are some differences between the number of procedures recorded in CCGs and those recorded in primary care trusts that share similar boundaries. This is due to differences in how the data for CCGs have been collected as some practices closed, opened or merged in the years before the CCGs began operation in April 2013. However, the data modelling was performed consistently across each CCG area and provides the most accurate picture available to date in England for 2011–2012.

Analysing access to surgery for older people by commissioner

In this section, we analyse the treatment rates for six surgical procedures in turn. The data are presented for the over-65 and over-75 population for each CCG area. Our analysis includes a short summary of:

- » the procedure, related conditions and burden of illness in older age
- » the differences in the median treatment rate for the over-65s and over-75s
- » the extent of variation in access to surgery for both age groups
- » the spread of rates (ie whether treatment rates are relatively consistent with few outliers or whether they are more evenly distributed across the range)

The ‘box and whisker’ charts in each section illustrate the distribution of procedure rates across CCGs. The top and bottom ‘whiskers’ show the highest and lowest procedure rates respectively. The coloured boxes show where 50% of the CCGs lie in the distribution. The blue line represents the median rate for the over-65s and the purple line represents the median rate for the over-75s.

The column charts illustrate the variation in the rate of each procedure across all CCGs, with each column representing the rate in each CCG. The green, yellow and red bands correspond to the high, middle and low bands of CCGs according to their procedure rate.

This section should be read alongside the detailed condition-specific analyses in

- » Median rates for each of the procedures hide wide variation between certain CCG areas.
- » In some CCG areas, treatment rates declined substantially between the over-65s and over-75s.
- » Access to cancer treatments declined by 25% across 1 in 7 CCGs between the over-65s and over-75s.



Note on hip replacement data

Box 3

It is important to note that no CCGs recorded a drop of more than 25% in the rate of hip replacements between the over-65s and over-75s. The procedure data cover both elective and emergency procedures. As a result, they are likely to reflect increases in hip replacements performed as an emergency operation among older age groups, owing to falls and fractures, as opposed to those performed as an elective procedure to treat mobility problems caused by osteoarthritis. These data are disaggregated according to the type of procedure on a national basis as part of *Access all ages*. However, commissioners will need to scrutinise them carefully to understand the patterns and reasons for surgery in their locality.

Table 1 Highest and lowest treatment rates per 10,000 by CCG for each procedure

Procedures	Over-65s		Over-75s	
	Highest rate	Lowest rate	Highest rate	Lowest rate
Breast excision	37.0	0.0*	26.8	0.0*
Colorectal excision	154.3	23.8	138.1	14.9
Cholecystectomy	34.7	3.9	26.0	0.0*
Inguinal hernia repair	50.5	6.8	60.7	0.0*
Hip replacement	112.7	10.7	150.6	21.9
Knee replacement	107.9	15.1	93.0	0.0*

*Where there has been a small number of patients in an area receiving a procedure (<5), the exact numbers are unknown. This is to ensure the data are not patient identifiable. These have therefore been calculated as zero.

Table 2 Average percentage change in procedure rates across all CCGs between the over-65s and over-75s

Procedures	Percentage change	Age of peak incidence rate of condition that the procedure is used to treat
Breast excision	-16.7%	Breast cancer – 85 ⁺¹⁶
Colorectal excision	-5.44%	Colorectal cancer – 85 ⁺¹⁷
Cholecystectomy	-33.64%	Gallstones – incidence increases with age ¹⁸
Inguinal hernia repair	6.68%	Inguinal hernia – 85 ⁺¹⁹
Hip replacement	32.5%	Osteoarthritis of the hip – 80+; ¹⁹ falls incidence – 80+ ²¹
Knee replacement	-7.4%	Osteoarthritis of the knee – 80+ ²⁰

Access all ages, which includes a clinical commentary on the potential causes of variation, and the background section of this report, which highlights the factors that may affect access to surgery (see Figure 1 and Box 2).

Summary of variation

Table 1 shows the extent of variation among CCGs across each of the six procedures. It provides a snapshot of the rates at the top and bottom of the range, and it is therefore

important to read these data alongside our analysis of the distribution of rates, which is included in the following sections.

The figures set out in Table 1 demonstrate the wide variation in the rate of each procedure in both age groups. In the rest of this section, we examine the variation in rates for each procedure in more detail as well as the difference between procedure rates for the over-65s and over-75s.

Table 3 Percentage change in procedure rates between the over-65s and over-75s for CCGs showing a decline in procedure rate of at least 25% across four or more procedures

CCG	Colorectal excision	Breast excision	Hip replacement	Knee replacement	Inguinal hernia repair	Cholecystectomy
A	-67.84%	-43.13%	38.02%	-45.76%	-68.86%	-100.00%
B	-8.03%	-49.07%	29.93%	-52.48%	-74.61%	-46.38%
C	-44.22%	-42.97%	17.16%	-12.01%	-29.07%	-62.40%
D	-48.44%	25.00%	10.69%	-48.09%	-30.66%	-36.05%
E	-40.66%	-34.88%	26.65%	25.19%	-46.60%	-32.12%
F	-29.66%	-38.20%	13.35%	-14.88%	-74.53%	-26.22%
G	46.00%	-77.94%	117.02%	-59.03%	-72.19%	-52.09%
H	-10.26%	-100.00%	39.23%	-100.00%	-31.50%	-40.00%

Summary of the decline in access to treatment with increasing age according to CCG

Table 2 (page 17) sets out the average percentage change across CCGs for each of the six procedures we analysed. For the majority of procedures, there was a significant drop in the procedure rate between the over-65 population and the over-75 population. There was an increase in the average procedure rate in hip replacements and inguinal hernia repairs.

An analysis of the rates across all CCGs and procedures has revealed that there were 41 CCGs (19% of all CCGs) recording a decline between the over-65s and over-75s of at least 25% in the rate of treatment for three or more of the procedures analysed.

In addition, a number of CCGs reported a decline in treatment rates of at least 25% across all of the procedures analysed except for hip replacement. These data are shown in

Table 3. (The names of the CCGs have been anonymised.)

Furthermore, when the procedures examined are limited to those used to treat cancer (colorectal excisions and breast excisions), we found that 28 CCGs (ie 1 in 7) reported a drop of 25% in procedure rates. This points to potential issues across the cancer patient pathway in these CCGs (from awareness and early presentation, through to clinical decision making and approaches to patient involvement), which may be affecting older people's access to high quality surgical care and, in turn, their individual outcomes. CCGs that show a decline in procedure rates between the over-65s and over-75s should investigate the reasons for this trend and use the tools included in this report to identify and address any obstacles to the provision of high quality treatment and care for older patients.



7

Breast excision

- » Breast excision is the removal of some or all of the breast tissue from the body either laparoscopically or as open surgery.
- » The main reason to undergo breast excision is the treatment of breast cancer.
- » The incidence rate of breast cancer increases with age and older people are also more likely to present later.^{5,16}
- » Lower rates of breast cancer surgery have been linked to social deprivation.¹⁰

- » There was a **37-fold difference** in the rate of breast excisions for the over-65s, depending on where a patient lives.
- » For the over-75s, **17 CCGs** had a breast excision rate of **0 per 10,000**.
- » **105 CCGs (49.8%)** recorded a **decline** in the rate of breast excisions of at least **25%** between the over-65s and over-75s.

