

JULY 2014



IS ACCESS TO SURGERY A POSTCODE LOTTERY?

THE ROYAL COLLEGE OF SURGEONS OF ENGLAND

Contents

Executive summary	2
Background	5
What has the government said about the rationing of treatment?	5
CCGs and the role of commissioning guidance	6
Methodology	7
Findings	9
Hip replacement	9
Tonsillectomy	13
Inguinal hernia	16
Otitis media with effusion	18
Annex: Clinical commissioning groups	20
References	21

Executive summary

One year on from the formal establishment of NHS England and clinical commissioning groups (CCGs), this is the first major report to review whether new commissioners are rationing essential clinical treatments. We compare CCGs' commissioning policies against the clinical evidence base, including guidance from the National Institute for Health and Care Excellence (NICE) or the Royal College of Surgeons (RCS) and surgical specialty associations (SSAs), for a number of major surgical operations that account for more than 177,000 of the total number of procedures carried out on the NHS.¹

Under the previous commissioning system, which consisted of strategic health authorities and primary care trusts, a number of reports showed that commissioners sometimes ignored clinical evidence by restricting access to some surgical procedures. At the time, both the House of Commons Health Committee and the Committee of Public Accounts suggested some of these attempts may have been a cost-cutting exercise aimed at coping with the financial challenge facing the NHS.

The government has been clear that restricting clinically necessary treatment is unacceptable, and that commissioners are required to cease imposing minimum waits and inappropriate constraints on planned treatment. The NHS Constitution also says patients have a right 'to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence'.

The RCS also believes that patients' access to treatment must be based purely on clinical assessment and informed discussion between the clinician and patient. Denying access to treatment can impact on the outcomes of surgery and patient safety, with evidence that patients are less mobile and suffer more pain if operations are delayed or denied. In the case of groin hernia repair, delays in operating can lead in rare circumstances to a strangulated hernia, which is a medical emergency.

Commissioners play a fundamental role in securing equitable access to evidence-based, high-quality healthcare for their local populations. Without commissioners, NHS resources would be distributed arbitrarily without concern for local need and access. However, this report shows that in too many instances local commissioners are still imposing arbitrary referral criteria for essential care despite clear clinical evidence and guidance from the Department of Health, NICE and surgeons. This is creating a postcode lottery for access to surgical treatment.

For some procedures a number of commissioners also have no policies in place. This can be equally problematic as it may lead to too many or too few referrals.

Our main findings are:

- 73% of CCGs we reviewed do not follow NICE and clinical guidance on referral for hip replacement or have no commissioning policy in place for this procedure. We are alarmed that 44% require patients to be in various degrees of pain and immobility (with no consistency applied across the country) or to lose weight before surgery. This is considered to be unacceptable by NICE, the RCS and the British Orthopaedic Association (BOA).
- Only 27% of CCGs from our sample have policies that comply with NICE or surgical guidance on inguinal hernia repair, while 58% told us they had no policy at all. 15% required evidence of a hernia increasing in size or a history of the hernia not being able to return to the abdominal cavity (incarceration) even if a patient is suffering from debilitating pain.
- Two CCGs had minimum 'watchful waiting' periods, meaning some patients may not access tonsillectomies for a year and a half.
- 77% of CCGs do follow clinical evidence on the commissioning of treatment for glue ear. However, six CCGs require minimum waits to watch for additional symptoms, contrary to clinical guidance.

Procedure	CCG follows clinical guidance	CCG does not follow clinical guidance	CCG does not hold a policy
Hip replacement	27%	44%	29%
Tonsillectomy	79%	19%	2%
Inguinal hernia repair	27%	15%	58%
Otitis media with effusion	77%	11.5%	11.5%

In the past, some commentators have suggested such arbitrary criteria are motivated by the need to make short-term savings in the NHS. While it is impossible to prove categorically that CCGs are imposing arbitrary criteria for financial reasons alone, some CCGs' policies do not reflect clinically accepted evidence-based guidance so we question how these policies were conceived. *Our primary concern is that there is no clinical justification for many of the policies discussed in this report.*

As this report explains, such policies (if not backed up by sufficient evidence) are at risk of legal challenge. We are keen to work alongside our colleagues in CCGs to review their referral policies against the clinical evidence to help them avoid both under and over-commissioning for procedures, ensuring access to the highest quality surgical care for their local populations.

