Thresholds- summary feedback September 2016

Between June 2015 and September 2016, Rotherham CCG has held a number of conversations with different bodies on the introduction of clinical thresholds. This was instigated at the AGM in June 2016, when the concepts were introduced, alongside the need to ensure that all had access to the consistent treatment pathways, informed by best practice.

During 2015-2016 these conversation continued with stakeholder and clinical groups, and were picked up in more detail at the subsequent AGM; with community groups, and with the patient participation group network.

This summarises feedback received from the PPG Network, and through the financial challenge activity.

From the PPG presentation and discussion;

- People were generally in agreement with the approach
  'don't think patients will have a problem with this, but the right infrastructure is needed to support it'
  'Its got to be clinically right – not too early, not too late'
- However, people expressed a number of concerns, including
  - Sufficient and fast access to other services if declined or deferred for treatment; ie physiotherapy or weight loss support
  - Impact on other parts of the system; ie social care
  - Impact on GP time
  - Opportunities for patients to 'play' the system
  - There may need to be clear exceptions, for example when people have weight gain caused by medications
  - People were reassured by the pathway for exceptions using IFR
- Several people felt it was important to consider how this information and message is shared with the public

From the financial activity

Should patients be required to lose weight before surgery?

- All groups made a 50-100% saving.
- For some groups, the decision was clear and straightforward to implement this
- Others wanted to use some savings to support weight loss programmes
- Several groups stated preference for encouragement rather than force, supporting and advising

Should we stop procedures that are not life threatening? Ie mole removal etc

- One group (patients) felt that all should be stopped
- Other groups felt that some exceptions/discretion needed to be in the pathway

Should surgery be restricted for smokers

- Only discussed by one group (GPs); who felt this was hard to police/check, and a lifestyle choice

Should we implement thresholds ie for second cataract etc

- Discussed by 5 groups
- Patients/public felt that these were clinical decisions that should be discussed between the patient and clinician, supported by good information
- GPs wanted the views of patients and patient groups before agreeing.
- All noted the need for equitable service for patients

PPG meeting feedback

- Concerns that thresholds are about cutting activity
- Concerns that consultants will agree to the thresholds
- Will thresholds mean that people are left in pain waiting for surgery? And that they will wait for longer - People shouldn't have to wait for surgeries
- Will people be able to access physio or other services ie weight loss quickly, without months waiting
- This could be time consuming for GPs, and concern was expressed about the impact on GPs.
- This could be positive for GPs, giving them something to work to, and taking out variation between practices
- It might be harder for people to lose weight if hips or knees are bad.
- Discussed Ganglion & Dupetrens, and were broadly in line with the thresholds for these
- Hips, knees and cataracts (i.e.progressive conditions)- concern about the implications for parts of the health system ie this could put pressure on pain management services, physio and social care etc.
- Re carpal tunnel; hip and knee surgeries
    - *'Absolutely nothing wrong with these criteria, they will help GPs'*
    - *'we need proper support for patients ie weight management'*
    - *'Will help with demanding patients when surgery is not right'*
    - Hips/knees – the group noted a slight difference in functional limitations – one severe. There were also some questions about thresholds
- Were in broad agreement with idea and criteria,
- Felt there is a role for PPGs in educating patients
- Concerns about waiting times for MSK service (physio).
- People will see this as cost cutting - how will it be publicised?
- Patients will get to know criteria and tailor their symptoms to thresholds.
- If people are to be referred to physio or weight management, the services must be there.
- If the referral criteria are met, people should get treatment quickly.
- Implementing thresholds should not undermine GPs
- Public health are consulting on what services should be prioritised, this could impact on what services for smoking cessation and weight management are available
- It seems like common sense to try things like splints first (Carpal tunnel)
- Noted that good practice and NICE guidance are changing all the time, and that its good to have one system that makes sure everyone uses the best information
- By deflecting to other services, overall savings may be reduced, as some might need additional capacity
- Hips and knees – people can still be referred if they don't lose weight, but should try
- What is the capacity of RIO to take additional referrals, is the weight long?
- We should be making sure children don't get obese – preventative
- There should be exceptions for some drugs that can make people put on weight, i.e. some drugs for mental illness.
- People will need support and reviewing during this time, not just left to fail
- Some problems will impact on other long term conditions; the plans might shift costs, not remove them
- Issues that consultants might only look at one problem, not the whole person
- Example noted of someone getting a knee replacement who the surgeon knew would not exercise – knee now not functional
- *'don't think patients will have a problem with this, but the right infrastructure is needed to support it'*
- *'Its got to be clinically right – not too early, not too late'*
- *'it will be good (for demanding patients) if the checklist is clear and visible'*

People who are very overweight (i.e. BMI over 35) often have significant complications following hip/knee surgery; increasing costs. **Should patients be required and supported to lose weight before they have surgery?** You could save around £1m from the planned care budget this year and in future.