Key findings

There is a significant decline in the rate of breast excisions between the over-65s and the over-75s, which can be seen in Figure 2. The median rate of breast excision drops from 18 per 10,000 for the over-65s to 15 per 10,000 for the over-75s. Possible reasons for the difference in the rate of breast excisions between the over-65s and over-75s were identified in *Access all ages*. These factors included:

- » the lack of routine screening for those aged over 70
- » the increased prevalence of co-morbidities in older people
- » low levels of awareness contributing to late presentation
- » consideration of the potential impact on quality of life if surgery is undertaken

There was widespread variation among the over-65s, with the rate varying 37-fold, depending on where a patient lives. This was the largest variation for any type of procedure examined. The variation among the over-75s, which can be seen in Figure 3, was significantly lower, ranging 9-fold from the highest rate to the lowest positive rate (ie >0).

The majority of CCGs fell in the middle range for both the over-65s and over-75s, as can be seen in Figure 2. However, for the over-75s, the number of CCGs with a higher rate of breast excisions was significantly larger than for the over-65s while the number of CCGs with breast excision rates close to the median was lower. It should also be noted that 17 CCGs had a rate of 0 per 10,000 for the over-75 age group.

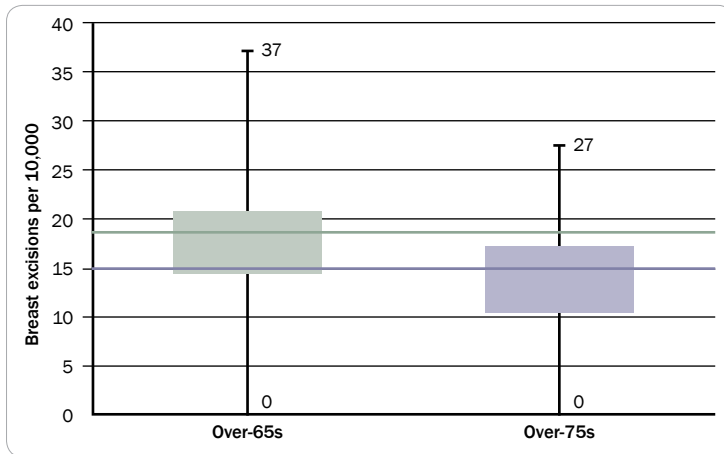


Figure 2 Distribution of breast excision rates across CCGs for the over-65s and over-75s. This chart illustrates the distribution of procedure rates across CCGs. The top and bottom ‘whiskers’ show the highest and lowest procedure rates respectively. The coloured boxes show where 50% of the CCGs lie in the distribution. The blue line represents the median rate for the over-65s and the purple line represents the median rate for the over-75s.

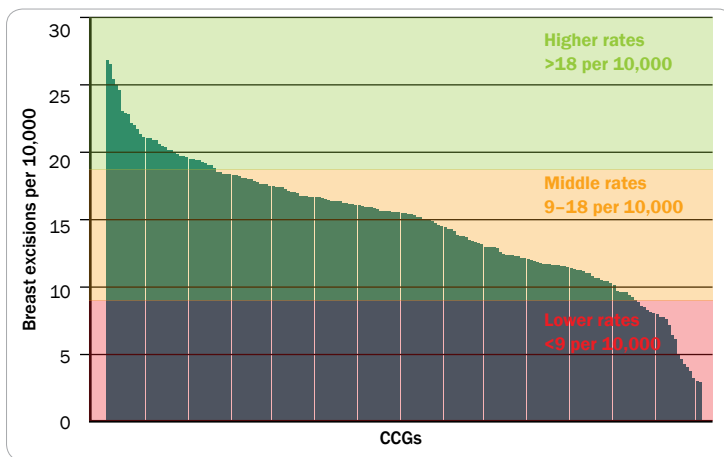


Figure 3 Variation by CCG in breast excision rates for the over-75s. This chart illustrates the variation in the rate of each procedure across all CCGs, with each column representing the rate in each CCG. The green, yellow and red bands correspond to the high, middle and low bands of CCGs according to their procedure rate.

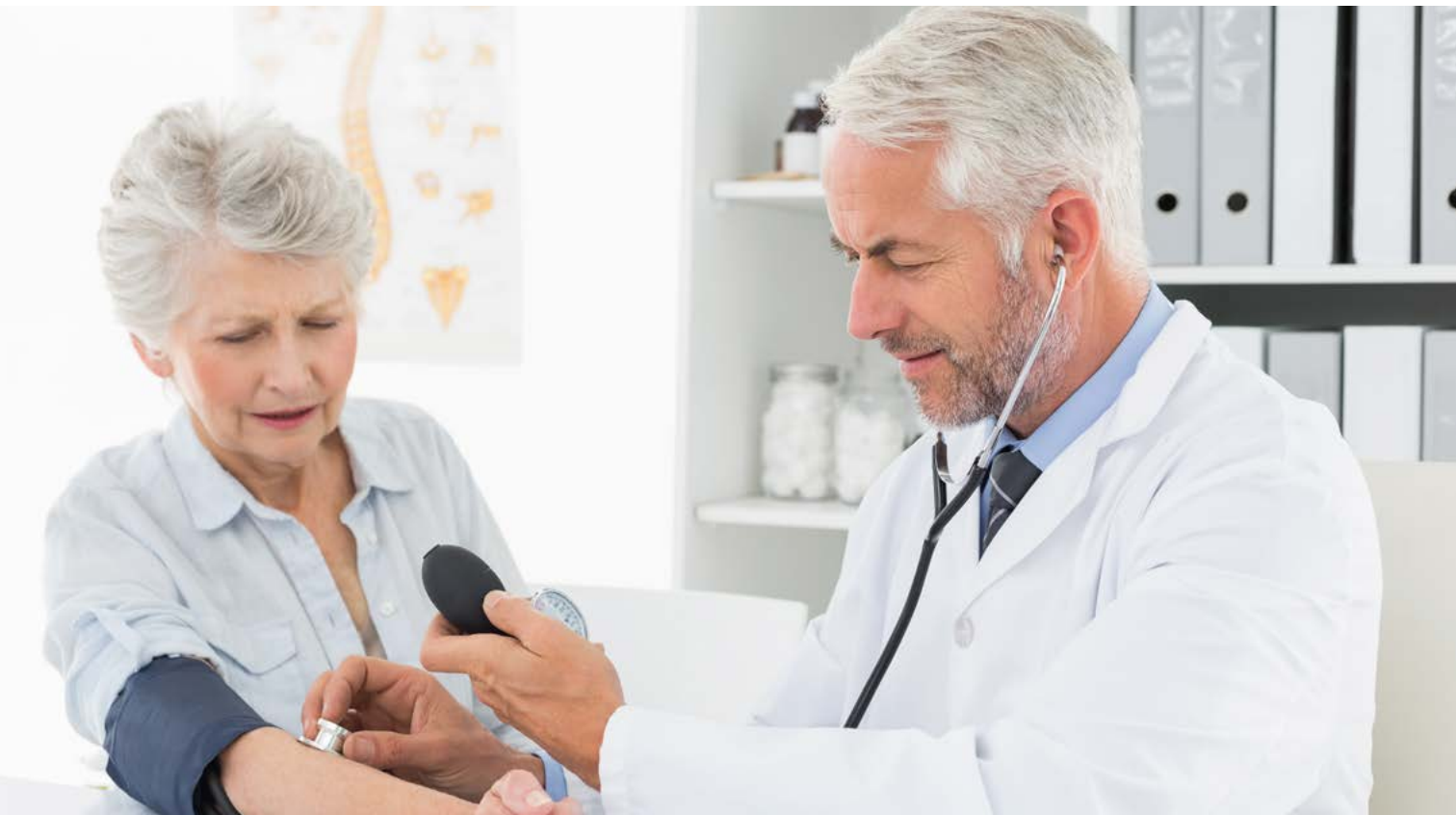
Slightly more than three-quarters of CCGs reported an overall decline in their breast excision rate between the over-65s and over-75s. In addition, 105 CCGs (49.7%) recorded a decline in the rate of breast excisions of at least 25% between the ages of 65 and 75, and of those, 16 CCGs (7.5%) had their breast excision rate fall to zero. Conversely, 29 CCGs (13.7%) had an increase in their rate of breast excisions of at least 25%. The average percentage difference in the rates of breast excisions across CCGs between the over-65s and over-75s was -16.7%.

