British Orthopaedic Association
Caring for Patients; Supporting Surgeons

BESS
BRITISH ELBOW & SHOULDER SOCIETY

BSSH
The British Society for Surgery of the Hand

Professor Stephen Powis
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Submitted by email

CC:
Dr Aoife Molloy, Evidence Based Interventions Clinical Lead
Professor Peter Kay, National Clinical Director for MSK

28th November 2018

Response to Evidence-Based Interventions Final Document

Dear Professor Powis,

We have reviewed the latest Evidence-Based Interventions document, having also previously responded to the consultation on this programme. We write in relation to the following orthopaedic interventions included in Category 2:

- L: Arthroscopic shoulder decompression for subacromial shoulder pain
- M: Carpal tunnel syndrome release
- N: Dupuytren's contracture release in adults
- P: Trigger Finger Release in adults

Our three organisations (British Orthopaedic Association (BOA), British Society for Surgery of the Hand (BSSH) and British Elbow and Shoulder Society (BESS)) recognise the need to ensure that procedures commissioned by NHS England are evidence-based and effective, and we support in principle the aims of this initiative. We have already contributed to various aspects of this programme and would like to raise some particular issues that we are concerned about as it reaches implementation stage. We also suggest ways to work together in this next phase.

1. Prior approval process for category 2 interventions

At the consultation stage we raised various concerns about this, including the potential for such a process to be cumbersome, to lead to delays that cause suffering or harm to patients and to waste significant amounts of clinical time. In the final document, there is not a prescribed national process and this will instead be handled at the local level. Our concerns stated above remain.

We noted the following extract of the latest report:

> *"Whilst CCGs need to ensure compliance with the guidance, we agree that they should have discretion as to how they do this. For example, a number of CCGs told us that regular audit and engagement with clinicians would be an appropriate approach. However, where there are concerns about achieving the desired clinical change and proposed activity reduction*

> *goals we encourage the use of other measures such as prior approval or the use of additional financial levers." (Para 64)*

It would appear therefore that there are likely to be very divergent practices adopted across the UK. This is disappointing as we understood that one advantage of the EBI programme was to promote consistency across England.

2. Questionable targets and goals for reductions in procedures

We raised at the consultation stage our very strong views about the arbitrary nature of the targets for reduced numbers of procedures. At that time we said:

> *"It is unclear to us whether any attempt has been made to try to understand the variations in the age-sex standardised rates of different CCGs, or to review rates of surgery in other comparable countries. Our view is that there should be full analysis of the variation, and for example audits undertaken to identify the numbers of patients who would or would not have met the proposed criteria. We are not aware that this has occurred, which would make the scenarios modelled entirely arbitrary. For a document of purportedly evidence-based interventions, it is disappointing that the savings projections are not also aiming to be evidence-based."*

We are therefore disappointed to see the principle of an arbitrary target has been maintained in the final policy, with the goal for all CCGs to reach the 25 percentile level. It appears to us that there is a fundamental contradiction between the principle of evidence-based interventions being provided to those patients for whom they are clinically indicated and setting targets as to the number that should be performed.

For the procedures listed above, the reductions we have calculated as follows:

Procedure	Reduction
L: Arthroscopic shoulder decompression for subacromial shoulder pain	49%
M: Carpal tunnel syndrome release	33.6%
N: Dupuytren's contracture release in adults	28.6%
P: Trigger Finger Release in adults	33.1%

These high levels of reduction for these four suggest that these procedures are currently being performed in significant numbers for patients where they should not be, and we do not believe this to be the case on this scale. (Although please note that for ganglion surgery, where the projection is a reduction of 40.3%, the BSSH view is that the reduction could in fact be greater than projected if the guideline is followed and that this would be appropriate.) BSSH cited evidence in our consultation document regarding other comparable countries for carpal tunnel release: Previous data had suggested that the rate of carpal tunnel surgery in England was approximately 80 per 100,000 population per year, which already was much lower than rates of 130 – 330 per 1,000 in comparable countries including France, Scandinavia and USA.

We are concerned that an undue focus for CCGs on meeting these targets (for example using 'financial levers' as mentioned above) could lead to patients being denied treatment that they would

benefit from and which the evidence would support. We would be extremely disappointed if this was the outcome of this programme. As a result, we propose that sprint audits should be undertaken in sites adopting the programme to review how the implementation is managed and whether patients that should qualify for the procedure are denied it.

3. Proposed sprint audits for implementation of the policies

As mentioned above, the BOA, BSSH and BESS would like to propose close monitoring of the implementation of this initiative in the form of sprint audits. We wish to test the effectiveness of the proposed changes and publish the results to provide transparency and to better inform the process. These audits would specifically look at the numbers of patients who met the clinical criteria but were declined and any administrative delays consequent upon a prior approval process. The system for sprint audits is now well established and this should be quite feasible

We believe this will be vital for two reasons, first and foremost to ensure that patients who meet the clinical criteria receive the appropriate treatment in a timely fashion and secondly for the credibility of the programme among the clinical community, to demonstrate that this really is about evidence-based interventions and not about reducing interventions in an arbitrary and inappropriate manner. We hope that you will welcome this approach and would be grateful for an opportunity to discuss how this might work. Our preferred approach would be to begin with sprint audits with your three 'demonstrator communities'.

As a final a comment, the EBI document repeatedly states that the aim is to "prevent avoidable harm to patients"; for these category 2 interventions we would emphasise that there is avoidable harm caused where patients are not treated or delayed in treatment by this process. We very much hope this will not occur.

We would welcome future opportunity to discuss with NHS England the issues raised in this letter.

Yours sincerely

Prof Philip Turner	Mr David Shewring	Mr Peter Brownson
BOA President	BSSH President	BESS President