Elective Surgery and the NHS

A Surgical Forum Discussion Paper

THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH

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Introduction

The Surgical Forum, which comprises of the four Royal Colleges of Surgeons of Great Britain and Ireland and the Federation of Surgical Specialist Associations, debated the question 'Elective Surgery – What Can the NHS Afford?' in January 2018. The theme had been decided upon well before the current winter pressures crisis was apparent and the discussion took on additional urgency and relevance. This winter, all commentators agree that the NHS is in crisis lacking manpower, infrastructure and financial resource leaving the health service unable to deliver a comprehensive service. While short term expedients have been introduced to cope with winter pressures it is clear that a longer term solution is required.

Historical perspective

The NHS was conceived 70 years ago at a time when a quarter of homes had no electricity, children left school at 15 and most of the male population worked in manual industries. Most women worked in the home, infectious diseases were a major cause of death and industrial injuries were common. When the NHS launched in 1948, 30 million people registered with NHS doctors. In the year before the launch, 7 million prescriptions were issued monthly but, by 1951, 19 million prescriptions were being issued each month. Another indicator of the success of the new scheme was that £1 million a year had been allocated for optician services but, in the first year, £32 million was spent. The NHS has never been adequately funded.

UK population demographics have changed beyond recognition since the introduction of the NHS in 1948. In 2007, pensioners outnumbered children in the population for the first time increasing the burden of degenerative disease and elective surgery workload. The incidence of obesity has increased from 13.2% to 26.9% between 1993 and 2015 and diabetes now affects 3% (2 million) of the population – bringing with them a significant surgical workload. A 50% reduction in NHS bed capacity between 1987 and 2016 and an estimated population increase to 74 million by 2039 (Office of National Statistics) add to the pressures. The limited bed base is a significant problem already and is likely to be compounded by the demographic changes.

Current spending on the NHS

Figures from the Institute of Fiscal Studies (IFS) show that we spend 8% of our Gross Domestic Product (GDP) on healthcare, which places us 8th in the league table of G20 countries. The Government has made clear its intention to cap growth in healthcare spending and the projected funding gap is projected to widen.

What is the legal basis of NHS treatment?

As the law stands, no individual has the right to demand a specific NHS treatment but the NHS Constitution sets the 18 week wait for treatment. Clinical Commissioning Groups (CCGs) need only to have regard for that timing. Indeed, not to prioritise treatment could be argued as unlawful. On the other hand, a blanket ban on any procedure could be seen as fettering the discretion of the purchaser and so be unlawful. The result is there must be a process to enable provision of care for exceptional circumstances. Exceptionality is not based on uniqueness or on social factors alone. To exclude any treatment from NHS provision would most likely require re-drafting the NHS Act.

How are funding constraints dealt with at present?

The introduction of the purchaser provider split in the 1990s was supposed to introduce an element of competition into the system. Prior to that time, all treatments (including cosmetic surgery) were available but access was governed by waiting lists, which could be infinite in practice.

As a result of defining waiting times, mechanisms had to be found to control the inflow of patients requesting non-urgent treatments. The details of the system used vary according to the jurisdiction, but usually involves tightly controlled criteria, which must be fulfilled before treatment is funded. The National Institute of Clinical and Healthcare Excellence (NICE) plays a pivotal role in this system. If a treatment is covered by NICE guidance, by and large, it should be funded. This system has led to Judicial Review being used to challenge funding decisions, but even a successful challenge does not mean a treatment will be funded and provided, only that the decision must be looked at again by the purchaser.

Lack of understanding and clarity on what is required in requesting exceptional funding has led to increasing frustration in the profession and progressive disengagement from the process because it is incessant and inconsistent between purchasers and so viewed as fundamentally flawed. The new Accountable Care Organisations and Integrated Care Systems are in their very early stages and will take years to have their full impact on care delivery.

The role of The National Institute of Clinical and Healthcare Excellence (NICE)

Over 180 NICE surgical guidelines exist, which should be seen as a starting point for any discussion on thresholds or prioritisation but they are not a mandate for what should or should not be provided. Going forward, urgent assessment of the cost effectiveness of any new (and often expensive technology, such as robotics) is required to demonstrate benefit. NICE is well placed to perform this function and is producing decision aids to help move the focus of what the patient wants or needs and what is cost effective and achievable. A system needs to be designed to reduce the risks of NICE guidance not being followed and hence avoid patient and professional disengagement.

The Commissioner's perspective

The current situation is perceived by all as being grim and there is widespread concern on all fronts about the future. The number of Clinical Commission Groups (CCGs) is being reduced by their amalgamation into larger organisations, which seem to be not far removed from the old Strategic Health Authorities. It is thought they will eventually match the Sustainability and Transformation Partnerships (STPs), which appear to be morphing into Integrated Care Systems (ICS) especially in metropolitan areas. There is, however, widespread agreement that setting thresholds for interventions is important and that requires close co-operation between commissioners and clinicians. The tension between guidelines, individual opinion and common sense needs to be overcome when it comes to setting thresholds.

