

We need to respond to the NHSE consultation to limit access to 17 procedures (*'thin end of the wedge'*) by 28 September

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1: NHSE consultation to limit access to 17 procedures and why we should respond

What is the issue?

NHSE is going to severely restrict access to 17 procedures on the NHS: four interventions that 'should not be routinely commissioned, because they are ineffective or have been superseded by a safer alternative; with patients only able to access such treatments where they successfully make an Individual Funding Request'; and 13 interventions that 'should only be commissioned or performed in specific circumstances where they have been proved to be clinically effective and specific criteria are met'.

Why we should respond *NHSE aims to save £200m per year – less than 0.2% of the NHS budget – and plans to build on this with numerous future restrictions to NHS care.*

Even if this 'consultation' is flawed in design and intent, it is still worth doing the survey – making the political point that the proposals have not gone unopposed.

It would also help if KONP members wrote letters to the press about it. The general public has little or no idea that this is happening.

Reading See John Lister's lead article in July's HCT paper: [NHSE England plan to exclude treatments](#)

2: Link to [consultation](#) and link to [online survey](#)

The consultation runs till 28 September 2018 (from 4 July).

- Link to [NHSE consultation](#)
- [Complete the online survey](#)
- Sending written feedback to: england.EBinterventions@nhs.net
- NHSE is holding a number of events to gather further clinical, professional and patient views.

3: List of 17 interventions being restricted

Four interventions that 'should not be routinely commissioned, with patients only able to access such treatments where they successfully make an Individual Funding Request'

1. Snoring Surgery (in the absence of obstructive sleep apnoea (OSA))
2. Dilatation and curettage (D&C) for heavy menstrual bleeding in women
3. Knee arthroscopy for patients with osteoarthritis
4. Injections for nonspecific low back pain without sciatica

Thirteen interventions that 'should only be commissioned or performed when specific criteria are met'

5. Breast reduction
6. Removal of benign skin lesions
7. Grommets for Glue Ear in Children
8. Tonsillectomy for Recurrent Tonsillitis
9. Haemorrhoid surgery
10. Hysterectomy for heavy menstrual bleeding
11. Chalazia removal
12. Arthroscopic shoulder decompression for subacromial shoulder pain
13. Carpal tunnel syndrome release
14. Dupuytren's contracture release
15. Ganglion excision
16. Trigger finger release
17. Varicose vein surgery

4: More background

NHS England plans to ration/cut 17 medical procedures/interventions and force doctors to make 'Individual Funding Requests' for a range of them, rather than using their clinical judgment as to whether a patient needs them or not. They include gynaecology, orthopaedics, dermatology, ENT (ears, nose and throat) and general surgery (details in link below).

This policy is far from new and formalises rationing that has been in operation since at least 2012.

- 1) Read John Lister's lead article in **HCT paper, July 2018**: [NHS England plan to exclude treatments](#)
- 2) [Guardian 31 August 2012](#) 'NHS rationing is putting health at risk, says doctors' leader':....The use of referral management centres, in which family doctors' decisions to refer a patient to hospital are analysed by a third party before any treatment can be given, "are particularly distressing for GPs who know how they would like to deal with patients but find their ability to do so is more constrained than ever before". The situation was in stark contrast to "rhetoric" from ministers about how patients and GPs are being given more power than ever before as a result of their changes to the NHS in England, Porter added.
- 3) Locally, [South Warwickshire Clinical Commissioning Group set out in 2013](#) extremely stringent criteria for GPs to follow in order to refer patients for a long list of procedures, dividing these between '1) Treatments subject to clinical eligibility thresholds and (2) Low priority treatments'.
- 4) In February 2018, the [Independent](#) revealed 'NHS GP practices offered cash rewards to not send patients to hospital'. 'Cash incentives based on how many referrals GPs make have no place in the NHS,' GP leaders say.
- 5) In April 2018, the [South Warwicks KONP Blog](#) said A quarter of Clinical Commissioning Groups in England use referral management centres to control referral rates, and asked supporters to join the Royal College of General Practitioners campaign against this dangerous rationing.

- 6) In May 2018, the GP magazine, [Pulse](#), revealed that London GPs faced new restrictions on referring patients for treatment. This pre-figured the national policy now being formalised.

NHS England is steam-rolling these restrictions through. We oppose this rationing. The policy is an insult to doctors and their commitment to act in a patient's best interests. It is another route to privatisation, forcing people to have these procedures done privately - or suffer if they can't afford it.

5: NHSE questions and our guidance on answers

NHSE Q1. In what capacity are you responding?

NHSE Q2. Have you read the document: Evidence-Based Interventions: Consultation Document?

[Evidence Based Interventions: Consultation document](#)
[Easy read consultation guide](#)
[Frequently asked questions](#)

NHSE Q3. Do you agree with our six design principles?

Answer 3: *I do not believe the claim that 'We will ensure that the programme is rooted in research, and evidence-based guidance, on what is, and is not, clinically and cost effective for patients and local communities'. What does 'cost effective' mean? The principles underlying this policy remove discretion and clinical judgment from GPs and consultants for each individual.*

The six design principles simply hide the real objectives, which is to ration NHS treatment and force people to pay for private treatment for the treatments you propose to ration.

NHSE Q4. Do you agree that selecting circa 17 interventions is about the right number for this first phase?

