Paper for Bristol Health, Well Being and Adult Social Care Scrutiny Commission

Briefing on trends in surgery for hips, knees and cataracts.

Section 1: Purpose

To answer the question posed by Bristol Health, Well Being and Adult Social Care Scrutiny Commission raised in relation to the data published by the BBC on the levels of activity for hips, knees and cataracts in 2010 and 2012.

Section 2: Executive Summary

The data used by the BBC was produced by the Dr Foster organisation and looked to produce trends in activity between just two fixed points. Whilst the actual data was reasonably accurate this methodology of making assumptions on the trend (i.e. that activity is increasing or decreasing) from just two fixed points is limited, because there will be annual fluctuations.

The number of interventions undertaken when looking at a five year period has been fluctuating for hips and knees whereas for cataracts the numbers have decreased over a five year period. An increase or decrease does not correspond with good or bad, the more complex issues to be discussed with the Health Scrutiny Members include:

- **Who is making referral decisions?**
- **Why do commissioners need to manage demand for services and how do they do this?**

The issue of managing referrals and resources effectively should be openly shared and debated with the wider public as it is challenging, and should meet the needs of both patients and the wider population.

Section 3: Background

An email from the Commission was received based upon the report produced by the BBC, it is reproduced below:

"Health scrutiny members have been discussing recent press coverage about reducing numbers of knee and hip replacements and cataract operations. It appears from the figures provided for Bristol CCG (below) that the number of procedures within Bristol CCG has dropped significantly for knees and cataracts between 2010 and 2012. (Link to website http://www.bbc.co.uk/news/health-25185356)

	2010	**2012**	**Change**
Cataracts	2078	1679	-19.2%
Hips	481	458	-4.78%
Knees	665	558	-16.09%

This issue relates to the session the Commission had in January 2013 on GP referrals, and it seems timely to revisit this issue. Members would like to look at the reasons for the reduction in numbers of procedures."

Section 4: Who is Making Referral Decisions?
The referral decision is made by the referring GP or for internal referrals by the referring consultant. There is no reference to any further body or organisation.

The Bristol, North Somerset and South Gloucestershire (BNSSG) CCG's have adopted Clinical Commissioning Polices, in order to influence these referral decisions, but these Policies have been agreed by local GP's and secondary care Clinicians at many stages along the way. Firstly in the initial discussions about why a policy may be needed, then subsequently during the Policy Development process at the Clinical Policy Review Group then finally when being considered for adoption at the Clinical Commissioning Group Board, (see Appendix 2 for details of how BCCG develops policies).

In all instances for Cataract, Hip and Knee interventions the policies adopted are categorised as 'Criteria Based Access' Policies. This means that a GP wishing to make a referral to Secondary care can use the guidelines to help them make the decision. (Patient records can be retrospectively audited by the CCG to check that the guidelines are being followed).

Section 5: Why Does a Commissioner Need to Manage Demand for Services?
Commissioners as planners and purchasers of services manage demand for services to ensure that the whole health system does not fail. Each CCG has as statutory duty to break even. The NHS system would not work, if all demand (whether appropriate or not) were met within the first six months of a year, and all those who fell ill in the second half of the year had no resources left to fund services for them. This would not be acceptable or desirable. The CCG, as the responsible commissioner, has an obligation to manage the demand for services, and ensure that a good range of services are available to all, equitably, across the whole year.

There are many methods employed to manage demand, some of which are transparent and others that are not. Examples of not being transparent but inherently managing demand occurs when an Accident and Emergency (A&E) Department is relatively empty or full, when A&E is full it is possible that patients with minor ailments would be asked to attend their GP practice instead, thus managing demand for services, however, when A&E is empty staff on duty may attend to these same patients, in order to satisfy the patients' immediate needs thus inherently managing demand through the A&E Department.

A transparent method of managing demand is to agree with Clinicians the groups of patients that benefit most from a particular intervention and to write this down, as an access to treatment policy. This is rational, transparent and equitable.

