1. Introduction

1.1. The Royal College of Surgeons (RCS) is a professional membership organisation and registered charity, representing surgeons in the UK and abroad. We advance surgical standards and improve care for patients. This is joint evidence from the RCS and its Faculty of Dental Surgery (FDS), a professional body committed to enabling specialist dentists to achieve and maintain excellence in practice and patient care.

2. Summary

2.1. We welcome the commitment of extra funding to the NHS in the recent Comprehensive Spending Review. This funding should be used to improve and transform the way care is delivered and not just used to maintain current performance.

2.2. However, the long-term sustainability of the NHS in its current form is still in question and there are increasing instances of rationing of surgery and specialist dental treatment by commissioning groups in efforts to make savings. We strongly support calls for a cross-party commission to review the future funding and provision of health and care services, and we encourage the Committee to show their support for this.

2.3. The social care sector is under severe strain and 2015 witnessed the first fall in care home beds since records began. The NHS is now seeing the consequences, in particular through a dramatic increase in delayed hospital discharges. We encourage the Committee to highlight the impact of social care cuts on the NHS.

2.4. While we welcome the recent Carter review, the Department of Health needs to clarify how it is monitoring Trusts’ savings plans and how it intends to engage clinical and managerial leaders who are vital for actually implementing savings.

2.5. The College is extremely concerned by the proposed £200m cuts to the 2016/17 public health grant, in particular the impact on oral health where prevention is crucial to tackle rising hospital admissions for children's tooth decay. We recommend that the impact of cuts on preventive oral health services, and services to prevent and tackle smoking and obesity, are closely monitored to ensure that they do not have serious, long-term impacts on public health.

---

1 LaingBuisson. Press release: Government austerity measures have created two-tier long term care market which is failing state supported residents. 2015 September 30.
3. Healthcare funding

3.1. NHS England investment

3.1.1. The Spending Review allocated an additional £3.8 billion to the 2016/17 NHS budget, front-loading the extra £8bn a year the Government committed to the NHS by 2020/21. We strongly welcome this move, having made this call jointly with the Royal College of Physicians.\(^2\) It is important that this funding is not just used to maintain existing performance, but used to improve the delivery of the health service.

3.1.2. However, the NHS is under increasing pressure as a consequence of our ageing population and increasing costs of new treatments. Patients were seen over 15 million times in hospitals in 2014/15, a 30 per cent increase since 2004/05.\(^3\) The April-September 2015 provider deficit of £1.6 billion\(^4\) and the fact that all surgical specialties are missing referral to treatment targets\(^5\) are manifestations of these pressures.

3.1.3. Urgent and emergency care is under particular strain, with wide variation in emergency surgery mortality rates. The UK Emergency Laparotomy Network found that mortality following emergency laparotomies varied from 3.6 per cent to 41.7 per cent across 35 hospitals.\(^6\) We are concerned that Monitor and NHS England have made slow progress in their specific review of prices in urgent and emergency care which is further hampering efforts to improve emergency surgery.

3.1.4. The College supports the valuable aim of providing the highest standards of care across all days of the week. We welcome the announcement of the Sustainability and Transformation Fund, and would like to see more detail on how much of this fund will go towards seven-day urgent and emergency care. We also recommend in-depth financial modelling to help hospitals anticipate the costs of implementing seven-day care across urgent and emergency services. To date the Government has focused on encouraging the availability of hospital consultants and junior doctors at weekends. As we have previously set out,\(^7\) the availability of other hospital services such as pharmacy and physiotherapy are just as important, alongside improvements in the accessibility of social care, community and primary care services at the weekend. We would therefore encourage a greater focus on these factors in the implementation of seven-day care.

---

\(^2\) Templeton SK. Care rationed as NHS hits breaking point, say medical colleges. The Sunday Times. 2015 November 15.
\(^7\) Royal College of Surgeons. Policy briefing: Seven day care – our view. 2015 September.
3.2. Efficiency savings

3.2.1. The current provider deficits being accumulated highlight the difficulty the NHS faces in meeting the ambitious efficiency savings being asked of the health service. As frontline surgeons we are well aware of examples of wastefulness and inefficiency in the NHS but we remain sceptical about the ability of the NHS to fully meet the efficiency targets, particularly as many large savings have already been extracted from the system. The large proportion of the NHS’ budget spent on pay further reduces room for manoeuvre on savings.