A lower rate of breast excisions may be indicative of staging as people who present at a later stage in the disease may not benefit from treatment. It is possible, therefore, to make an assumption that a higher rate of

breast excisions may indicate better levels of care and awareness among those who present earlier. CCGs will also need to explore underlying factors such as local incidence to help understand what is driving a higher than average rate of intervention.

Where a CCG has a low rate of intervention, it might wish to consider taking action to raise awareness of the signs and symptoms of breast cancer, particularly among older people. This would help ensure that people with breast cancer present early enough to increase their opportunities to receive curative treatment.

Multidisciplinary teams should also include geriatric specialist support to ensure that patients considering surgery to treat breast cancer have access to meaningful and age appropriate information and support in order to make the best possible decision for them.



8

Colorectal excision

- » Colorectal excision is a procedure involving surgery on the colon (large intestine) or rectum, to remove tissue.
- » The procedure is used most commonly to treat bowel cancer but it can also be used to treat Crohn's disease and diverticular disease.
- » Incidence rates of bowel cancer increase with age, with 84.7% of all cases of bowel cancer being diagnosed in those aged over 60.¹⁷
- » People in more deprived areas are more likely to be diagnosed as an emergency and less likely to receive surgery.¹¹

Key findings

The rate of colorectal excisions differs according to age. There was a significant decline in access to surgery as patients age, with the median rate of intervention dropping from 80 per 10,000 for the over-65s to 73 per 10,000 for the over-75 age group. This difference can be seen in Figure 4. *Access all ages* set out a number of possible factors that might affect access to colorectal surgery as people age:

- » the impact of co-morbidities on the level of risk associated with undergoing the procedure and the potential postoperative side effects
- » the stage and growth of rate of the tumour
- » the life expectancy of the patient

- » There was a **9-fold difference** in the rate of colorectal excisions for the over-75s, depending on where a patient lives.
- » **45 CCGs (21.3%)** recorded a **decline** in the rate of colorectal excisions of at least **25%** between the over-65s and over-75s.
- » **The majority of CCGs** recorded a **decline** in the rate of colorectal excisions between the over-65s and over-75s, with a small number reporting very high increases in their procedure rate.

As there is less risk to life associated with Crohn's disease and diverticular disease, the risk-to-benefit ratio of undergoing surgery will shape the decision making process in different ways.

Figure 5 shows the variation between surgery rates by CCGs among the over-75s and reveals a 9-fold difference in the colorectal excision rates for this age group, depending on where a patient lives. Of all the procedures, colorectal excision is the one that is associated with the least amount of variation – but, notably, this is still significant. Variation was slightly less among the over-65s, with a 6-fold difference by CCG.

In terms of the overall spread of rates, the majority of CCGs for both the over-65s and

over-75s fell within the middle band of CCGs. However, compared with the other procedures analysed, there was still a significant amount of deviation from the median, which suggests less consistency in terms of approaches to treatment across CCGs.

Across all CCGs, 45 (21.3%) recorded a decline in the rate of colorectal excisions of at least 25% between the over-65s and over-75s, and 26 (12.3%) saw a rise of at least 25% between the two age groups. The average percentage change between the rate of colorectal excisions between the over-65s and over-75s was -5.44%. This was the smallest average decline in a procedure rate between the over-65s and over-75s across the procedures we analysed. However, this small decline belies the fact that in the majority of CCGs, the rate of colorectal excisions declined, with a small number reporting very high increases in their procedure rate.

In colorectal cancer, access to surgical intervention provides some indication of staging. Disease that is identified when it is advanced is no longer treatable. As a result, we might reasonably interpret relatively high rates of intervention as an indication of high quality care across the clinical pathway and higher levels of disease awareness, which would support earlier detection. Higher rates of intervention may also indicate higher levels of incidence, which is a further factor for CCGs to explore.

CCGs falling in the band of low rates will want to take additional steps to ensure that the local older population is aware of the signs and symptoms of colorectal cancer to support

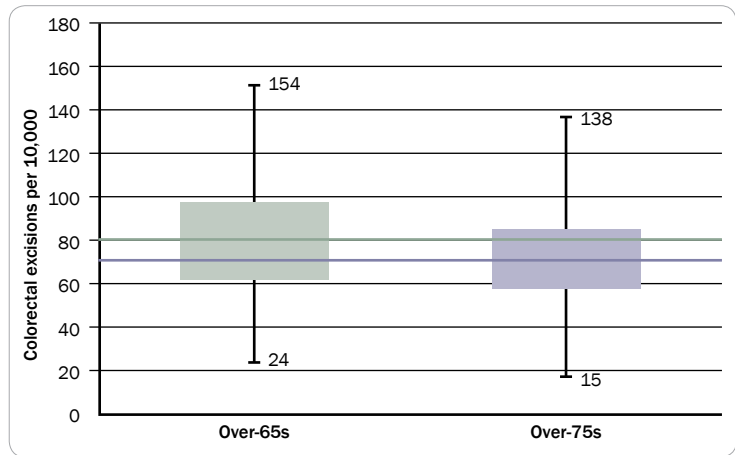


Figure 4 Distribution of colorectal excision rates across CCGs for the over-65s and over-75s. This chart illustrates the distribution of procedure rates across CCGs. The top and bottom 'whiskers' show the highest and lowest procedure rates respectively. The coloured boxes show where 50% of the CCGs lie in the distribution. The blue line represents the median rate for the over-65s and the purple line represents the median rate for the over-75s.

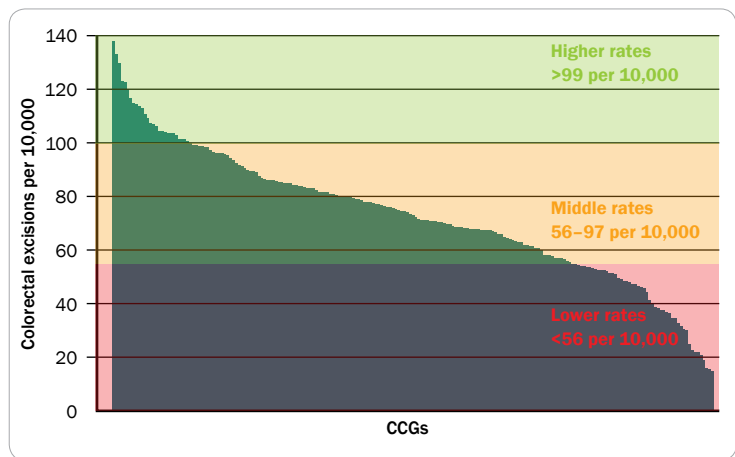


Figure 5 Variation by CCG in colorectal excision rates for the over-75s. This chart illustrates the variation in the rate of each procedure across all CCGs, with each column representing the rate in each CCG. The green, yellow and red bands correspond to the high, middle and low bands of CCGs according to their procedure rate.

earlier detection and increase treatment options (including surgery). Moreover, they will want to make sure that multidisciplinary teams have the appropriate skills and geriatric expertise to support patients to undergo surgery, based on an objective evaluation of needs, risks and benefit.