The NHS is not funded to provide for every health need and every eventuality, and most people will recognise that there are limitations to what the NHS can and cannot fund. Budgets in the NHS have been protected, but have not seen considerable growth for a number of years. The 'Nicholson Challenge' has required that each CCG redistributes resources to best effect to manage more efficient, productive yet high quality and innovative services that meet the needs of the local population.

The NHS acknowledges that no treatment should be universally *un*available, as there may be reasons why one patient could benefit from an intervention over and above others who would not be eligible for a particular treatment. This is why all CCG's also have an Individual Funding Panel, where individual cases can be heard by the panel and funded if

there is evidence presented that the patient being considered would benefit from the treatment significantly more than others who are not able to access the treatment.

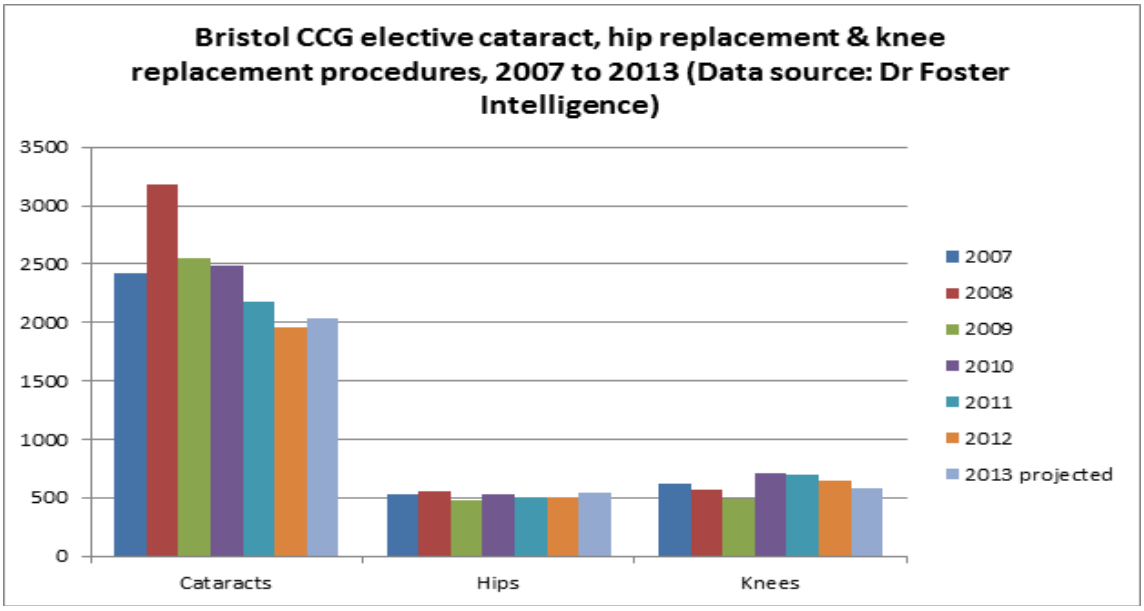
The Audit Commission report of April 2011, suggested that the financial challenge facing the NHS could be in part met by, “Releasing money to spend on treatments that have better outcomes for patients.” It is within this spirit of releasing resources to improve patient outcomes that policy development has occurred across the BNSSG area. The Audit Commission report suggested that PCT’s (now CG’s) could spend their money better, for example on other types of treatment, either for people with the same condition or to meet unmet needs in another group of patients. This is often termed allocative value. Allocative value is described succinctly below,

“During an era of growth..unmet need can be solved by investing three, four or five per cent more resources each year. In the era in which we now exist this option is not open to the NHS. We therefore need to move from simply considering whether decisions are evidence based and whether or not services are of high quality and safe. We need to think of value, the relationship of outcomes to cost.
There are three types of value:

- *Allocative value, how resources are divided among populations, for example between cancer and musculoskeletal disease or, within respiratory health between asthma, COPD, sleep apnoea and prevention.*
- *Technical value, how the resources are used to maximise the benefit and minimise the harm.*
- *Personalised value, how each individual’s decision relates to their values”.*

Healthcare Public Health Newsletter *Number 9 - October 2013*

Section 6: Was the Data Accurate?
In order to determine if the data was accurate we compared the BBC information with locally held information used for contracting purposes. Furthermore, in order to review trends over a longer period to determine if activity is indeed increasing or decreasing, and identify the trend, rather than any increase or decrease between two fixed points, a five year timescale was used.