3.2.2. The recent Carter review has highlighted areas where the review believes £5 billion in efficiency savings can be made by 2019/20,\(^8\) and detailed plans have been set out for Trusts to make savings. As the Committee will be aware, Professor Tim Briggs (a member of our Council) was recently appointed National Director for Clinical Quality and Efficiency to implement the review’s findings. This work has the potential to build on Professor Briggs’ work from the ‘Getting it Right First Time’ (GIRFT) project which shed light on the huge variation in standards and costs of orthopaedic procedures across the country. We strongly support his plans to expand this GIRFT methodology into a broader clinical quality and efficiency project across other surgical specialties, and in due course into medical and dental specialties. We also recognise the importance of concentrating surgical services where appropriate in order to ensure the highest quality of care and the best value for money.

3.2.3. The success of Professor Briggs’ work will ultimately be dependent on the ability of the Department of Health to persuade individual hospitals (especially independent Foundation Trusts), managers, and clinical leaders to implement any identified savings. As identified in the Government’s 2013 Procurement Development Programme for the NHS, in order to improve NHS procurement, it is important to improve the procurement ability of trusts themselves.\(^9\) This is not an easy task and we encourage the Health Committee to probe the Department of Health on what plans it has to engage clinical and managerial leaders in this process.

3.3. Cross-party commission

3.3.1. The Government’s commitment to extra money for the NHS in the Comprehensive Spending Review was very welcome, although questions remain about whether this secures the long-term sustainability of the NHS in its current form. Therefore we strongly support calls to establish a cross-party commission on health and social care, as proposed by Norman Lamb MP and others,\(^10\) and we would encourage the Committee to show their support for this. A recent 12 per cent rise in patients being unnecessarily delayed from leaving hospital following treatment suggests we need to urgently review how we can better provide and fund the care of older people in the community. An independent cross-party commission would allow these issues to be scrutinised

---

and solutions aired.

3.4. Health Education England budget

3.4.1. We are concerned that the announcement in the Comprehensive Spending Review of cuts to the central Department of Health (DH) budgets, which includes Health Education England (HEE), could have negative consequences for the health service. The work of HEE is crucial to tackle workforce issues key to delivery of services. We encourage the Health Select Committee to scrutinise what the full impact of the Spending Review will be on the budget and work of HEE. Given the reduction in the DH budget, we are concerned that HEE’s work to improve the delivery of acute surgical services may not be continued, despite the importance of this work to reduce variation in mortality.

3.5. Rationing of surgical procedures

3.5.1. The College is becoming increasingly aware of instances of rationing of elective surgical procedures as a means for commissioners to make savings. In 2014 we published a report, ‘Is Access to Surgery A Postcode Lottery?’, which found that clinical commissioning groups (CCGs) are imposing arbitrary referral restrictions and denying access to vital surgical procedures, which can significantly improve the quality of life for patients. It revealed that 73 per cent of the CCGs reviewed did not follow NICE and clinical guidance on referral for hip replacements, or had no policy in place for this procedure. Over a third of CCGs (44 per cent) required patients to be in various degrees of pain and immobility (with no consistency applied across the country) or to lose weight before surgery.

3.5.2. There have also been reports of the rationing of specialist dental treatment. We are aware of instances where patients with head and neck cancer, traumatic injuries and disfigurement of the face and mouth have been denied access to NHS dental implant treatment, preventing them from eating or speaking normally. In certain areas of the country such treatments are considered standard, whereas in others they are inaccessible to patients, creating an unacceptable postcode lottery.

3.5.3. The College will shortly be publishing research showing some commissioning groups are restricting access to surgery for obese patients or smokers. For example in 2015 North East Essex CCG agreed a new policy where overweight patients have to attend a weight loss programme and smokers have to use cessation services before elective surgery. Not attending such programmes may result in patients not accessing surgery. While there is merit in patients being persuaded to voluntarily lose weight or stop smoking, to deny access to surgery on the basis of weight or smoking status is ethically contentious and potentially counter-productive given delaying surgery may simply increase illness and/or immobility. The need for an operation should always be judged by

---

a doctor based on their clinical assessment of the patient and the risks and benefits of the surgery, not determined by arbitrary criteria.