Currently, we have a system designed for single episodes of care, which relies on Primary Care to control costs and complex contracting systems which are viewed as unbalanced. In addition, we have the demographic changes and increasing patient needs and expectation. It is clear that the internal market has not delivered what was expected of it. For commissioners, it is difficult to know what the intervention rate for any condition should be nationally. A number of different data sources are being developed, which may prove useful in looking at this (e.g. the Atlas of Variation).

The complexity of healthcare delivery is huge. There are multiple commissioners, multiple regulators and multiple providers, including the primary/secondary care split. The Clinical Commission Groups (CCGs) use benchmarking tools to compare intervention rates between areas and they develop policies with input from relevant specialists. These policies are normally agreed by Local Review Groups and they are a powerful tool in the application of thresholds for treatment. Despite this, policies can be perceived as opaque, it is unclear who is in charge and the thinking may appear fragmented and the purpose ill-defined. In addition, organisations may have conflicting priorities and clinician groups are fragmented.

Getting It Right First Time (GIRFT)

GIRFT is an initiative that is being strongly backed by the Government. It was born out of the findings of the National Joint Registry, which is producing high quality data about which orthopaedic procedure work and those where the evidence is less secure. Funding has been provided to roll out the concept across the specialties. GIRFT should help reduce the variability in surgical performance around the country and should lead to increasingly cost-efficient management strategies and, hopefully, reduce the need for revision or secondary surgery.

The Public Health Information Network (PHIN) perspective

Independent Sector Treatment Centres (ISTCs) already provide elective surgical care for NHS patients in the private sector. Figures from the BMA in 2016[1] showed that £7 billion out of the £101.3 billion total NHS budget was spent on ISTCs and they performed 490,000 operations in 2014 (4.4% of the total), which was roughly equivalent to the numbers of NHS procedures performed in the private sector. In other words, just under 10% of elective NHS surgery already takes place in the independent sector and 1 in 3 NHS hip and knee replacements are performed in the independent sector. It would appear that the 'Rubicon has already been crossed'. Patient reported outcomes (PROMS) are used widely in the independent sector and must be part of any assessment of cost/benefit outcomes.

Provided that appropriate governance arrangements can be put in place, there are opportunities for the NHS and the private sector to work more closely, especially at times of pressure, when utilising spare capacity in the private sector might be considered, such as undertaking elective surgical procedures, and even providing ICU/HDU facilities during winter pressures. It is essential, however, that any short term expedient measure does not damage the future NHS provision of care.

For example, inpatient lists could be moved, on a planned basis, during winter pressures to the private sector. The surgeon and anaesthetist are already being paid by the NHS to perform the list (as are the theatre team if they also move to staff the list) and so there would be no need to pay waiting list rates. If a hospital fee can be negotiated even slightly below tariff, the NHS trust will also make some income from the cases done. Even if the list is done at tariff, the NHS is not paying more than if one of its own trusts were doing the work. With this proposal, important opportunities for junior staff training would not be missed because the list would remain an NHS list. All agree that the NHS bed base is too small at present and such a scheme would allow flexibility in the bed base and, perhaps, obviate the need for the NHS to return to the days when the bed base was sufficient to absorb winter pressures, but which meant over capacity and over staffing in the rest of the year.

It has been suggested that care homes might be used as a step down facility during winter pressures, but their business plans are based on longer term stays rather than high turnover short term care, making their use an unlikely option.

The opportunities for surgical training in the independent sector should not be overlooked but approval of this will need input from the Joint Committee on Surgical Training (JCST.org) via the Schools of Surgery and the Deaneries, who would need to provide governance structures.

Training

The Association of Surgeons in Training (ASiT) and the British Orthopaedic Trainees' Association (BOTA) have shown the adverse effect on training of the cessation of elective work over the winter months and this must be reflected in the Annual Review of Competence Progression (ARCP) assessments, perhaps by applying a no fault extension to the length of training for those trainees who have been disadvantaged. There is little doubt that the current problems with rota gaps and cancelled elective work are having a negative impact on morale of the surgical workforce in training.