Given the concerns raised by our report, we make a number of recommendations:

- The government and NHS England need to review what further action is required to ensure the NHS is providing equitable access to high-quality surgical care.
- While CCGs presently face a number of pressures, they urgently need to ensure their commissioning policies are in line with the clinical evidence base. This could include reviewing their guidance against RCS/SSA evidence-based guidance as well as NICE guidance.
- NHS England needs to remind CCGs that they are required by law to publish their commissioning policies. We were disappointed that a small number of CCGs refused to provide their policies despite legislation following from the government's *Health and Social Care Act 2012*, which should have improved transparency around decision making.
- Patients should not be afraid to challenge their CCG, via their local Healthwatch if necessary, if they feel they are being denied access to necessary surgical treatment.

Background

What has the government said about the rationing of treatment?

The RCS believes that a patient's access to treatment should be driven by need based on clinical assessment only and must not be compromised by financial pressure. We believe most methods to restrict access to surgery use unproven and arbitrary thresholds that unfairly deny patients effective operations that can greatly improve their quality of life.

The government has also been clear that rationing essential health services is unacceptable; any restrictions should be based on clinical criteria:

- On 21 September 2011 the NHS Medical Director, Professor Sir Bruce Keogh, wrote to strategic health authorities to say that any decision 'to restrict access to a treatment or intervention must be justified in relation to a patient's individual circumstances' and that 'decisions should not be made solely on the basis of cost, and any refusal to offer the intervention in question must be fair and consistent'.²
- In November 2011 the Department of Health announced that it was requiring commissioners to cease imposing minimum waits, activity caps and inappropriate constraints on elective activity by no later than 31 March 2012.³
- At Prime Minister's Question Time on 20 June 2012 Foreign Secretary Rt Hon William Hague MP (standing in for the Prime Minister) said: 'It is totally unacceptable if trusts are rationing on the basis of financial considerations.'⁴

As the government has highlighted, there has previously been some concern that commissioners might be restricting access on the basis of financial considerations. According to Monitor, the NHS faces a financial challenge of around £30 billion by 2020–2021, necessitating the need for healthcare commissioners and providers to adopt radical solutions to deal with increasing demand and tightening healthcare budgets.⁵ Under primary care trusts (commissioning organisations that existed before April 2013), the House of Commons Health Committee⁶ and Committee of Public Accounts⁷ both found that the magnitude of the financial challenge had yet to be fully grasped by the NHS. There was 'disturbing evidence that the measures currently being used to try to control the financial situation could fairly be described as "short-term expedients" or "salami slicing"'.⁶

While we cannot conclusively prove that rationing decisions highlighted in this report are based purely on financial motivations, some CCGs' policies do not reflect clinically accepted evidence-based guidance so we question how these policies were conceived. Data published on the RCS website⁸ also demonstrate wide variations in age- and population-standardised rates of access to key surgical services, indicating a number of procedures are likely being rationed by CCGs or providers.

CCGs and the role of commissioning guidance

In this report we compare CCG commissioning policies with guidance from the RCS/SSAs, along with NICE guidance where available.

In NICE the NHS already has an established authority to produce evidence-based guidance for health practitioners and commissioners. NICE's role in assessing the evidence base for clinical interventions and their conclusions on the cost effectiveness of different procedures provides the NHS with an invaluable resource in making decisions on service commissioning. While CCGs are not required by law to follow such general guidance (apart from 'technology appraisals'), failure to provide a clear rationale for deviating from the guidance could potentially leave CCGs open to legal challenge. This follows from a recent legal case that ruled that CCGs are under an obligation in public law to have regard for NICE guidance and to provide clear reasons for any general policy that does not follow NICE guidance.^{9,10}

In addition to NICE guidance, the RCS (funded by NHS England and using a NICE-accredited process) has developed in conjunction with the relevant SSAs commissioning guidance for 29 surgical procedures. The guidance is designed to assist CCGs in making decisions about appropriate healthcare for specific clinical circumstances. Every piece of guidance was put together by an expert committee, making use of the available clinical evidence, and subject to a public consultation.

Methodology

For this report we analysed commissioning policies relating to five surgical interventions carried out in the NHS and compared those policies with evidence-based guidance published by the RCS/SSAs as well as by NICE.

The five surgical interventions investigated were:

- tonsillectomy
- hip replacement
- inguinal hernia repair
- surgical treatment of otitis media with effusion (often referred to as glue ear)
- surgical treatment of gallstone disease (although we have removed this procedure from the analysis as the majority of CCGs do not have policies in place).