3.5.4. On 21 September 2011, then NHS Medical Director, Professor Sir Bruce Keogh, wrote to the then strategic health authorities that any decision ‘to restrict access to a treatment or intervention must be justified in relation to a patient’s individual circumstances’ and that ‘decisions should not be made solely on the basis of cost, and any refusal to offer the intervention in question must be fair and consistent’. We strongly endorse this principal that decisions to restrict access to treatment should be based on clinical evidence, and not driven by the need to make savings. Given the current scale of rationing in surgery, we would welcome a similar letter from NHS England to trusts, asserting that rationing should not be used as a means to make savings.

4. Delayed discharge and social care funding

4.1. Delayed discharge

4.1.1. The NHS and social care systems are closely linked, and we are concerned that the Comprehensive Spending Review settlement insufficiently supports social care. According to the Local Government Association, the adult social care funding gap is increasing by £700 million each year, and is expected to reach £2.9 billion by 2020. 2015 was also the first year that the number of care home beds fell despite rising demand.

4.1.2. Lack of social care availability contributes to unnecessary delayed transfers of care (DTOCs) from hospitals, which are costly, increase risks to patients remaining in hospital unnecessarily, and reduce the number of beds available for new admissions. We therefore encourage the Committee to analyse and highlight the impact of social care cuts on the NHS.

4.1.3. A 2015 survey of NHS leaders found that 99 per cent agreed that cuts to social care funding are putting increasing pressures on the NHS including an increase in the time a patient remains in hospital, and a rise in the numbers of individuals attending hospital and emergency admissions. At East Sussex Healthcare Trust, for example, recent reductions in the capacity of social services have had an immediate effect on bed occupancy, and in early January 2016 all of the beds were full and elective surgery was not taking place at all.

4.1.4. In 2014 we conducted a survey among surgeons on what they feel needs to be done to improve the co-ordination of care of patients. It found that discharge from hospital is a particular area of concern, as is follow-up care and

---

15 James R, Ursell F, McDermott V, Webster R. Social care sector response to Spending Review. 2015 Dec 03.
17 LaingBuisson. Press release: Government austerity measures have created two-tier long term care market which is failing state supported residents. 2015 September 30.
18 House of Commons Library. Delayed transfers of care in the NHS. 2015 December 2.
19 NHS Confederation. National survey of NHS leaders. 2015
20 Royal College of Surgeons. Coordinated care survey. 2014 August.
access to care outside of hospital. Only a quarter of surgeons and stakeholders believe there is a thorough discharge planning process in place for patients.

4.1.5. Since 2010/11 over 60 per cent of DTOCs have been attributable to the NHS, with 24-33 per cent attributable to social care (and 6-7 per cent attributable to both).\(^{21}\) The number of NHS attributable DTOCs has been steadily increasing since 2010. Social care attributable DTOCs, on the other hand, had been decreasing until August 2013, at which point their numbers began to increase. Then, from September 2013 to 2015, the number of delays caused by social care increased by 44 per cent.\(^ {22}\) This suggests that strain on the social care system over the last few years has been impacting the NHS through increased numbers of DTOCs.

4.1.6. Recently there has been a dramatic increase in DTOCs, with 160,000 delayed transfer days during October 2015.\(^ {21}\) This reflects a 12 per cent increase on the previous October, with over two thirds of this increase occurring in the last month. NHS Improvement suggests that in the year to 30 September 2015, all DTOCs cost Trusts £270 million.\(^ {23}\)

4.2. **How to tackle delayed discharge**

4.2.1. The number of DTOCs attributable to the NHS has also been increasing, so we need a comprehensive approach from trusts to tackle this issue, including better focus on the discharge planning from admission. In addition trusts would benefit from personalised plans to tackle delayed discharge. For example, Oxfordshire has the largest number of patients awaiting delayed discharge in England, with an average of 150 patients waiting to be discharged at any one time.\(^ {24}\) Oxfordshire CCG has devised a plan to tackle this problem, which may be allocated up to £2 million. We would like to see more CCGs being encouraged to take this approach – it would be helpful if specific funding were made available for such programmes through the Better Care Fund. The effect of the Fund on the number of DTOCs should continue to be used as a key measure of its success.