A4: *No. These treatments are based on individual clinical judgment and should be left to clinicians, not to overall rules. Cutting these treatments cut the scope of the NHS.*

NHSE Q5. Are there interventions you think we should add for the first phase?

A6: *No. I think you should stop the first phase and consult further with the health professions and the public.*

NHSE Q6. Are there interventions we should remove?

A6: *Yes. You should remove all these rationing policies. Doctors are not cavalier in recommending these treatments. These proposals undermine doctors' clinical judgment and discretion in consultation with their patients. In the vast majority of situations, doctors do not offer unnecessary or ineffective treatment. It is wrong to tie their hands.*

NHSE Q7. Do you agree this should become an on-going rolling programme, subject to making sufficient progress?

A7: *No I disagree with this proposal which in effect rations healthcare.*

NHSE Q8. What positive and negative impact will these changes make to improving access, experience and outcomes for the following groups and how can any risks be mitigated to ensure the changes do not worsen health inequalities for:

Groups protected under the Equality Act 2010? Those individuals who experience health inequalities such as homeless people/rough sleepers, vulnerable migrants, gypsy traveller groups and carers?

A8: These cuts would disproportionately affect women who are more likely to suffer from many of the treatments you suggest (e.g. gynaecology) and these proposals do not comply with the Equality Act 2010. There will be a discriminatory impact on patients who need the intervention, can't afford to go privately versus those who can afford it whether they need it or not, and who go privately for operations that the NHS no longer funds.

NHSE Q9. At what level should we pitch our ambition? Ambitious/moderate/conservative

A9: Leave blank or select 'conservative'. Calling these plans 'ambitious' is a loaded concept. Leave treatment options as they are, for clinicians to decide on with their patients.

NHSE Q10. Do you have any suggestions to improve our methodology?

A10: Yes. Abandon these rationing plans and reaffirm the primacy of the doctor-patient relationship.

NHSE Q11. What further suggestions do you have to enable effective communication and engagement to support with implementation?

A11: Loaded question. I do not agree with the premise of this rationing exercise. Further, these rationing processes are already in place, despite this consultation – with referral management processes widespread, and delaying referral and treatment in many areas.

NHSE Q12. Are you aware of any particular communities making good progress in implementing any of the clinical recommendations on the 17 interventions, which might like to be part of this before December 2018?

A12: No. NICE guidance and evidence-based practice should continue to be the guidance for individual clinicians and teams making decisions in discussion with patients, and further bureaucratic barriers to advice, assessment and treatment should not be erected.

NHSE Q13. Do you agree that with our proposals for Individual Funding Requests (IFR) for Category 1 interventions? [If 'no' give alternatives]

A13: No. I do not agree with your proposals. The current referral process is more equitable and safe. The condition of concern to the patient should be allowed to be referred for specialist opinion without hurdles and evidence-based decision-making should continue to be the guidance, in discussion with the patient, to decide what is best for that individual.

NHSE Q14. Do you agree that with our proposals for prior approval for Category 2 interventions? [If 'no' give alternatives]

A14: No. I do not agree with your proposals. The current referral process is more equitable and safe. The condition of concern to the patient should be allowed to be referred for specialist opinion without hurdles and evidence-based decision-making should continue to be the guidance, in discussion with the patient, to decide what is best for that individual.

NHSE Q15. Do you agree with our intention to mandate through the National Tariff by introducing arrangements so that providers should not be paid for delivering the four Category 1 interventions, unless a successful IFR is made?

A15: *No. A 'successful' IFR – Individual Funding Request – leaves clinical judgment to a bureaucracy which does not know the patient and is a dangerous interference in doctors' clinical expertise: eg When is a skin lesion benign? Who decides the risk of a skin cancer? Treatment decisions should be part of a face-to-face diagnosis, not part of a distant 'triage'. Moreover, this extra stage in decision-making will add a layer of bureaucracy and will not save the NHS money. It would be a gross bullying tactic and put doctors under enormous threat of financial penalty.*

NHSE Q16. Do you agree that this change should apply from 2019?

A16: *No. I strongly disagree with the rationing policy and it should not apply at all.*

NHSE Q17. Do you support our intention to mandate compliance with the Evidence Based Interventions Policy through the NHS Standard Contract?

A17: *No. I do not agree with your proposals. The current referral process is more equitable and safe. The condition of concern to the patient should be allowed to be referred for specialist opinion without hurdles and evidence-based decision-making should continue to be the guidance, in discussion with the patient, to decide what is best for that individual.*

NHSE Q18. In relation to the proposed wording for the NHS Standard Contract, as set out in Appendix 5:

Do you support our proposed wording for the new Contract requirements?

Do you have any specific suggestions for how the Contract wording could be improved?

A18: *No. I do not agree with your proposals. The current referral process is more equitable and safe. The condition concerning the patient can be referred for specialist opinion and evidence-based decision-making in discussion with the patient to decide what is best for that individual.*

NHSE Q19. Given the mixed record of applying research-based evidence to decommission ineffective treatments, do you agree that we should introduce the range of performance management measures proposed above?

A19: *No. There should be a return to trusting the health professionals and to adjustment of any clinical practice through discussion of audit and research and not through bureaucratic controls.*

With thanks to South Warwicks KONP and Anna

[We had sight of 999's guidance which is also useful]