These procedures were selected on the basis that good evidence-based guidance exists to inform commissioners of which clinical circumstances are appropriate for referring patients for the procedure. In addition, information hosted on the RCS website indicates that wide variation in access exists for these procedures, suggesting that some areas may be under or over-commissioning the service.⁸ We may review further procedures in due course.

The commissioning policies for each procedure were sought from 58 CCGs, a number that represents 27% of the total 211 CCGs in England. The CCGs chosen comprised two groups: 'wave 1' and 'deficit'. For a list of CCGs, please see *Annex: Clinical commissioning groups*.

Wave 1 CCGs are made up of the 35 commissioning groups that were assessed in the first wave of authorisation by NHS England during 2012–2013. They were chosen for this investigation because, by virtue of having been in the first wave of commissioning organisations authorised, they should theoretically have in place the most developed commissioning plans.

The group of 'deficit' CCGs consists of the 24 CCGs identified in November 2013 that were forecasting a deficit for their first year of operation.¹¹ This group was selected in a

bid to assess whether those CCGs in greater financial difficulties are more likely to have restrictive referral criteria in place.

Freedom of Information requests were submitted to each of the CCGs identified in April 2014. Of the total 58 CCGs (Oxford is both a deficit and a wave 1 CCG so the total number is 58), we received responses from 54. Two of these refused to disclose their policies, citing section 22 of the *Freedom of Information Act 2000* (future publication); one of these CCGs, Bury, was a wave 1 CCG while the other, Oldham, was a CCG in deficit. The total number of commissioning policies obtained was therefore 52.

The commissioning policies were collated and compared with any available guidance from NICE and the joint commissioning guides from the RCS/SSAs. Where it was unclear whether a CCG's policy was in line with NICE or RCS/SSA guidance, we asked for additional opinions from the SSAs or other surgical specialists.

The majority of CCGs reported that they did not hold a commissioning policy for the surgical treatment of gallstone disease. This meant there was insufficient information to proceed with analysing this procedure and, consequently, it was decided to exclude it from this report.

It is disappointing that a small number of CCGs were not prepared to share their policies. Government legislation requires CCGs to publish on their websites their general policies on whether particular healthcare interventions (such as hip and knee replacements) are made available for their populations.¹² It is important that the government and NHS England remind CCGs of their obligations to publish their policies.

Findings

Below we have analysed the commissioning policies for each of the procedures examined in this report. As well as highlighting why they are an important and clinically necessary procedure, we have detailed the criteria listed in evidence-based guidance from NICE and the RCS/SSAs.

In the results section we have segregated the CCGs into groups based on whether they conform with the guidance or, if not, on which criteria they differ from it.

Hip replacement

Elective hip replacement is a common surgical treatment in response to painful conditions of the hip joint, such as osteoarthritis.

While we know that roughly 60% of people with hip pain will exhibit sustained improvement within 12 months,¹³ over 64,000 currently have a total hip replacement on the NHS every year owing to limitations to their mobility and quality of life as a result of acute pain.¹⁴ Total hip replacement can be cost effective, returning 90% of patients to their previous job and enabling older people to remain independent.¹⁵ The cost of a total hip replacement is £10 per week if the prosthesis survives 10 years (of which there is a 95% probability) and £7.50 per week if it survives 15 years (of which there is an 85% probability). According to the BOA, the national tariff for total hip replacement is therefore deemed to be cheaper than long-term conservative treatment.

However, widespread variation in bilateral and unilateral hip replacement procedures exists in England, with 77.87 age-standardised procedures per 100,000 of the population in Newham CCG compared with 360.31 in Kernow CCG.¹⁶

What does the guidance say?

Neither NICE¹⁷ nor the RCS commissioning guidance¹⁵ recommend any referral threshold (for example, a particular pain 'score' that should be reached before surgery is considered). NICE guidance states explicitly that decisions should be based 'on discussions between patient representatives, referring clinicians and surgeons, rather than using scoring tools for prioritisation'.¹⁸

The Oxford hip score (referred to in a number of CCGs' guidance) is used as a reliable outcome measure to assess results following joint replacement surgery. It uses a range of scores from 0 to 48, with a lower number indicating greater pain and immobility.

