Rationing of surgery

November 2017

Royal College of Surgeons
ADVANCING SURGICAL CARE

RCS briefing paper on rationing

Introduction

The NHS continues to treat a growing number of people each year and has made enormous efforts to improve efficiency. Patients had over 16.5 million finished admissions for care in hospitals in 2016/17, a 27.5% increase since 2006/07.[1] This is a remarkable achievement.

Yet the service is under enormous pressure, with ever-growing financial burdens, increasing demand from an ageing population, the rising costs of new treatments, a shortage of bed capacity and staff in hospitals, and greater public expectations. This is reflected in deteriorating performance standards such as waiting times. The Royal College of Surgeons (RCS) is also concerned that financial pressures and policy decisions are leading to restrictions on care, or rationing policies, that disproportionately affect planned (elective) surgery. This includes operations such as hip and knee replacements or heart and brain surgery.

In 2016, we published a report, *Smokers and Overweight Patients: Soft targets for NHS savings?* which explored how widespread the practice of restricting surgery on the basis of weight or smoking status has become. Commissioning policies revealed that 34% of clinical commissioning groups (CCGs) had at least one policy restricting access to surgery by either BMI level or smoking status.[2]

Since we published this report, we have seen even harsher examples of arbitrary rationing. These broadly fall under four types of restrictions:

1. "Financial" rationing
2. "Lifestyle" rationing
3. "Pain threshold" rationing
4. Individual funding requests

While this document focuses on the practices of CCGs rationing treatment in England, the principles could also apply to similar restrictions in other parts of the UK.

"Financial" rationing

We believe most types of rationing are motivated by financial considerations but, in some cases, commissioning groups take measures explicitly to save money over a defined period of time. For instance in February 2017, West Kent CCG implemented a policy to suspend all elective surgery until the end of its

[1] NHS Digital, *Hospital Admitted Patient Care Activity*, November 2016 https://www.gov.uk/government/statistics/hospital-admitted-patient-care-activity-2015-to-2016

[2] Royal College of Surgeons, *Smokers and Overweight Patients: Soft targets for NHS savings?* April 2016 https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/smokers-soft-targets/

For further information please contact the RCS public affairs team via publicaffairs@rcseng.ac.uk

Rationing of surgery

November 2017

financial year in April 2017, in a bid to make savings of £3.2 million.[3] The CCG estimated that this would affect 1,700 patients.

More recently, Cambridgeshire and Peterborough CCG proposed a new policy requiring patients to wait a minimum of 12 weeks for surgery. In its board papers, the CCG says that the policy will ensure "a one-off saving to the system in the current financial year".[4] However, this decision was reversed in November 2017.[5]

"Lifestyle" rationing

Rationing of treatment based on "lifestyle" factors, such as whether patients are obese or smoke, is increasingly common. In November 2016, Vale of York CCG announced plans to delay planned operations for many smokers or patients with a BMI of over 30 by either 6 or 12 months if they could not prove they have stopped smoking for 2 months or lost 10% of their weight.[6] A similar policy has been adopted in North Kirklees, where almost 24% of the adult population have a BMI of over 30 and 14% of adults are smokers, and will therefore be affected by the restrictions.[7]

More recently, CCGs in Hertfordshire announced an indefinite ban on surgery for smokers and obese patients.[8]

Further examples are detailed in our 2016 report *Smokers and Overweight Patients: Soft targets for NHS savings?*

We support every effort to help patients lose weight and stop smoking. In particular there is evidence that smoking cessation schemes reduce the risk of post-operative complications. On the other hand, while obesity leads to poorer health outcomes, its relationship with post-operative success is less clear and there is a lack of evidence that rapid weight-loss before surgery makes much difference. For example, there is evidence of a lower risk of post-operative cardiac and respiratory complications among obese patients. In addition, we are unaware of any clear clinical evidence to suggest that denying or delaying access to NHS treatment helps patients to lose weight or stop smoking.

Surgery may be needed to help someone lose weight, for example if a patient is unable to move or exercise due to immobility or pain. Sometimes these policies also risk preventing a patient from

[3] The Guardian, *NHS cash crisis in Kent halts non-urgent surgery until April,* February 2017 https://www.theguardian.com/society/2017/feb/02/nhs-cash-crisis-in-kent-halts-non-urgent-surgery-until-april

[4] Cambridgeshire & Peterborough CCG, September 2017 https://www.cambridgeshireandpeterboroughccg.nhs.uk/easysiteweb/getresource.axd?assetid=11195&type=0&servicetype=1

[5] https://www.cambridgeshireandpeterboroughccg.nhs.uk/_resources/assets/inline/full/0/11759.pdf

[6] Vale of York CCG, March 2017 http://www.valeofyorkccg.nhs.uk/our-work/optimising-outcomes-from-elective-surgery/

[7] Huddersfield Examiner, June 2017 http://www.examiner.co.uk/news/you-could-sent-back-queue-13248417

[8] The Telegraph, October 2017 http://www.telegraph.co.uk/news/2017/10/17/nhs-provokes-fury-indefinite-surgery-ban-smokers-obese/

For further information please contact the RCS public affairs team via publicaffairs@rcseng.ac.uk

Rationing of surgery

November 2017

seeing a consultant who can advise them on the best form of treatment, which may not be surgery.