9

Cholecystectomy

- » A cholecystectomy is the surgical removal of the gallbladder, normally due to proliferation of gallstones.
- » Cholecystectomies are a very common operation in the NHS, with around 60,000 procedures taking place every year.²²
- » It is estimated that 19% of the female population and 10% of the male population have gallstones, and incidence of gallstones increases with age.²³

Key findings

The difference in cholecystectomy surgery rates between the over-65s and over-75s is the starkest of all the procedures we have examined, which is clear from Figure 6. The median rate for the over-65s was 17 per 10,000 while the median rate for the over-75s fell to 11 per 10,000.

In *Access all ages*, the following were identified as possible factors affecting the rate of cholecystectomies in older people:

- » The potential impact of co-morbidities on recovery
- » A decline in the number of patients in those age groups presenting with symptoms
- » Older people may not be choosing to undergo surgery because of perceptions about symptoms.

- » There was a **9-fold difference** in the rate of cholecystectomies for the over-65s, depending on where a patient lives.
- » For the over-75s, **14 CCGs** had a cholecystectomy rate of **0 per 10,000**.
- » **146 CCGs** (69.2%) recorded a **decline** in the rate of cholecystectomies of at least **25%** between the over-65s and over-75s.

For the over-65s, the rate of cholecystectomies varied 9-fold across CCGs and for the over-75s, the rate of cholecystectomies varied 8-fold from the highest rate to the lowest positive rate (ie >0). It should be noted that for the over-75 age group, there were 14 CCGs with a cholecystectomy rate of 0 per 10,000.

There was a very wide spread for ranges across CCGs. While the majority of CCGs had cholecystectomy rates in the middle band for both the over-65s and the over-75s, there were significantly more CCGs in the lower band for both age groups than in the upper ranges. This is clear from Figure 7, which shows the spread of cholecystectomy rates among the over-75s across all CCGs.

Across all CCGs, 146 (69.1%) reported a decline of at least 25% in the rate of

cholecystectomies between the over-65s and over-75s while 9 (4.3%) recorded an increase of at least 25%. Furthermore, in 14 CCGs (6.6%) that had commissioned cholecystectomies for those over 65, the number of procedures fell to zero for the over-75s. More CCGs noted a decline in the cholecystectomy rate between the two age groups than for any other procedures we analysed. The average percentage change in the rate of cholecystectomies across CCGs between the two age groups was -33.64%.

The fall in the rate of cholecystectomies was the most pronounced across the procedures we analysed and it may be worthwhile for CCGs to explore the reason for this in their local area. As striking as the difference is in cholecystectomy rates between the over-65s and over-75s, there is wide variation of rates of cholecystectomies across all CCGs in both age groups. CCGs should also use the tools developed as part of this report to ensure equality of access in their local area.

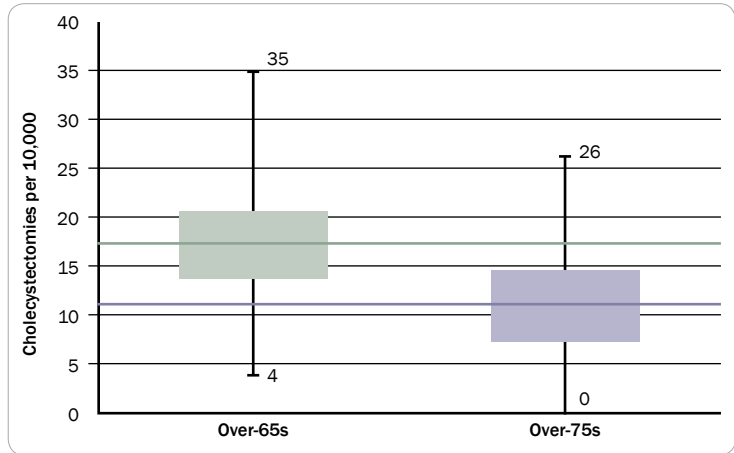


Figure 6 Distribution of cholecystectomy rates across CCGs for the over-65s and over-75s. This chart illustrates the distribution of procedure rates across CCGs. The top and bottom 'whiskers' show the highest and lowest procedure rates respectively. The coloured boxes show where 50% of the CCGs lie in the distribution. The blue line represents the median rate for the over-65s and the purple line represents the median rate for the over-75s.

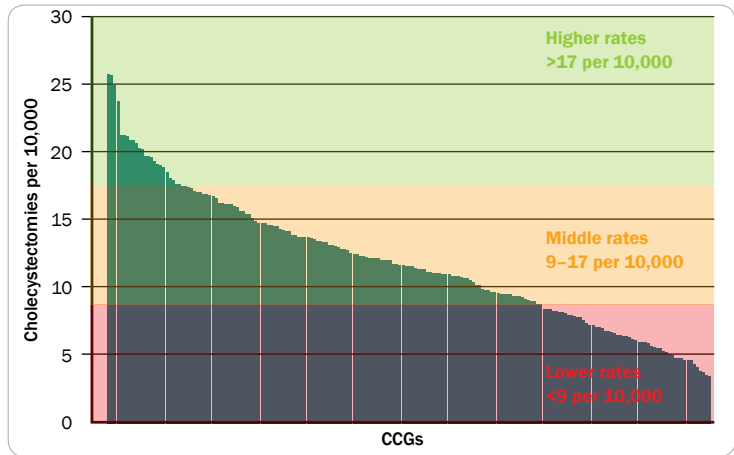


Figure 7 Variation by CCG in cholecystectomy rates for the over-75s. This chart illustrates the variation in the rate of each procedure across all CCGs, with each column representing the rate in each CCG. The green, yellow and red bands correspond to the high, middle and low bands of CCGs according to their procedure rate.

10

Inguinal hernia repair

- » An inguinal hernia is caused by fatty tissue or part of the small intestine pushing through the abdominal wall into the inguinal canal.
- » Inguinal hernia repair may be used to push the bulge back into place and strengthen the abdominal wall.
- » Inguinal hernias are more common in men and become more prevalent with age.²⁴
- » Low rates of inguinal hernia repairs have been linked to social deprivation.¹²

Key findings

The median surgery rate for the over-65s and the over-75s was the same at 31 per 10,000. However, as the incidence of inguinal hernias increases as people get older, in real terms, this may represent a drop in the rate of inguinal hernia procedures for the over-75s. This can be seen in Figure 8.

In *Access all ages*, the following factors were considered to have a potential impact on surgery rates in older people:

- » Patients may decide not to undergo surgery, particularly if they are asymptomatic.
- » ‘Watchful waiting’ may be considered a better alternative to surgery.
- » Consideration of the level of postoperative care required may impact on the decision.

- » There was a **12-fold difference** in the rate of inguinal hernia repairs for the over-75s, depending on where a patient lives.
- » **40 CCGs (19.0%)** reported an **increase** in the rate of inguinal hernia repairs of at least **25%** between the over-65s and over-75s.
- » **27 CCGs (12.8%)** recorded a **decline** of at least **25%**.