However, its use as a preoperative tool to assess a patient's need for surgery has never been validated and evidence suggests that the system is unsuitable for setting referral criteria.¹⁹⁻²¹ The BOA and the British Hip Society have said that there is 'no evidence for using the Oxford hip score as a screening tool' and its use in setting thresholds or prioritising patient access to surgery is therefore 'not appropriate'.²²

NICE recommends that referral to surgery should occur when the individual experiences joint symptoms (such as pain, stiffness and reduced function) that have a substantial impact on his or her quality of life and that have remained unimproved through non-surgical treatments. NICE guidance maintains that patient-specific factors (such as age, sex, smoking, obesity and co-morbidities) should not be barriers to referral in commissioning policies, and that referral should be made before there is prolonged and established functional limitation and severe pain.

The RCS/BOA guidance says surgery should be considered when:

- pain is inadequately controlled by medication
- there is restriction of function
- quality of life is significantly compromised
- there is narrowing of the joint space on radiography

It is standard practice for conservative treatments such as physiotherapy and medication to be tried thoroughly before surgical referral. The BOA states that these methods should be tried for up to 12 weeks.¹¹ If these interventions have failed to alleviate a patient's pain and disability following this period, there is no evidence to suggest they will become effective beyond the 12-week period.

Having established the need for surgical intervention, the operation should be performed as early as possible in order to achieve the best outcome.

What do CCG policies say?

27% of CCGs (14 of 52) had policies clearly following the RCS/BOA and NICE clinical guidance.

29% of CCGs (15 of 52) had no policies in place whatsoever. This in itself is of concern given the wide variation in the number of age- and sex-standardised procedures carried out per

100,000 of the population across different CCGs in England. This variation suggests CCGs would benefit from having a clear policy in place to standardise referral practice and avoid either over- or under-commissioning of hip replacement procedures.

Of most concern is that 44% of CCGs (23 of 52) had arbitrary referral criteria in place. These policies broadly require patients to be experiencing a certain amount of pain or disability (with no consistency in the threshold used across different CCGs) or for patients to lose weight before surgery. Such criteria are in explicit contravention of NICE and surgical commissioning guidance, and have no clinical justification in being applied to a general population.

Policy sets a hip score threshold (16 CCGs)

Sixteen CCGs imposed an Oxford hip score threshold as part of a case management approach. As mentioned previously, such scores are unsuitable for setting referral criteria and assessing a patient's need for surgery.

As an example of how the CCGs examined in this report incorporated hip scores into their policies, Mid Essex and Stoke on Trent CCGs' policies mandate that referrals will not be accepted if the patient has an assessed score of ≥ 20 . East Leicestershire and Rutland CCG, however, states that it expects 90% of referrals to have a confirmed hip score of < 25 . A score of around 25 roughly means a patient is regarded as experiencing moderate to severe hip pain with restricted function that has significant impact on his or her quality of life. Any patient with a score above 25 will only be referred in extenuating circumstances.

CCGs that set a hip score threshold

Basildon and Brentwood
Castle Point and Rochford
Coastal West Sussex
Croydon
East Leicestershire and Rutland
Gloucestershire
Kingston
Leicester City
Liverpool
Mid Essex
North Staffordshire
Oxfordshire
Stoke on Trent
Wandsworth
Warrington
West Leicestershire

Guidance from both the RCS/BOA and NICE is unequivocal in stating that such scoring systems should not be used for prioritisation or the setting of referral thresholds

The reliance by some CCGs on the use of scoring thresholds may withhold access to surgery for some patients, thereby denying them medical intervention that can improve their quality of life dramatically. Delaying access to surgery also adversely affects surgical outcomes, meaning the operation may not be as beneficial as if it had been carried out earlier.

The inclusion of such criteria, which clearly differentiate from evidence-based guidelines and add to the restrictiveness of the commissioning policy, could therefore have a significant impact in reducing patient access.

Policy requires patients to be below a certain BMI or to have demonstrated weight loss (7 CCGs)

In total, seven CCGs had some form of criteria related to weight or body mass index (BMI). For example, Sandwell and Birmingham CCG's policy states that referred patients should have a BMI of 'below 40kg/m² or, if above, that there is documented participation in a comprehensive weight management programme for at least six months and the patient has reduced their body weight by at least 10%'.

CCGs that require BMI score or weight loss

Coastal West Sussex

Dudley

Gloucestershire

Sandwell and West
Birmingham

Shropshire County

Wakefield

Warwickshire North

Coastal West Sussex and Gloucestershire CCGs have criteria relating to both hip score and BMI.