The local data shows that for hips and knee surgery numbers have fluctuated from year to year so no trend is identified. However, for cataract surgery there has been a downward trend in numbers for the period 2008 – 2012.

In 2008 there was a steep spike in cataract activity (this was also experienced across North Somerset and South Gloucestershire, but not across the wider South West area). This local fluctuation was identified by commissioners and subsequently a cataract policy was developed to ensure that access to treatment was equitable. The policy was developed using the latest evidence base and guidelines around treatment (this evidence and guidance is still current). The BNSSG CCG Policies for Cataracts is provided for reference in Appendix 1.

The decrease in cataract operations from 2009 onwards was an expected trend, this is because this interventions is in the category 'Effective intervention with a close benefit or risk balance in mild cases' and whilst it is highly effective for some people, there a group of patients that could have the intervention for mild cases, but there would be a narrow risk/ benefit margin for these people, and the risks may outweigh the benefits. This is illustrated in the two case studies below.

Cataract Case Study Pre 2010
Mrs A was told by the optician that she had a cataract. The cataract was not affecting her sight at all, and as she did not know it was there, it was having no impact at all upon her quality of life, she was still able to drive, and look after her grandchildren. The optician referred her to the Doctor and advised that she have her cataract removed. The patient expected to have the cataract removed because this was what the optician had said was best. The GP found it difficult to change this expectation, and therefore made the referral onwards. The patient had the cataract removed. The risks of surgery were made clear to her. Unfortunately she had an infection in her eye following surgery, this meant she was unable to look after her grandchildren for two weeks, which meant her daughter had to take time off work, and Mrs A needed help at home. In this case the risks of the surgery were greater than the benefits, as she did not have an improved outcome following the surgery, as she was able to drive and participate in everyday life with no restraints prior to surgery.

Cataract Case Study After 2010
Mrs B was told by the optician that she had a cataract. The cataract was not affecting her sight at all, and as she did not know it was there, it was having no impact at all upon her quality of life, she was still able to drive, and look after her grandchildren. The optician advised her that as this was not affecting her quality of life or sight that they would monitor the cataract. Mrs B mentioned this to the GP next time she visited, and she ran through the criteria to access Cataract surgery with her, and provided her with a patient leaflet on cataracts to take home and read. The doctor explained that the criteria relate to both vision and quality of life, and Mrs B understood that the risks of surgery would outweigh the benefits at this time, but that her situation would continue to be monitored, and when both she and the Clinicians felt there would be a benefit to the surgery for he, she would be offered Cataract surgery. She would be fully involved in this decision, and understood the risks and benefits. She continued to drive and look after her grandchildren for several more years before she had surgery.

Summary
In summary whilst the data presented by the BBC was reasonably accurate for the two years, two points are not useful to identify trends in activity.

There was no acknowledgement by the BBC of the complexities of managing a whole health system, including the need for the NHS to manage demand for services and to balance the budget in each CCG area.

Bristol CCG welcomes the opportunity to discuss the need to manage demand for activity with key partners including members of the health scrutiny commission.
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Claire Beynon, Head of Threshold Management and Individual Funding Requests, South West Commissioning Support for Bristol Clinical Commissioning Group
February 2014

Appendix 1- Cataract Policy

	CATEGORY
Bristol	*Criteria Based Access*
North Somerset	*Criteria Based Access*
South Gloucestershire	*Criteria Based Access*

NHS Bristol Clinical Commissioning Group
NHS North Somerset Clinical Commissioning Group
NHS South Gloucestershire Clinical Commissioning Group

Cataract Policy (Referral for Assessment of Surgical Treatment)

Policy Statement: Date of Issue: 8th December 2010

A Referral for assessment for Cataract Surgery is regarded as a procedure of low clinical priority. This procedure is therefore subject to a RESTRICTED POLICY**.**

1. Before a referral is made, the referrer must confirm that:

   a) the patient understands that the purpose of referral is for assessment of surgery.
   b) The patient wishes to have surgery if it is offered.

