

Chairs of six Birmingham region CCGs

5 April 2016

Dear Chairs,

**Open letter: new Procedures of Lower Clinical Value policy**

I am writing to express concern with your recent consultation on Procedures of Lower Clinical Value.

The Royal College of Surgeons (RCS) believes patients' access to treatment must be based on clinical assessment and evidence-based practice. The proposals in your consultation document place thresholds to referral on several essential elective surgical procedures spanning six CCGs, and more than 2 million patients in the region, which would act as a barrier to patients receiving necessary clinical treatment.

The document makes extensive reference to guidance published by the RCS and surgical specialty associations (SSAs) in setting out new commissioning policies on thresholds to referral to surgical procedures. Policies for some procedures reference RCS and SSA guidance which is subsequently ignored or cited out of context, thereby presenting the policies as if they are supported by clinically-evidenced guidance, but that in places contravene it. The RCS and SSAs are keen to work with commissioners to improve patient care. I outline below particular areas of concern and urge you to reconsider your policies.

**BMI thresholds on hip and knee replacements**

Referring patients to hip and knee surgery only if their BMI is below 35 could affect a number of people, and the average prevalence of severe knee osteoarthritis is 6.8% across the population covered by the six CCGs<sup>1</sup>. The British Orthopaedic Association (BOA) challenges the decision of the CCGs to include hip and knee replacements in a list of procedures of lower clinical value, considering the low QALY cost of the procedures<sup>2</sup>. There is evidence that prolonging the wait for total hip replacement in patients with severe pain and reduced mobility results in poorer outcomes from surgery, and this is outlined in NICE guidance for osteoarthritis<sup>3</sup>. According to the BOA, there is no consistent evidence that patients with a high BMI who undergo hip replacement surgery, for example, do better or worse than other patient groups<sup>4</sup>.

---

<sup>1</sup> Arthritis Research UK. *Musculoskeletal Calculator*. 2015.

<sup>2</sup> Private correspondence with The Royal College of Surgeons of England: 2016.

<sup>3</sup> National Institute for Health and Care Excellence. *Osteoarthritis*. London: NICE; 2014.

<sup>4</sup> Private correspondence with The Royal College of Surgeons of England; 2014.

**The Royal College of Surgeons of England**

35-43 Lincoln's Inn Fields  
London WC2A 3PE

**T:** 020 7869 1234

**E:** [contact@rcseng.ac.uk](mailto:contact@rcseng.ac.uk)

**W:** [www.rcseng.ac.uk](http://www.rcseng.ac.uk)

Registered Charity No. 212808

In order to improve efficiency, we believe that reviewing local pathways to support early discharge and identify high-risk patients should take priority over implementing thresholds to access. The BOA also stresses that CCGs should ensure that knee arthroscopies are not being performed in the run up to knee replacement<sup>5</sup>.

### **Varicose veins treatment**

The policy proposes to only surgically treat more advanced cases of varicose veins. Varicose veins that are not treated at an earlier stage are likely to deteriorate and require later surgery. For instance, patients with complications such as ulceration require additional treatment from other services, and this could have been treated at an earlier stage at a relatively low cost. According to the Vascular Society, this cost-effective treatment is beneficial as varicose veins impact on a patient's quality of life<sup>6</sup>. There is no real evidence base for the proposed initial treatments, and NICE guidance states that compression hosiery should only be offered as a permanent treatment if no other treatments are suitable<sup>7</sup>. It is also of concern that the policy signals that if treatment for varicose veins is necessary, a clinician may first recommend the use of compression stockings for up to six months.

### **Hernia repair**

RCS guidance has been misrepresented for hernia repair. The policy states that only irreducible or partly reducible inguinal hernias, or those that cause pain that limits daily activity, or are strangulated or obstructed will be funded. RCS/SSA guidance suggests that all patients who present with overt or suspected inguinal hernia should be referred for surgical hernia repair<sup>8</sup>. Evidence in the European Hernia Society Guidelines shows that delaying inguinal hernia surgery causes the need for later surgery in the vast majority of patients, which can be more difficult in older patients<sup>9</sup>. The British Hernia Society is concerned that the CCGs' policy contradicts available evidence and puts patients at risk<sup>10</sup>.