Again, the clinical guidance is clear that obesity should not be a barrier to surgery. According to the BOA, there is no consistent evidence that patients with a high BMI who undergo hip replacement surgery do better or worse than other patient groups.²² Although a patient's weight is a consideration for any surgical intervention, BMI has no bearing on the function of the prosthesis and the procedure is an effective operation for any patient regardless of his or her weight. The BOA has said that weight should not be used as a criterion to refuse or delay referral to surgery for patients who may be in extreme pain with advanced arthritis. Doing so, it says, 'may be unethical'.²²

Similarly, NICE guidance says that 'patient-specific factors (including age, sex, smoking, obesity and co-morbidities) should not be barriers to referral for joint surgery'.¹⁷

Tonsillectomy

Tonsillectomy is one of the most common surgical procedures performed on the NHS, with 47,141 operations carried out in 2012–2013 on the NHS in England.¹⁴ The procedure has been shown to be effective in addressing severe and recurrent sore throat in children and adults, which primarily arises as a result of inflammation of the tonsils due to infection (tonsillitis).

In the 1950s there were about 200,000 tonsillectomies performed annually, in a number of cases for no clinical reason. However, in the understandable drive to reduce the number of unnecessary operations, there is a risk that there are now too few tonsillectomies performed in some areas, with others still over-relying on the procedure.²³ As an illustrative example, the number of age-standardised tonsillectomies performed in the 12 months up to the second quarter of 2013–2014 ranges from 7.48 per 100,000 of the population for North and West Reading CCG to 127.16 per 100,000 of the population for Tameside CCG.¹⁶

What does the guidance say?

The RCS has published guidance in conjunction with ENT UK outlining the criteria in which patients presenting with recurrent tonsillitis should be referred for tonsillectomy.¹⁸ The primary defining criteria the guidance recommends before primary care should refer the patient to secondary and surgical care settings are based on the Scottish Intercollegiate Guidelines Network criteria.²⁴ This stipulates that:

- the individual should have a sore throat due to tonsillitis;
- the episodes are disabling and prevent normal functioning;
- the individual should have seven or more well-documented, clinically significant, adequately treated sore throats in the preceding year
- five or more such episodes in each of the preceding two years *or* three or more such episodes in each of the preceding three years.

These criteria are designed to avoid over-referral and to treat patients with clinical need.

NICE has also published guidance on the management of sore throat, including details on when a patient should be referred for tonsillectomy.²⁵ Its guidance follows a similar formula to that from the RCS/ENT UK and recommends that:

- the child has five or more episodes of acute sore throat per year, documented by the parent or clinician
- symptoms have been occurring for at least a year
- the episodes of sore throat have been severe enough to disrupt the child's normal behaviour or day-to-day functioning.

What do CCG policies say?

The majority of CCGs (41 out of 52) follow the RCS/ENT UK and NICE guidance.

However, eight CCGs required documented absence from school or work and/or failure to thrive, which is contrary to clinical guidance. The latter requirement is particularly problematic as it is subjective and may lead to varied access to treatment.

Two CCGs require a minimum six-month period of watchful waiting in primary care. However, this is unnecessary given that symptom pattern has already been established over the course of one year (as is required by the policy). The addition of a six-month watchful waiting period on top of this only functions to postpone surgical intervention. It also potentially contravenes the Department of Health requirement that commissioners cease imposing minimum waits on treatment.³

Policy requires documented absence from school or work and/or failure to thrive (8 CCGs)

Eight CCGs have imposed a requirement that the episodes of tonsillitis have significant impact on quality of life as documented by absence from school or work and/or failure to thrive. In the case of Coastal West Sussex CCG, for example, the policy says that sore throats must be 'disabling and prevent normal functioning, the symptoms must have been present for at least a year, and there must have been five or more episodes a year and two or more weeks' absence from work/school/college'.

CCGs that require documented absence and/or failure to thrive

Coastal West Sussex

Croydon

East Staffordshire

Haringey

Kernow

Kingston

Somerset

Wandsworth

As outlined above, the guidance states that the episodes of sore throat should be disabling and prevent normal functioning. However, there is no recommendation that the impact of

the disease on a patient's quality of life be quantified through documented evidence of absence from school, work or any other institution and this requirement is especially unsuitable for patients who may be unemployed or who do not attend school.

Both these criteria (documented evidence of absence from school and/or failure to thrive) add an additional layer of complexity that is supplementary to the guidance and may in some cases act to deny patients surgery.