4.2.2. It may also be beneficial to increase the number of emergency residential and nursing home places available as an immediate means to reduce DTOCs.

5. **Public health**

5.1. **Public health budget**

5.1.1. In order to build a sustainable NHS, alongside additional healthcare resources, we must reduce the number of patients requiring care through prevention. Lifestyle-related disease is on the increase worldwide, with tobacco, alcohol, and poor diet now three of the biggest global risk factors for disease.\(^ {25}\)

---

\(^{21}\) NHS England. [Delayed Transfers of Care Data 2015-16](#).

\(^{22}\) House of Commons Library. [Delayed transfers of care in the NHS. 2015 December 2.](#)

\(^{23}\) Monitor, TDA. [Quarterly report on the performance of the NHS foundation trusts and NHS trusts: 6 months ended 30 September 2015.](#)

\(^{24}\) Oxfordshire Clinical Commissioning Group. [Board Meeting paper: Delayed Transfers of Care. 2015 November 26.](#)

\(^{25}\)
Smoking and obesity are responsible for a substantial portion of the nation’s ill health, despite being preventable. Recent research has estimated that, if current trends continue, over the next 20 years obesity will cause an additional 670,000 cancer cases and that by 2035 it will lead to an additional yearly £2.5 billion in NHS and social care costs.\textsuperscript{26}

5.1.2. Therefore we are seriously concerned by the £200m cuts announced to the 2016/17 public health grant and believe this undermines the key aim of the Five Year Forward View to invest in prevention. The Faculty of Public Health estimates that these cuts are likely to lead to at least £1 billion in extra costs to health and social care.\textsuperscript{27} Oral health is an area where investment in prevention is vital, as approximately 90 per cent of tooth decay is preventable.\textsuperscript{28} We are also concerned that the reduction in public health spending may lead to the restriction of services to prevent and tackle smoking and obesity, with severely negative long-term consequences for public health and NHS service costs. Such short-term savings would risk a deterioration in the public’s health and would likely be outweighed by longer-term costs to the NHS.\textsuperscript{29}

5.2. Oral health

5.2.1. There is a risk that NHS services commissioned by local authorities will be hit by reductions to public health budgets. Indeed, as highlighted in the Academy of Royal Colleges’ letter to George Osborne in October 2015, many of the services delivered via local authorities through the public health budget go towards clinical NHS care. Since local authorities are responsible for oral health improvement, we are particularly concerned that preventive oral health services will be affected.

5.2.2. NHS England spends £3.4 billion a year on dental care (and an estimated £2.3 billion on top of this is spent on private dental care),\textsuperscript{31} despite the fact that poor oral health is largely preventable.\textsuperscript{32} Almost a third of five-year-olds are suffering from tooth decay and it is the most common single reason why five- to nine-year-olds are admitted to hospital.\textsuperscript{28} Approximately 46,500 children and young people under 19 were admitted to hospital for a primary diagnosis of dental caries in 2013–14, and this figure is increasing.\textsuperscript{28} Therefore it is important that local authorities are not forced to cancel oral health prevention programmes for financial reasons, but the public health grant reduction may lead to this.

\textsuperscript{25} Horton R. \textit{GBD 2010: understanding disease, injury, and risk.} Lancet 2012; 380: 2053–2054
\textsuperscript{26} Cancer Research UK, UK Health Forum. \textit{Tipping the scales: why preventing obesity makes economic sense.} 2016 January.
\textsuperscript{27} Faculty of Public Health. \textit{Response to the Department of Health consultation on local authority public health allocations 2015-16.} 2015 August 28.
\textsuperscript{28} Royal College of Surgeons Faculty of Dental Surgery. \textit{The state of children’s oral health in England.} 2015 January.
\textsuperscript{29} The King’s Fund. \textit{Making the case for public health interventions.} 2014 September 18.
\textsuperscript{30} Academy of Medical Royal Colleges. \textit{Letter to George Osborne MP on public health funding cuts.} 2015 October 22.
5.2.3. We recommend that the impact of cuts to public health on key services, including oral health and services to prevent and tackle smoking and obesity, are closely monitored to ensure that they do not have serious, long-term impacts on public health.

22 January 2016