### **Grommets for glue ear**

Rationale for a policy to document five or more episodes of glue ear in a child before being referred for grommets treatment is not evidenced in RCS/SSA or NICE guidance. NICE guidance states that the persistence of bilateral otitis media with effusion (glue ear) and hearing loss should be confirmed over a period of three months before intervention is considered, and that the child's hearing should be tested at the end of this period<sup>11</sup>. The CCGs' policy does not mention re-testing and hearing loss, which raises concern as hearing loss often goes

---

<sup>5</sup> Private correspondence with The Royal College of Surgeons of England: 2016.

<sup>6</sup> Private correspondence with The Royal College of Surgeons of England: 2016.

<sup>7</sup> National Institute for Health and Care Excellence. *Varicose veins in the legs*. London: NICE; 2014.

<sup>8</sup> The Royal College of Surgeons of England; Association of Surgeons of Great Britain and Ireland; British Hernia Society. *Commissioning guide: groin hernia*. London: RCS; 2013.

<sup>9</sup> Aufenacker, T. Miserez, M. Peeters, E. et al. 'Update with level 1 studies of the European Hernia Society guidelines on the treatment of inguinal hernia in adult patients'. *Hernia*. 2014. 18:151-63.

<sup>10</sup> Private correspondence with The Royal College of Surgeons of England: 2016.

<sup>11</sup> National Institute for Health and Care Excellence. *Otitis media effusion in under 12s: surgery*. London: NICE; 2008.

undetected without formal testing. ENT UK also stresses that glue ear that may require intervention with grommet insertion is a chronic disorder and not an episodic acute illness. Such a chronic condition may induce recurrent episodes of acute otitis media as well as hearing loss<sup>12</sup>.

### **Back pain treatment**

In most cases of back pain, physiotherapy or combined physical and psychological therapy should be the first line of treatment, and patients should only be referred for surgical opinion if they do not respond to this first line of treatment. This pathway is not mentioned in the policy document. RCS guidance does not prescribe a single injection in the circumstances outlined in the policy, and the guidance should not be referenced in this way. According to the BOA, the priority for improving back pain care is implementation in full of the National Pathway of Care for Low Back and Radicular Pain, which is supported by NHS England. Furthermore, it may be sensible for CCGs to delay implementing the proposed policy until after NICE has consulted on Guidance on Low Back Pain and Sciatica<sup>13</sup>, to ensure the policy is aligned with NICE guidance<sup>14</sup>. The consultation closes on 5 May.

### **Adenoidectomy**

The policy for adenoidectomy is not in line with RCS guidance, as is suggested in the document. The RCS does not agree with a policy of only referring patients for the procedure if undertaken at the same time as grommets or tonsillectomy<sup>15</sup>. It seems particularly unusual to insist on performing a tonsillectomy at the same time if a patient requires an adenoidectomy, as this may increase surgical risk for the patient who may only need an adenoidectomy to treat sleep-disordered breathing.

We strongly urge you to reconsider your position on the points of concern outlined above. Aspects of the policy amount to rigid thresholds which would act as a barrier to essential elective surgical procedures. The RCS has produced clear guidance, accredited by NICE, and this should be fully taken into account in CCGs' commissioning policies. In this case, our guidance has been misrepresented and incorrectly referenced in many places.

I look forward to hearing from you.

Yours sincerely,

**Mr Paul O'Flynn**

Royal College of Surgeons Council Member and Lead for Commissioning

---

<sup>12</sup> Private correspondence with The Royal College of Surgeons of England: 2016.

<sup>13</sup> National Institute for Health and Care Excellence. Consultation: Low Back Pain and Sciatica. [www.nice.org.uk/guidance/indevelopment/gid-cgwave0681](http://www.nice.org.uk/guidance/indevelopment/gid-cgwave0681)

<sup>14</sup> Private correspondence with The Royal College of Surgeons of England: 2016.

<sup>15</sup> The Royal College of Surgeons of England; ENT UK. *Commissioning guide: rhinosinusitis*. London: RCS; 2013.