Policy requires extended period of watchful waiting (2 CCGs)

Two CCGs require a minimum six-month period of watchful waiting in primary care. For example, North East Lincolnshire CCG's policy states that the patient must have 'five episodes of sore throat in one year requiring antibiotics, symptoms for at least two years, the episodes are disabling and prevent normal functioning, and there must be a *six-month period of watchful waiting under the care of the patient's GP*'.

CCGs that require
extended period of
watchful waiting

Gloucestershire

North East Lincolnshire

This six-month period of watchful waiting is cited as an opportunity for symptom pattern to be firmly established and for the patient to have the necessary time to fully consider the implications of surgery. However, this would seem unnecessary given that symptom pattern has already been established over the course of one year. The addition of a six-month watchful waiting period on top of this therefore only serves to delay access to treatment.

Additionally, in the case of North East Lincolnshire CCG specifically, the requirement for the patient to be exhibiting symptoms for at least two years is in excess of the one year recommended in evidence-based guidelines.

Both these requirements add to the restrictiveness of the policy and can act to reduce patient access to care.

CCG has no policy for this procedure

One CCG did not have a policy or referral thresholds for tonsillectomy.

CCGs that have no policy

Rotherham

Inguinal hernia

Groin hernia repair operations are another common surgical procedure carried out on the NHS, with around 65,000 operations in 2012–2013.¹⁴ Surgery is usually required to relieve troublesome pain or discomfort, interfering with daily activities, leisure or work and impairing quality of life, or to prevent complications such as obstruction or strangulation of the hernia.

The variation in the rate of inguinal repair operations ranges from 98.43 per 100,000 of the population in North East Lincolnshire CCG to 353.24 per 100,000 of the population in the Isle of Wight CCG.¹⁶

What does the guidance say?

Guidance from the RCS and the Association of Surgeons of Great Britain and Ireland (ASGBI) states that surgical repair should be offered to all patients presenting with symptomatic hernias.²⁶ Patients with totally asymptomatic inguinal hernias may require surgery in the future, although they can be managed conservatively in the first instance. This decision should be based on a patient-by-patient basis through discussion between the patient and clinician.

NICE guidance simply states that surgical repair should be undertaken in most individuals presenting with an inguinal hernia in order to close the defect, alleviate symptoms of discomfort and/or prevent serious complications (ie obstruction or strangulation of the hernia).²⁷

What do CCG policies say?

The majority of CCGs did not have any policy in place for this procedure. Again, this is problematic as it denies clinicians at a local level a set of clearly defined conditions on who to refer and when, and it undermines equitable local access to inguinal hernia repair.

Only 27% of CCGs (14 out of 52) comply with RCS/ASGBI and NICE guidance.

Policy requires history of incarceration and/or hernia to increase in size from month to month

Eight CCGs (15%) have criteria requiring there to be a history of incarceration and/or for the hernia to increase in size from month to month. Delaying surgery in this manner can be dangerous since it exposes patients to unnecessary risk and can also affect their outcome as they become older and less fit. In addition, hernias will not increase in size in a smooth fashion and in some months there may be significant increases while in

others the increase may be very limited. This makes it extremely difficult to assess when a patient may require surgery.

Both of these elements, either taken together or in isolation, are added requirements that are beyond those necessary to determine whether a patient is in need of an operation to repair an inguinal hernia. For example, a hernia may be symptomatic and therefore require surgical intervention but it may not actually increase in size. Similarly, a patient may not have a history of incarceration but could still suffer from debilitating pain that can have an impact on his or her quality of life.

CCGs that require history of incarceration/increase in size

Cambridgeshire and Peterborough

East Surrey

Gloucestershire

Harrow

Hillingdon

Oxfordshire

Shropshire County

Warwickshire North

These requirements deny patients access to a procedure that, if not carried out, can lead to dangerous complications such as strangulation. Strangulation is a potentially life-threatening complication that requires emergency surgical intervention. Such intervention is associated with a mortality rate that is seven times higher than when the operation is carried out electively²⁸ and is also an extra burden on hospital resources.

Although the guidance advocates a watchful waiting approach for asymptomatic or minimally symptomatic cases, the majority of patients will develop symptoms requiring surgical intervention over time. Clinical opinion feeding into this report has indicated that, more often than not, there is merit in repairing asymptomatic hernias in most cases. The decision to operate should therefore always be taken in consideration of the risks and benefits of surgery after full discussion with the patient.²⁹ As a result, it is not acceptable to impose restrictive criteria that deny patient access to a procedure that potentially limits pain, improves quality of life and has indirect economic benefits.

