Item 9 – Tabled note from Dr Nick Mann, Hackney KONP

Nick Mann 9 Jun 2019, 18:09

to Ben, Jarlath

Dear Cllr Hayhurst,

Thank you very much indeed for your continued keen attention to consideration of risks attached to the current rapid and unprecedented changes to NHS delivery, provision, and contractual aspects, of NHSE/I and STP transformation plans.

I have written to Jon Williams about this already. I think this needs to be taken as Simon Stevens (nearly) says, as a minimal structure - to be widely expanded (there is a steering committee) to include many more treatments - within which restricted access and eligibility to care becomes normalised, insidiously pressurising patients to pay or have insurance. Simultaneously, it removes professional judgement of doctors from NHS medical care, by the mandatory effect of these restrictions - not advisory guidance by NICE, but enforcement by quango NHS England.

Compliance with NHSE restriction lists is mandatory and will supersede NICE advisory guidance and CCG-derived policies, where they do not concur. This is why 'removal of benign skin lesions' has been dropped from the POLCV list; it does not appear in the NEL ACP list, but it does appear in NHSE's 17EBI list.
It is not anticipated by anyone that removal of cosmetic lesions from POLCV ACP will suddenly become funded locally; instead, CCG will refer to over-arching NHSE national 17EBI list to deny provision. Similarly for pre-approval criteria for surgery for Varicose Veins, Ganglions, Carpal Tunnel release, Tonsillectomy, Knee Arthroscopy for Osteoarthritis, and D&C for Menorrhagia.

It's clear that the effect of restrictions runs directly counter to NHS England's aim of "reducing unwarranted variation" in implementing NICE guidelines. Nowhere is an increase in any activity expected or considered. It is a race to the bottom. And the process could easily render NICE guidance redundant, as CCGs may soon be. Although NHSE reference NICE guidance as their over-arching rationale, many procedures (see John Puntis's EBI breakdown attached) do not have NICE guidelines at all.

Important to consider 'CCG-driven' (implicitly, with NHS England's support) ACP restrictions together with 17EBI and medicines' blacklists. Knee and hip replacement, spinal surgery, and particularly cataracts (good article in BMJ last week). Restriction of this entirely different category of treatments is unnecessary and extremely alarming.
Cataract referrals by GPs: 97% refused in Cambridge and Peterborough; average refusals where implemented=3%. NHS England haven't even coughed about this 'variation'.

It is also important to factor in the future mutability of these restrictions; such that clinical, lifestyle, temporal criteria and financial caps can all be tightened at any time, within this basic structure.

The willingness for NEL STP to include in this ACP some key conditions which are undeniably essential, cost-effective treatments - eg Knee & Hip replacements, and Cataract surgeries - conflates the basis on which the lists were originally drawn up, ie to reduce unwarranted variation and to reduce use of ineffective procedures. NHSE have not, as yet, included hips, knees and cataracts - no doubt for fear of reprisals, but it seems CCGs are

setting the precedent for rationing of effective procedures all by themselves. There is no clinical evidence to support that, nor any evidence at all that it will save money. This development is extremely alarming.

NHSE/I are seeking to reassure CCGs that development of 17EBI and STP POLCV lists is merely about unifying eligibility to treatment. Introducing factors such as smoking, weight loss, treatment and time barriers, formulates reasons to deny care which may invidiously affect certain populations, eg with adverse mental health or deprivation. It also removes the ability for doctors to exercise any professional judgement over management of differing individual circumstances for otherwise very straightforward conditions.

It is clinically obvious that subsets of patients receiving some treatments considered ineffective overall - eg spinal injections for back pain - do in fact benefit significantly. For some elderly patients, these injections mean the difference between being able to self-care or not. These are now Category 1 and will be banned; it is not possible to prove exceptionality for these patients under the IFR process. There has been a natural attrition of referrals by GPs for conditions where treatments have been shown to be poor eg snoring, tonsillectomy, grommets, leading some to say of the restrictions: "Well, we don't do that anyway any more". This provides an easy shoe-in for more contentiously debated treatments eg subacromial decompression to join the list. One indirect consequence of this is that the loss of incentive to fund or to continue to research innovative, potentially more effective, new treatments for these conditions.

It will be argued that restrictions for cataract, hip and knee surgeries are not overly restrictive, and criteria for other procedures have been altered after stakeholders' interventions. This may be true currently, but this is just the beginning - a structure. It is notable that POLCV concept was derived from McKinsey's work at World Economic Forum 2012 along with the STP concept, and the presence at WEF of key NHS leaders and others who subsequently became STP leaders.

There is an "expectation" in NHSE guidance that hospitals will not provide privately any treatments excluded by this rationing eg benign skin lesions. But it is very clear that patients will tacitly be forced, by an increasing number of barriers, to seek treatment in the private sector for these conditions.

NHSE are unequivocally introducing rationing of NHS care, and their basis for doing so is conflated and contradictory. STPs, moving to "managed care", and rationing, all appear to have their origins in Mckinsey's WEF 2012 workplans.

Best wishes,

Nick

ACP for clinicians: http://www.cityandhackneyccg.nhs.uk/Downloads/About%20Us/Our%20work/ACP%20for%20clinicians%20-%20INEL.pdf
NHSE 17 EBI : https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
Attached: John Puntis, KONP: Analysis of 17 EBI vs NICE guidance and background.