For the over-65s, the inguinal hernia repair rates varied 7-fold across CCGs and for the over-75s, the rates varied 12-fold from the highest rate to the lowest positive rate (ie >0). It is worth noting that one CCG in the over 75 age range had a rate of 0 per 10,000.

The majority of CCGs were in the middle band of rates for inguinal hernias and there were slightly more CCGs in the upper band than in the lower range. The spread of rates among the over-75s was similar to that among the over-65s with the majority of CCGs falling in the middle band. There were also fewer CCGs in the upper and lower bands. As can be seen in Figure 9, there was one outlier CCG in the over-75 age group with a particularly high rate of inguinal hernia repairs.

In addition, the rate of inguinal hernia repairs fell by at least 25% between the over-65s and over-75s in 27 CCGs (12.8%) and increased by at least 25% in 40 CCGs (19%). The average percentage change in the rate of inguinal hernia repairs between the over-65s and over-75s was 6.68%. While the average rate shows an increase, it should be pointed out that the majority of CCGs saw a decline in the rate of inguinal hernia repairs but where there was an increase, the increase tended to be very high.

Differing attitudes among patients and clinicians regarding the usefulness of surgical intervention in treating an inguinal hernia may have an impact on surgery rates. Those CCGs with particularly high and particularly low rates for inguinal hernia repairs may wish to consider using the tools in this report to ensure that people are receiving the appropriate treatment for their condition.

The potential impact of postoperative care may also be a concern for some patients, and it may be worthwhile for CCGs to consider how they might be better able to allay those concerns and reassure patients that they will receive the support they need after an operation. Support and advice from a geriatric specialist may be useful in this context to ensure that patients are able to access information that is meaningful and appropriate to them.

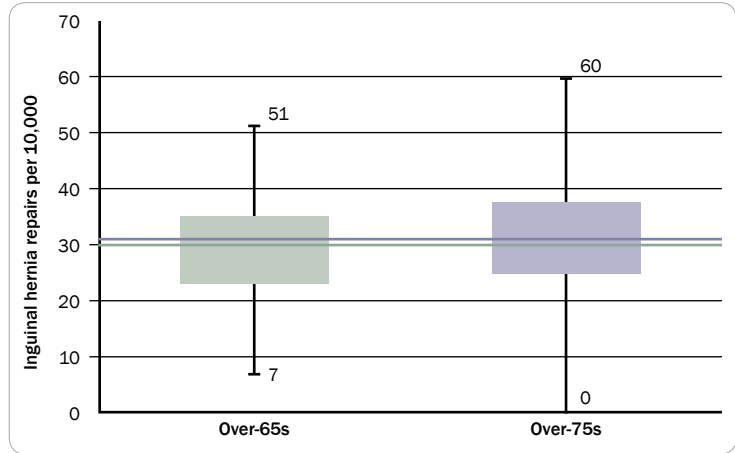


Figure 8 Distribution of inguinal hernia repair rates across CCGs for the over-65s and over-75s. This chart illustrates the distribution of procedure rates across CCGs. The top and bottom ‘whiskers’ show the highest and lowest procedure rates respectively. The coloured boxes show where 50% of the CCGs lie in the distribution. The blue line represents the median rate for the over-65s and the purple line represents the median rate for the over-75s.

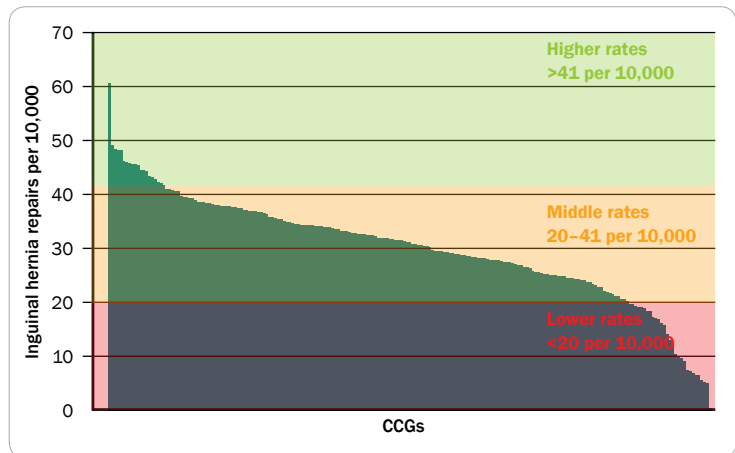


Figure 9 Variation by CCG in inguinal hernia repair rates for the over-75s. This chart illustrates the variation in the rate of each procedure across all CCGs, with each column representing the rate in each CCG. The green, yellow and red bands correspond to the high, middle and low bands of CCGs according to their procedure rate.

11

Hip replacement

- » During a hip replacement, part or all of the hip is replaced with an artificial hip joint.
- » The procedure is carried out to relieve pain caused by osteoarthritis or to repair damage to the joint caused by injury (eg fractured neck of femur).
- » Falls are the most common reason for joint fractures in the hip and are much more frequent in older people.
- » People over the age of 65 make up the vast majority of the recipients of joint replacement surgery.²⁵
- » NICE has said that GPs should refer patients with joint pain to surgeons before they become incapacitated rather than seeing it as a last resort.²⁶
- » Living in an area of high social deprivation has been linked to a lower hip replacement rate.¹³

Key findings

Unlike the other procedures examined in this analysis, the rate of hip replacements per 10,000 was higher for the over-75s than for the over-65s, as shown in Figure 10. It should be made clear that these data include both emergency and elective hip replacements. The median hip replacement rate for the over-75s was 104 per 10,000 compared with 76 per 10,000 for the over-65s. This was the most pronounced difference between the over-65s

- » There was an **11-fold difference** in the rate of hip replacements for the over-65s, depending on where a patient lives.
- » Unlike the other procedures examined, the rate of hip replacements was **higher** for the over-75s than for the over-65s.
- » **139 CCGs (65.9%)** recorded an **increase** of at least **25%** in the rate of hip replacements between the over-65s and over-75s.

and over-75s across all surgery areas examined in this analysis.

In *Access all ages*, an increase in the number of emergency hip replacements for the over-75s compared with the over-65s was identified. This may be responsible for the overall rise in the rate of hip replacements for the over-75s in the aggregated data presented in this report.

The rate of hip replacements for the over-65s varied 11-fold, depending on which CCG a patient lived in. Variation was slightly less acute in the over-75 age group, which varied 8-fold across CCGs. The range of rates among the over-75s can be seen in Figure 11.

The spread of rates for hip replacements tended to be high. For the over-65s, slightly less than half of the CCGs had a rate around the median range, with a similar proportion in the higher range. For the over-75s, while the rates were generally higher, the number of people living in CCG areas with rates in the high and middle bands fell although there was still a very high number of CCGs in the high band.

In addition, 139 CCGs (65.9%) reported an increase in their hip replacement rates between the over-65s and over-75s of at least 25%. No CCGs recorded a decline of more than 25% in their hip replacements rate between the two age groups. The average percentage difference in the hip replacement rates between the over-65s and over-75s across CCGs was 32.5%. This was the most significant increase in a procedure rate between the over-65s and over-75s across the procedures we analysed, and the vast majority of CCGs noted at least some increase in their rate of hip replacements between the two age groups.