Otitis media with effusion

Otitis media with effusion (OME), a condition that results in the build-up of fluid in the middle ear, is a common condition of childhood that will affect 80% of children before the age of 10.¹ It can result in hearing loss, which is usually transient and self-limiting but may become more persistent, leading to increased risk of educational, language and behavioural problems.³⁰

Most cases of OME will resolve spontaneously but surgical intervention can be used to treat recalcitrant cases. This is usually in the form of grommet insertion. NICE provides guidance on when surgical intervention would be considered an appropriate course of action.³¹

What does the guidance say?

The care pathway guidance for OME produced by the RCS and ENT UK³⁰ is based on the NICE clinical guidance.³¹ This recommends that the following criteria define when a child would benefit from surgical intervention:

- Surgical intervention may be considered when there is persistent bilateral OME documented over a period of 3 months with a hearing level in the better ear of 25–30 decibels hearing level (dBHL) or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available).
- Alternatively, in exceptional circumstances, healthcare professionals may consider surgical intervention in children with persistent bilateral OME with a hearing level of less than 25–30 dBHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant.

What do CCG policies say?

We welcome the fact that most CCGs (77%) have a policy that follows the above guidance. Six CCGs had no policies with a further six CCGs requiring extended watchful waiting.

Policy requires extended watchful waiting (6 CCGs)

Six CCGs require patients to undergo a further watchful waiting period in excess of that recommended by evidence-based guidance. For example, Portsmouth CCG's policy requires that 'there has been a period of watchful waiting for three months in primary care from diagnosis of OME, followed by a further period of watchful waiting for up to three months in secondary care'. Stafford and Surrounds CCG, on the other hand, requires there to have been 6 episodes over the past 12 months *or* a period of at least 6 months of

watchful waiting *and* persistent hearing loss detected over two occasions separated by 3 months or more.

The guidance is clear that hearing loss should be assessed over a period of three months between hearing tests. Mandating an extended watchful waiting period therefore only serves to delay access to this treatment and can act as an arbitrary barrier to surgical intervention.

CCGs that require
extended watchful
waiting

Cannock and Chase

Coastal West Sussex

North East Lincolnshire

North Hampshire

Portsmouth

Stafford and Surrounds

Annex: Clinical commissioning groups

Freedom of Information (FOI) requests were sent out to the following list of CCGs.

Of these 58 CCGs, we heard back from 54. Those CCGs that did not respond to our FOI request were Wokingham, Newbury and District, North and West Reading, and South Reading.

Of the 54 that did respond, 52 supplied their policies and 2 declined, citing section 22 of the *Freedom of Information Act 2000* (future publication). The two CCGs that declined were Bury and Oldham.

CCGs that received FOI requests	
Barnet	Liverpool
Basildon and Brentwood	Luton
Bassetlaw	Mid Essex
Bedfordshire	Newbury and District
Blackpool	North and West Reading
Bury	North East Lincolnshire
Calderdale	North Hampshire
Cambridgeshire and Peterborough	North Somerset
Cannock Chase	North Staffordshire
Castle Point and Rochford	North Tyneside
Coastal West Sussex	Oldham
Croydon	Oxfordshire
Cumbria	Portsmouth
Dudley	Rotherham
East and North Hertfordshire	Sandwell and West Birmingham
East Leicestershire and Rutland	Shropshire
East Riding	Somerset
East Staffordshire	South East Staffordshire and Seisdon Peninsular
East Surrey	South Gloucestershire
Eastbourne, Hailsham and Seaford	South Reading
Gloucestershire	Stafford and Surrounds
Great Yarmouth and Waveney	Stoke on Trent
Haringey	Wakefield
Harrow	Wandsworth
Hillingdon	Warrington
Islington	Warwickshire North
Kernow	West Cheshire
Kingston	West Leicestershire
Leicester City	Wokingham