- Need to look at why people have extra weight, other issues we need to address first?
- Might be caused by meds
- Should be allowed to have the first surgery done but not a second one if haven't lost any weight
- Look at what's best for the patient
- Yes help needed to lose weight first, better for health during recovery
- Could affect mental health if told overweight, use judgement if only slightly over 35
- One group – YES! No one can complain about that!

Team 1 - Save 500,000 and use clinical decision on patients – money put in savings.
Team 2 – 1 million into savings.
YC- it's in someone's best interest to lose weight – but it might be hard to do so if someone is overweight, and isn't mobile, and bad hip/knee makes this worse. Felt that 'it's a bit harsh' to put in blanket bans- shouldn't force people, but can recommend and support. Any weight loss would be good.
Save half the amount.
GP – 1

- Should be encouraged to offer opportunity to lose weight
- Should not leave it to last minute as further complications can arise
- Advise but patients choice
- Do not make GP implement government policy

GP – 2

- GP's are doing this
- Show to be losing weight, not have to reach a specific target but show a % of weight loss
- £1m added to savings

GP – 3

- Over 35 BMI may struggle to exercise to lose the weight
- If lost weight they may no longer need the surgery, better patient care
- £1m added to saving

GP – 4

- Yes patients need to lose weight
- Employ someone to do weight loss programme with individual patients who really need, rest can go to Rio
- What happens if patients need it but won't lose weight?
- Helps patient in long run ad less risk, speedier recovery, healthier
- National campaign needed to tell patients it's in their best interest to lose weight before surgery
- Portions size needs addressing
- Can public health offer more?
- General guidance needed with some exceptional allowed
- £800,00 saving from planned care to invest £200,000 primary care and prevention and £400,000 added to savings

Mole removal, verruca treatment and acupuncture are examples of procedures that are not life threatening. They cost the CCG around £500,000 per year, each year. **Do you carry on providing these, or make a saving in Planned Care?**

- Yes stop doing them unless dangerous or life threatening.

Team 2 – 500,000 into savings.
GP – 3

- Stop providing if only cosmetic
- Still need GP discretion
- Patients can be given the option to go private, maybe leaflets to explain where to go and why cuts

GP – 4

- Remove if clinically needed not cosmetic
- Acupuncture does work and saves on prescribing for pain
- Need national/Rotherham wide guidance so all fair
- Some patients have acupuncture and drugs so no savings made
- Need to look at research
- Exceptions still needed
- £200,00 (not full) saved from planned care and added to savings

You could save £500,000 by restricting planned surgery for smokers; people will have to stop smoking before they are eligible for elective (non-emergency) surgery. The money would be saved through the reduction of costs associated with complications. **What do you do?**

GP – 1

- Don't like it, smoking is a choice and it's difficult to stop

- How would they prove that they have stopped?
- Should not stop care due to lifestyle choices

In the past, Rotherham patients have received treatment than other areas, e.g. second cataracts done routinely. Implementing tight clinical thresholds in line with NICE guidance could save £2.5m from planned care

What do you do? Do you consult the public? Will this be unpopular?

Give patients the opinion and say where the money could be spent

- Clinical decision – left up to clinicians as to whether its needed
- GP should have the conversation with patients rather than sending to TRFT. Give patients the option with the clinical information to make a decision before referral.

Team 1 - One group happy to make saving, money split between Social Prescribing, Prevention and CAHMS (CAHMS only keep the money if they can prove that the money has done well and take away if not).

YC- better to cut something like this than something that is really important- i.e. has a bigger impact on people's health and if they can work etc. discussed if people it would impact on would feel the same – 'let them moan'

GP – 3

- If only one cataract bad then on, if other needs doing then not fair on patient to suffer
- Ophthalmology automatically add patient onto list for other, intervention maybe needed
- Engage patient groups in discussion rather than tell and see what they think
- Explain to patients if they want money in future to be in NHS to provide treatment then need to save now
- £1.5m added to saving

GP – 4

- If PPGs are happy
- Retain equality by everyone receiving same level of care
- Consult with everyone, if have support it makes it easier to implement
- GPs get reaction from patients, need guidelines for GPs to show and explain to patients
- £2.5m added to savings