As identified in *Access all ages*, the number of emergency hip replacements in people over the age of 75 is significantly higher than for the over-65s while at the same time the number of elective procedures is significantly lower. CCGs with higher rates of hip replacements for the over-75s could look at how they can reduce falls in their area, working with social care providers, local authorities and the voluntary sector. CCGs should also ensure that they can incorporate NICE’s latest guidance on osteoarthritic pain into their practice.

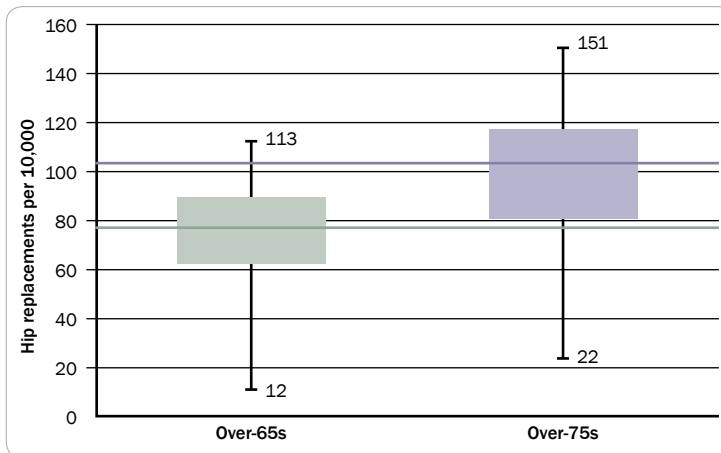


Figure 10 Distribution of hip replacement rates across CCGs for the over-65s and over-75s. This chart illustrates the distribution of procedure rates across CCGs. The top and bottom ‘whiskers’ show the highest and lowest procedure rates respectively. The coloured boxes show where 50% of the CCGs lie in the distribution. The blue line represents the median rate for the over-65s and the purple line represents the median rate for the over-75s.

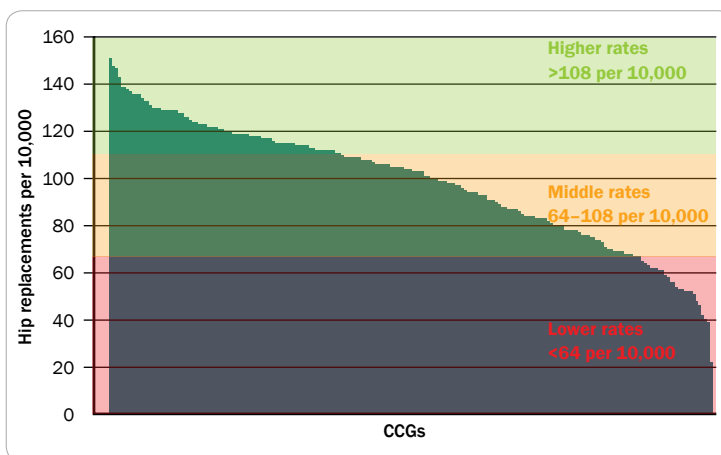


Figure 11 Variation by CCG in hip replacement rates for the over-75s. This chart illustrates the variation in the rate of each procedure across all CCGs, with each column representing the rate in each CCG. The green, yellow and red bands correspond to the high, middle and low bands of CCGs according to their procedure rate.

12

Knee replacement

- » A knee replacement is a procedure to replace part or all of the knee joint and is carried out to replace a damaged, worn or diseased knee joint.
- » There are over 70,000 knee replacements carried out every year, the vast majority on people aged over 65.²⁷
- » Osteoarthritis is one of the most common reasons for having a knee replacement and elective knee replacements are more common than emergency procedures.
- » People living in areas of high deprivation are less likely to receive knee replacement surgery.¹³

Key findings

There are differences in the rate of knee replacements by CCG for people aged over 65 and those aged over 75. The median rate of knee replacements for the over-65s was 56 per 10,000, which fell to 52 per 10,000 for the over-75s, as can be seen in Figure 12.

In *Access all ages*, concern among older people regarding immobility after surgery was identified as a factor that may impact on knee replacement rates. Indeed, examples were given of where older people who were carers had particular concerns that a long recovery time might stop them from being able to provide care for a loved one.

- » There was a **17-fold difference** in the rate of knee replacements for the over-75s, depending on where a patient lives.
- » The **majority of CCGs** recorded a **decline** in the rate of knee replacements between the over-65s and over-75s.
- » **40 CCGs (19.0%)** recorded a decline of at least **25%**.

For the over-65s, the rates of knee replacements varied 7-fold whereas for the over-75s, variation was much more pronounced, ranging 17-fold from the highest rate to the lowest positive rate (ie >0). For all the procedures analysed, knee replacements were associated with the widest variation in rates among the over-75s. It is worth noting that two CCGs had rates of 0 per 10,000.

The spread of CCGs shows that the large majority had rates of knee replacements for the over-65s in the middle band. However, there were more CCGs in the lower range than in the higher range. For the over-75s, the number of CCGs with higher rates of knee replacements was significantly increased while the number of CCGs in the middle band remained largely the same and the number in the lower range fell. It should be pointed out that for the

over-65s, there was one outlier CCG with an exceptionally high rate of knee replacements. The spread of rates across all CCGs can be seen in Figure 13.

In addition, 40 CCGs (19%) reported a decline of at least 25% in their knee replacement rate between the over-65s and over-75s, and 23 CCGs (11%) saw the rate of knee replacements increase by at least 25% between those aged over 65 and those aged over 75. The average difference in knee replacement rates across CCGs between the over-65s and over-75s was -7.44%. The majority of CCGs recorded at least a small decline in their rate of knee replacements between the over-65s and over-75s.

Variation across CCGs increased significantly among the over-75s for knee replacements and this may be due to local attitudes or policies on referring people with osteoarthritic joint pain for surgery, which may alleviate that pain. *Access all ages* identified equality of access as an issue nationally and this may also be playing out at a local level. CCGs with lower rates of knee replacements may wish to consider the potential impact on a person's mobility and independence when that individual is living with severe joint pain.

Another concern for many patients identified in *Access all ages* is the impact recovery from surgery will have on mobility. Many may be caring for a loved one and may be concerned that recovering from surgery would not allow them to continue to care for this person. CCGs with lower rates of

knee replacements could explore how they can support people recovering from knee replacement surgery to ensure that they are able to recover mobility as soon as possible, in order to reassure older carers.

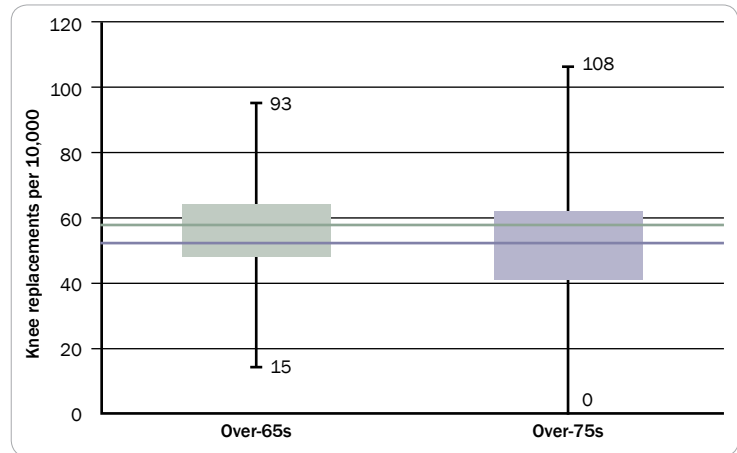


Figure 12 Distribution of knee replacement rates across CCGs for the over-65s and over-75s. This chart illustrates the distribution of procedure rates across CCGs. The top and bottom 'whiskers' show the highest and lowest procedure rates respectively. The coloured boxes show where 50% of the CCGs lie in the distribution. The blue line represents the median rate for the over-65s and the purple line represents the median rate for the over-75s.