References

1. Figure based on 2012–2013 finished consultant episodes for each of the procedures listed in this report (tonsillectomy, total hip replacement and inguinal hernia repair). No figures are available for surgical treatment of otitis media with effusion.
2. The letter is available at <http://www.hsj.co.uk/Journals/2011/10/10/k/d/d/Keogh-letter.pdf> [cited July 2014].
3. Department of Health. *Patient Choice*. London: DH; 2011.
4. Hansard, HC Deb, 20 June 2012, c855.
5. Monitor. *Closing the NHS Funding Gap: How to Get Better Value Health Care for Patients*. London: Monitor; 2013.
6. House of Commons Health Committee. *Public Expenditure: Thirteenth Report of Session 2010–12*. London: TSO; 2012.
7. House of Commons Committee of Public Accounts. *Department of Health: Progress in Making NHS Efficiency Savings: Thirty-ninth Report of Session 2012–13*. London: TSO; 2013.
8. Information on the Data Tools. Royal College of Surgeons. <http://www.rcseng.ac.uk/healthcare-bodies/nscc/data-tools> [cited July 2014].
9. R (on the application of Rose) v Thanet CCG, Court of Appeal, Administrative Court, April 2014.
10. Price C. CCG warned in court for disregarding NICE guidance. *Pulse*. 2014 May 7.
11. Dowler C. Revealed: the 24 CCGs forecasting deficits in their first year. *HSJ*. 2013 November 22.
12. The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012. [legislation.gov.uk. http://www.legislation.gov.uk/ukksi/2012/2996/part/7/made](http://www.legislation.gov.uk/ukksi/2012/2996/part/7/made) [cited July 2014].
13. van der Waal JM, Bot SD, Terwee CB *et al*. The course and prognosis of hip complaints in general practice. *Ann Behav Med* 2006; **31**: 297–308.
14. Hospital Episode Statistics, Admitted Patient Care, England – 2012–13. Health and Social Care Information Centre. <http://www.hscic.gov.uk/catalogue/PUB12566> [cited July 2014].
15. Royal College of Surgeons. *Pain Arising from the Hip in Adults*. London: RCS; 2013.
16. Procedures Explorer Tool. Royal College of Surgeons. <http://rcs.methods.co.uk/pet.html> [cited July 2014]. (NB: This uses data from Hospital Episodes Statistics.)
17. National Institute for Health and Care Excellence. *Osteoarthritis*. London: NICE; 2014.
18. Royal College of Surgeons. *Tonsillectomy*. London: RCS; 2013.
19. Coleman B, McChesney S, Twaddle B. Does the priority scoring system for joint replacement really identify those in most need. *N Z Med J* 2005; **118**: U1463.
20. Dieppe P, Judge A, Williams S *et al*. Variations in the pre-operative status of patients coming to primary hip replacement for osteoarthritis in European orthopaedic centres. *BMC Musculoskeletal Disord* 2009; **10**: 19.
21. Judge A, Arden NK, Price A *et al*. Assessing patients for joint replacement: can pre-operative Oxford hip and knee scores be used to predict patient satisfaction following joint replacement surgery and to guide patient selection? *J Bone Joint Surg Br* 2011; **93**: 1,660–1,664.

22. Private correspondence with The Royal College of Surgeons of England; 2014.
23. ENT UK. *Indications for Tonsillectomy: Position Paper, ENT UK 2009*. London: ENT UK; 2009.
24. Scottish Intercollegiate Guidelines Network. *Management of Sore Throat and Indications for Tonsillectomy*. Edinburgh: SIGN; 2010. (Similar to NICE, SIGN develops evidence-based clinical practice guidelines for the NHS in Scotland.)
25. Sore Throat – Acute. National Institute for Health and Care Excellence. <http://cks.nice.org.uk/sore-throat-acute> (cited July 2014).
26. Royal College of Surgeons of England. *Groin Hernia*. London: RCS; 2013.
27. National Institute for Clinical Excellence. *Laparoscopic Surgery for Inguinal Hernia Repair*. London: NICE; 2004.
28. Strangulated Hernia. British Hernia Centre. <http://www.hernia.org/types-of-hernia/strangulated-hernia/> (cited July 2014).
29. Mizrahi H, Parker MC. Management of asymptomatic inguinal hernia: a systematic review of the evidence. *Arch Surg* 2012; **147**: 277–281.
30. Royal College of Surgeons of England. *Otitis Media with Effusion*. London: RCS; 2013.
31. National Institute for Health and Clinical Excellence. *Surgical Management of Otitis Media with Effusion in Children*. London: NICE; 2008.

Produced by RCS Publishing

The Royal College of Surgeons of England
35-43 Lincoln's Inn Fields
London
WC2A 3PE

©The Royal College of Surgeons of England 2014
Registered charity number 212808

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior written permission of The Royal College of Surgeons of England.

While every effort has been made to ensure the accuracy of the information contained in this publication, no guarantee can be given that all errors and omissions have been excluded. No responsibility for loss occasioned to any person acting or refraining from action as a result of the material in this publication can be accepted by The Royal College of Surgeons of England and the contributors.