Summary

All agree that there is a problem, which cannot be ignored, but healthcare is not alone in suffering fiscal constraint. No one likes the term rationing when applied to healthcare, but we need to be realistic about the procedures we can provide and the Surgical Forum believes that a better, less emotive descriptor is needed. Currently, Realistic Medicine in Scotland, Choosing Wisely in England and Prudent Practice in Wales are all initiatives with similar goals encouraging shared decision making between patient and clinician to avoid inappropriate and sometimes costly interventions. Surgeons do need to be involved in funding decisions and, hence, with the CCGs but surgeons should not have complete discretion. There no single quick fix and the solutions will always have to reflect the current financial situation. There is widespread concern about the levels that some tariffs are currently set as they do not reflect the cost of performing the procedure.

It is clear that there remains widespread variation in surgical performance across the country. GIRFT will, hopefully, help address this variation but it not the whole answer. We need much more information on what procedures are clinically effective. Surgeons by nature tend to be enthusiasts, especially where new (and usually expensive) technology is concerned. NICE has the ideal place to adjudicate what the clinical effectiveness of any intervention is and, whilst surgeons are important in gathering that evidence, they can lack objectivity when it comes to weighing up the relative merits of procedures. Both NICE and GIRFT will be required to play pivotal roles in assessing the cost effectiveness of interventions. There may be a role for Public Health in weighing the evidence and incorporating Care of the Elderly specialists into preoperative care teams is viewed as essential. If we are to improve efficiency within secondary care, the entire patient flow needs to be considered from admission to discharge, including convalescent and step down care. However, improving efficiency alone will not bridge the gap in finite resources.

There is widespread agreement that the bed base is both critical and inadequate. There is no spare capacity in the NHS during the summer months to make up for the shortfall over the winter. Flexibility in the face of seasonal pressure is simply not possible with the current, inadequate bed base and high bed occupancy rates. There is additional capacity available in the independent sector and, because one third of NHS hip and knee joint replacements are already performed in the independent sector, it would require no change in policy to use that capacity. Increased use of the independent sector bed capacity would provide urgently needed relief from the current situation and would, in theory, also help in the long term. This opportunity should be explored. However, significant issues do exist with using the independent sector, particularly in relation to training junior surgeons, who cannot currently be indemnified for working in this sector. Nonetheless, establishing the precedent that six months of training in the private sector can be counted toward the Certificate of Completion of Training (CCT) should be urgently considered.

A solution could be to set up elective surgery units, which would stand alone from acute hospitals and so have ring fenced beds. They would not have problems with trainees working on site because they would be within NHS facilities. The ISTCs already fulfil part of this function and so no major policy change would be required. It is understood that ring fencing beds in acute NHS hospitals is not possible, politically or morally.

The Surgical Forum is an important voice in Great Britain and Ireland representing all four Royal Colleges of Surgeons and all the defined Surgical Specialty Associations. There is enthusiasm and willingness across the group to engage in finding a workable solution to the current problems. We should not forget the progress that has been made in the last two decades when waiting lists for a hernia repair could be as long as eight years. All are acutely aware that we risk making waiting lists infinite once again if patients are denied treatment if they do not fit closely defined funding requirements for procedures as laid out by the commissioning groups. In an ideal world, healthcare policy would be taken out of the political arena and the Surgical Forum's view is that a sustained cross party approach is urgently required, perhaps in the form of a standing Royal Commission. If that is deemed impossible to achieve, the Surgical Forum suggests the formation of a Joint Specialties Indications Committee, with a two year working life, to determine just what is affordable and deliverable. We strongly support the development of decision aids as outlined by NICE which will support CCGs and clinicians tasked to ensure cost effective care.

The Surgical Forum believes that seven day routine working in a health service which cannot currently deliver a five out of seven day service across all domains is unachievable within current funding. Our view is that efficiencies of scale by amalgamating CCGs into larger operating and strategic units with similar footprints to the STPs makes sense, but the provision of care still requires central coordination to avoid the postcode lottery.

Effective use of funding and effective provision of care

To address the problems we face in maintaining delivery of effective elective surgical care, we have to bear in mind that from the outset the NHS has never been fully funded. It is clear that an increase in funding, which will allow all that healthcare can provide to be delivered free at the point of delivery, is out of the question. No healthcare funding model can fulfil that aim today. A health tax or raising the general level of taxation or national insurance would raise public expectation that all healthcare will still be available but, in reality, that would not be the case and the consequence of unfulfilled promises would be politically explosive. To reach a level where all care is funded is simply not affordable. The Surgical Forum believes that there needs to be a discussion regarding whether or not all healthcare can remain free at the point of delivery. The NHS Acts make some provisions for that eventuality but excluding provision of some procedures would require re-drafting the Acts. Perhaps that time has come? The Surgical Forum is well placed and motivated to lead the national debate and the Royal Colleges of Surgeons are ideally equipped to provide assistance and advice to their national legislatures. All members of the Surgical Forum agree a paradigm shift in thinking is needed.

References

1. Privitisation and independent sector provision of NHS healthcare BMA, 2016

Acknowledgements

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