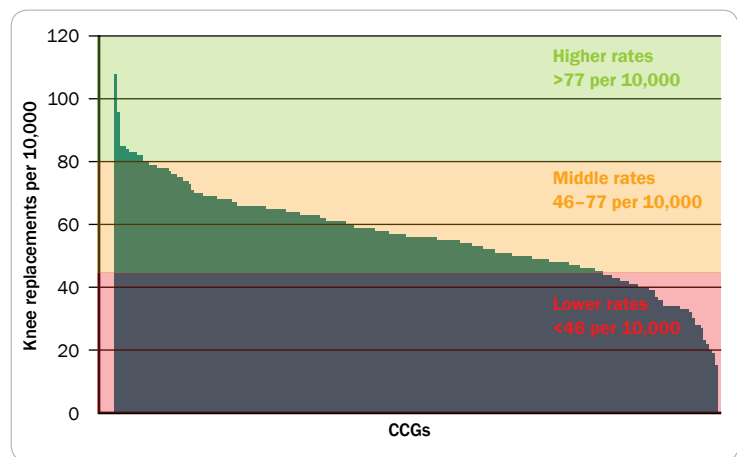


Figure 13 Variation by CCG in knee replacement rates for the over-65s. This chart illustrates the variation in the rate of each procedure across all CCGs, with each column representing the rate in each CCG. The green, yellow and red bands correspond to the high, middle and low bands of CCGs according to their procedure rate.



What does this mean for commissioners?

13

The previous section outlined significant variations in the access to surgery for people over the age of 65, for a range of common procedures, depending on where they live. Access to treatment for the over-75s was lower in almost all instances, which shows a pattern of declining intervention with age.

What action should CCGs take to understand whether their rates are appropriate? How could they start to plan, design and oversee care so as to optimise treatment rates for older patients?

At each stage of the commissioning cycle (Figure 14), CCGs should seek to identify the actions that will help to support access to high quality surgical care for older patients, based on individual need.

Strategic planning

Health and wellbeing boards should conduct a robust assessment of the needs of the older population as part of the joint strategic needs assessment (JSNA). The CCG and health and wellbeing board should work closely to ensure that the commissioning plan addresses the requirements of the older population as set out in the joint health and wellbeing strategy. The King's Fund has noted that health inequalities are high on the agenda of local boards, and it will be important to build on this from an age perspective and to ensure that the needs assessment translates into clear plans.²⁸

As part of the strategic planning process, CCGs will want to undertake a review of local providers to identify unmet need or persistent underperformance in relation to older people's treatment and care. This review should include an appraisal of capacity as well as an audit of workforce skills to inform education and training, working closely with the local education and training board.

Key considerations

- » Does the JSNA include an assessment of health needs among the over-65 population, disaggregated by five-year age bands, and an estimate of prevalence of co-morbidity and frailty among the older population?
- » Based on these data, is there an assessment of the number of patients likely to require surgical treatment for common conditions such as cancer, heart disease and osteoarthritis?
- » Do current health awareness campaigns work effectively among older patients to support early presentation and increase the treatment options available?
- » Do practitioners in primary, secondary and tertiary care have the skills and knowledge to treat older patients according to need?
- » Is the geriatrician-to-patient ratio sufficient to support the age profile of the local population?



Outcomes specifications

Box 4

Commissioners should use quality measures to focus providers on improving outcomes for older patients. Condition-specific outcome measures should reflect indicators set out in NICE quality standards where they exist. CCGs should ensure that all data are of a high quality, accurately coded and disaggregated by age (using five-year age bands up to 90+), working closely with the commissioning support unit where necessary.

- » X% improvement against the surgical quality indicators in relevant NICE quality standards
- » X% day-case rate
- » Length of stay
- » X% improvement against indicators in the CCG Outcomes Indicator Set 2014–2015:
 - » Reducing premature mortality (for over-75s)
 - » Patient-reported outcome measures for planned procedures
 - » Improving recovery from fragility fractures
 - » Reducing emergency admissions and readmissions (7-day and 30-day readmission rates)
 - » Quality of life for patients (feeling supported to manage condition) and carers
 - » Patient experience
 - » Reducing safety incidents (eg falls and fractures)
- » In-hospital mortality
- » Mortality within 30 days of treatment
- » Evidence of the involvement of older patients and carers in decision making and in co-developing models of good practice

Procuring services

CCGs should work closely with local providers to design and procure surgical care that improves the outcomes of older patients (Box 4). As outlined above, commissioners will need to take a whole-pathway approach in order to utilise every opportunity to optimise health prior to treatment, deliver high quality surgery and ensure that the right care and support is in place following treatment.

The standard contract should be used to focus providers on delivering high quality care and improved outcomes, based around a clear set of process and outcome requirements. Process requirements such as good practice in referral, staff qualifications and experience (including geriatrician input), and user involvement should be set out in the service specification, drawing on relevant NICE guidelines and quality standards as well as new commissioning guidance published by the Royal College of Surgeons and the surgical specialty associations. These guides are available at: <http://www.rcseng.ac.uk/healthcare-bodies/nssc/commissioning-guides/guide-topics>

If there are resource implications associated with providing higher quality care, commissioners should consider whether locally agreed Commissioning for Quality and Innovation (CQUIN) goals could be used to establish improved practices. In the same way, best practice tariffs could be introduced to help underpin the costs of enhanced geriatrician involvement in clinical decision making.

Monitoring and evaluation

CCGs will need to evaluate the performance of providers in improving the outcomes



Figure 14 The commissioning cycle

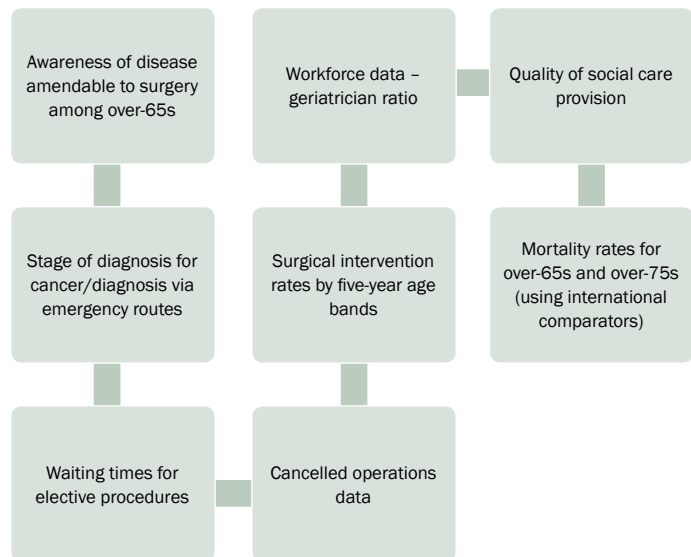


Figure 15 Access to surgery: proxy indicators

of older people against the criteria set out in the specification. Beyond the contract, there will be other proxy indicators that will allow commissioners to build up a picture of the quality of care of older people and the likelihood that they may be able to benefit from surgery. Examples of these proxy indicators are shown in Figure 15.