The National Institute for health and Care Excellence (NICE) also notes that "patient-specific factors (including smoking, obesity and comorbidities) should not be barriers to referral for joint surgery."[9]

Some of these CCGs have been explicit that such policies are designed to save money.

"Pain threshold" rationing

A number of commissioning groups require patients to be suffering increased pain or disability before accessing surgery. This often involves requiring patients to meet specific Oxford scores – a self-assessed scale which measures the degree of pain and/or disability a patient is experiencing. These scores vary widely across different parts of the country. Rotherham CCG imposes some of the most severe requirements and will only fund hip and knee replacements when a patient is in "intense to severe persistent pain which leads to severe functional limitations". This is defined as "pain of almost continuous nature" that occurs when "walking short distances on level surfaces."[10]

Individual funding requests

Individual funding requests, or IFRs, can be made by a clinician to a commissioning group to apply for treatment for a patient that is not routinely funded by the NHS. These requests are then assessed by a panel and may take time to be approved.

Historically commissioning groups used IFRs for treatments aimed at tackling rare diseases. However, some commissioning groups now require applications for hip and knee replacements which have previously been considered routine. This includes commissioning groups in East Berkshire.[11] Analysis by the BMJ found that the overall number of individual funding requests received by CCGs in England increased by 47% in the past four years.[12]

RCS position

Delaying treatment is a false economy, as it does not save the CCGs money in the long-term. In fact, these policies may actually increase costs if patients develop complications if treatment is delayed. Furthermore, as highlighted in a National Audit Report report on the costs of clinical negligence, 39% of current claims are related to failures or delays in diagnosis or treatment of a condition "so this is likely to

[9] NICE guidance CG177, *Osteoarthritis: care and management,* February 2014 https://www.nice.org.uk/guidance/cg177/chapter/1-Recommendations#referral-for-consideration-of-joint-surgery-2

[10] Rotherham CCG, October 2016 http://www.rotherhamccg.nhs.uk/Downloads/Governing%20Body%20Papers/October%202016/Enc%207%20-%20Implementing%20Clinical%20Thresholds.pdf

[11] https://www.thetimes.co.uk/article/nhs-units-impose-surgery-ban-on-obese-and-smokers-82zmgt2r0

[12] BMJ, *Pressure on NHS finances drives new wave of postcode rationing,* July 2017 http://www.bmj.com/content/358/bmj.j3190

For further information please contact the RCS public affairs team via publicaffairs@rcseng.ac.uk

Rationing of surgery

November 2017

Royal College of Surgeons
ADVANCING SURGICAL CARE

increase if waiting times are longer" and treatment is arbitrarily rationed.[13]

Hip and knee replacements have been disproportionately targeted by CCGs, yet they are one of the most effective life improving treatments available. For example, a recent trial published in the BMJ compared knee replacements with non-surgical management alone and showed large improvements in pain and physical limitations and significant increases in quality of life at 12 months.[14]

The NHS constitution states that "access to NHS services is based on clinical need" and patients "will not be refused access on unreasonable grounds".[15] However, these rationing decisions taken by CCGs call into question whether we truly have a "National" Health Service.

Why rationing is unacceptable

No health service in any part of the world has a bottomless pit of funds. Some form of rationing of treatment is always inevitable. However, we believe the examples detailed in this paper – where previously routine surgeries are restricted – can at best be described as counterproductive. This is because:

- Simply delaying access to surgery may worsen an individual's health problems and increase their dependency on the NHS.
- There is no evidence that denying patients access to surgery on the basis of weight or smoking status helps them to improve their healthy behaviour.
- In some cases, the policies risk preventing a patient from seeing a consultant who can advise them on the best form of treatment, which may not be surgery. Consultants may also spot other complications or conditions which warrant more urgent attention.

Recommendations

Recommendation 1: The RCS would like NHS England to ensure CCGs are held accountable for upholding clinical standards and providing quality care. NHS England should provide clear guidance that such policies listed above are clinically and ethically wrong.

Recommendation 2: CCGs' surgical commissioning policies should be based on clinical guidance from the RCS, surgical specialty associations, and NICE.

Recommendation 3: The RCS would like to see a financial impact assessment of such policies, which we believe will end up costing the NHS more in the long-term.

Recommendation 4: The RCS would like to see a comprehensive debate about

[13] NAO, *Managing the costs of clinical negligence in trusts,* September 2017 https://www.nao.org.uk/wp-content/uploads/2017/09/Managing-the-costs-of-clinical-negligence-in-trusts.pdf

[14] BMJ, *Impact of total knee replacement practice: cost effectiveness analysis of data from the Osteoarthritis Initiative*, March 2017 http://www.bmj.com/content/356/bmj.j1131

[15] NHS Constitution, July 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf

For further information please contact the RCS public affairs team via publicaffairs@rcseng.ac.uk

Rationing of surgery

November 2017

Royal College of Surgeons
ADVANCING SURGICAL CARE

what treatments the NHS can continue to fund in the future.

Recommendation 5: We would like to see commissioning groups instead look at reducing treatment that is clinically ineffective.

For further information please contact the RCS public affairs team via publicaffairs@rcseng.ac.uk