2. Cataract surgery should not normally be offered to patients with a visual acuity of better than 6/12 in the worst eye. This applies to both first and second eye surgery.

3. Patients with the following symptoms or clinical conditions may benefit from cataract surgery when their visual acuity in the worst eye is better than 6/12. This list is not exhaustive:

   a) Patients experiencing significant glare and dazzle in daylight or difficulties with night vision when these symptoms are due to lens opacities. This indication applies particularly, but not exclusively to driving.
   b) Patients requiring particularly good vision for employment purposes.
   c) Difficulty with reading due to lens opacities.
   d) Significant optical imbalance (anisometropia or anisekonia) following cataract surgery on the first eye.
   e) Management of coexisting other eye conditions.
   f) Refractive error primarily due to cataract
   g) To improve visual acuity to better than 6/10 **where activities vital to daily living would otherwise cease.**

4. Cataract surgery/lens extraction should not normally be performed solely for the purpose of correcting longstanding pre existing myopia or hypermetropia.

5. The reasons why the patient's vision and lifestyle are adversely affected by cataract and the likely benefit from surgery must be documented in the clinical records.

6. Providers will audit their indications for and outcomes of cataract surgery and justify them to purchasers.

Supporting information

The decision on whether cataract surgery is likely to benefit a patient is ultimately a matter for the patient and their professional advisors, particularly the operating surgeon. The current commonly used objective

measurements of visual acuity do not always accurately reflect a patient's degree of visual disability. The level of visual acuity that an individual patient requires to function without altering their lifestyle is very variable. A visual acuity of 6/12 or better [Snellen], 0.30 [LogMAR] in the worst eye normally allows a patient to function without significant visual difficulties. **Some patients may undertake activities where improvement to better than 6/10 is an essential requirement e.g. to enable them to continue activities of daily living.**

Acknowledgement
This statement is based on NHS Cambridgeshire and Peterborough Public Health Network Surgical Threshold Policy for Cataract. February 2007 http://www.cambsphn.nhs.uk/default.asp?id=144

Note: Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed at the Commissioner's Individual Funding Request Panel upon receipt of a completed application form from the Patient's GP, Consultant or Clinician. Applications can not be considered from patients personally.

Approved by (committee)	**CAF/PEC**		
Date Approved:	**8th December 2010**	**Version**	**0.1**
Produced by (Title);	**Commissioning Manager – Exceptional Funding**		
Review Date:	**Earliest of either SHA guidance, NICE publication or three years from issue.**		

Appendix 2 – How Does Bristol CCG Develop Policies?

South West Commissioning Support provides support to Bristol, South Gloucestershire, North Somerset and Somerset Clinical Commissioning Groups (CCG's). This support includes the co-ordination of the review of existing Clinical Commissioning Policies, through the Clinical Policy Review Group.

The Clinical Policy Review Group (CPRG) is a newly established group, which has an agreed terms of reference and nominated Chair and Deputy. This group takes over from a well - established group, the Commissioning Advisory Forum, which had a wider remit (including the development of new policies and medicine related policies). The CPRG make recommendations to the CCG's with regard to Clinical Commissioning Policies.

The Clinical Commissioning Policies are grouped into a list, called the Interventions Not Normally Funded (INNF) List. This forms part of the contract with all local providers, and specifies the specific commissioning position for many common interventions.

The purpose of specifying the specific commissioning position for a number of common interventions is to ensure that those people who access the intervention are doing so equitably across the area and that the intervention therefore brings most benefit to patients.