Checklist for commissioners

Strategic planning

- Does the JSNA include an assessment of health need among the over-65 population?
- Does this include an evaluation of the burden of disease, level of deprivation, overall age profile, and estimated prevalence of co-morbidity and frailty?
- Based on these data, is there an assessment of the number of patients likely to require surgical treatment for common conditions set out in this report such as cancer and osteoarthritis?
- Does the commissioning plan address the needs identified in the JSNA and joint health and wellbeing strategy?
- Do current health awareness campaigns work effectively among older patients to support early presentation and increase the treatment options available?
- Do practitioners in primary, secondary and tertiary care have the skills and knowledge to effectively assess, treat and manage older patients?
- Is the geriatrician-to-patient ratio sufficient to support the age profile of the local population?

Procuring services

- Is the service specification informed by relevant clinical guidelines, quality standards and best practice examples?
- Does the service specification set out both process and outcome measures broken down by age?
 - » X% improvement against the surgical quality indicators in relevant NICE quality standards
 - » X% day-case rate
 - » length of stay
 - » X% improvement against relevant indicators in the CCG Outcomes Indicator Set 2014–2015
 - » surgical conversion rates (proportion of patients referred to a surgeon who receive treatment)
 - » in-hospital mortality
 - » mortality within 30 days of treatment
 - » evidence of the involvement of older patients and carers in decision making and in co-developing models of good practice
 - » Have local CQUIN goals and best practice tariffs been developed/agreed with providers to improve geriatrician involvement as well as pre and postoperative care and support packages?
- Are there referral policies in place that might unfairly restrict access for older patients?

Monitoring and evaluation

- Are proxy indicators in place to evaluate improvement?
 - » awareness of disease amenable to surgery among the over-65 population
 - » stage of diagnosis for cancer/diagnosis via emergency routes
 - » waiting times for elective procedures
 - » cancelled operations data
 - » evidence of age equality in equity audits
 - » surgical intervention rates broken down by five-year age bands (Are they in line with the needs identified through the JSNA?)
 - » quality of social care provision
 - » mortality rates broken down by five-year age bands (using international comparators)

Across the cycle

- Have accurate, up-to-date data, broken down by five-year age bands, been obtained?
- Has an audit of disease and procedure-specific information provision for older people been undertaken?
- Are older people and their carers involved in planning and service design?
- Is a plan being developed to address undertreatment of older people if appropriate?
- Are changes in intervention rates for older people being monitored and benchmarked, and is the plan being modified accordingly?

Annex: Commissioning guides

The Royal College of Surgeons and the surgical specialty associations have developed commissioning guides to assist CCGs in making decisions about appropriate healthcare for specific clinical circumstances and fulfilling their obligation to commission healthcare for their population that meets the five domains in the NHS Outcomes Framework.

The guides are based on the best available evidence, including NICE clinical guidance and guidance produced by relevant professional bodies. They are developed using a defined process that is accredited by NICE.

The full list of commissioning guides is available at:

<http://www.rcseng.ac.uk/healthcare-bodies/nscc/commissioning-guides/guide-topics>

References

1. Kirkwood T. *The future of ageing*. London: Age UK; 2009.
2. King's Fund. *The care of frail older people with complex needs: time for a revolution*. London: King's Fund; 2012.
3. Health and Social Care Bill: Memorandum submitted by Age UK (HS 25). <http://www.publications.parliament.uk/pa/cm201011/cmpublic/health/memo/m25.htm> (cited June 2014).
4. De Angelis R, Sant M, Coleman MP et al. Cancer survival in Europe 1999–2007 by country and age: results of EURO-CARE-5 – a population-based study. *Lancet Oncol* 2014; **15**: 23–34.
5. Royal College of Surgeons of England, Age UK. *Access all ages: Assessing the impact of age on access to surgical treatment*. London: RCS; 2012.
6. King's Fund. *Continuity of care for older hospital patients: A call for action*. London: King's Fund; 2012.
7. Deprivation responsible for 450 breast cancer deaths each year. University of Cambridge. <http://www.cam.ac.uk/research/news/deprivation-responsible-for-450-breast-cancer-deaths-each-year> (cited June 2014).
8. For example: Audit Commission. *Reducing spending on low clinical value treatments*. London: AC; 2011.
9. Cancer Research UK. *Cancer and health inequalities: An introduction to current evidence*. London: CRUK; 2006.
10. Rachet B, Ellis L, Maringe C et al. Socioeconomic inequalities in cancer survival in England after the NHS cancer plan. *Br J Cancer* 2010; **103**: 446–453.
11. *National Bowel Cancer Audit 2012*. Leeds: HSCIC; 2012.
12. Seymour DG, Garthwaite PH. Age, deprivation and rates of inguinal hernia surgery in men. Is there inequity of access to healthcare? *Age Ageing* 1999; **28**: 485–490.
13. Dixon T, Shaw M, Ebrahim S, Dieppe P. Trends in hip and knee joint replacement: socioeconomic inequalities and projections of need. *Ann Rheum Dis* 2004; **63**: 825–830.
14. Department of Health. *Press release: No more age discrimination on the NHS*. London: DH; 2011.
15. *Health and Social Care Act (2012)*. [Legislation.gov.uk](http://www.legislation.gov.uk) <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted/data.htm> (cited June 2014)
16. Breast cancer incidence statistics. Cancer Research UK. <http://www.cancerresearchuk.org/cancer-info/cancerstats/types/breast/incidence/> (cited June 2014).
17. Bowel cancer incidence statistics. Cancer Research UK. <http://www.cancerresearchuk.org/cancer-info/cancerstats/types/bowel/incidence/> (cited June 2014).
18. Aerts R, Penninckx F. The burden of gallstone disease in Europe. *Aliment Pharmacol Ther* 2003; **18 Suppl 3**: 49–53.
19. Stevens A, Rafferty J, Mant J, Simpson S. *Health Care Needs Assessment*. Vol 1. London: Radcliffe; 2004.
20. Oliveria SA, Felson DT, Reed JI et al. Incidence of symptomatic hand, hip, and knee osteoarthritis among patients in a health maintenance organization. *Arthritis Rheum* 1995; **38**: 1,134–1,141.
21. Rubenstein LZ, Josephson KR. The epidemiology of falls and syncope. *Clin Geriatr Med* 2002; **18**: 141–158.
22. Gallbladder removal. NHS Choices. <http://www.nhs.uk/conditions/Laparoscopiccholecystectomy/> (cited June 2014).
23. Festi D, Dormi A, Capodicasa S et al. Incidence of gallstone disease in Italy: results from a multicenter, population-based Italian study (the MICOL project). *World J Gastroenterol* 2008; **14**: 5,282–5,289.
24. Ruhl CE, Everhart JE. Risk factors for inguinal hernia among adults in the US population. *Am J Epidemiol* 2007; **165**: 1,154–1,161.
25. Chidambaram R, Cobb AB. Change in the age distribution of patients undergoing primary hip and knee replacements over 13 years – an increase in the number of younger men having hip surgery. *J Bone Joint Surg Br* 2009; **91 Suppl 1**: 152.
26. National Institute for Health and Care Excellence. *Osteoarthritis: Care and management in adults (CG177)*. London: NICE; 2014.
27. Knee replacement. NHS Choices. <http://www.nhs.uk/conditions/Knee-replacement/> (cited June 2014).
28. King's Fund. *Health and wellbeing boards: One year on*. London: King's Fund; 2013.



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