Royal College of Nursing

Royal College of Nursing response to NHS England consultation on evidence based interventions

Key points

- The RCN supports the use of robust evidence to deliver healthcare interventions that have proven effectiveness and therefore supports the broader aims of this Evidence Based Interventions programme

- The RCN believes patients are partners in the shared-decision making of their healthcare. We are concerned that this intervention lacks patient engagement in the form of qualitative analysis for proposed treatment withdrawal.

- The healthcare workforce is evolving with role advancement. IFR requests could come from other clinicians as well as GPs; the IFR should include assessment from the wider team if appropriate. The current IFR process and approval system seems overly bureaucratic. IFR needs streamlining to ensure those who clinically need referral and treatment to benefit their health receive it in a timely manner

Recommendations

- A full impact assessment, including measures of cost, clinical effectiveness, patient choice and outcomes, should be undertaken for each of these interventions, and any future interventions which are proposed to be removed. We are concerned that the current focus is too narrow, and more weight should be given to patient choice and quality of life

- Clinical decisions should be based on a robust assessment of patient need, not affordability, in the first instance. These decisions should be based on available evidence and discussed with the patient. Any guidance related to these proposed changes should emphasise the need for clinical judgement to prevail over cost-saving measures

- These proposals should not limit clinical decision-making, and must give space to allow healthcare professionals to work innovatively in the best interests of their patients, without being confined by cost-saving measures

- NHS England should involve the Royal College of Nursing in developing policy and guidance related to evidence-based interventions

- Organisations such as Healthwatch and other patient groups should continue to be involved to facilitate wider patient education and engagement related to these changes

Supporting information

Using evidence to support decision-making

The RCN supports the use of robust evidence to inform all decisions within health and care settings. Using evidence, alongside clinical judgement, is particularly important in situations where health care has to be rationed in a resource constrained environment. Where there is a need to reduce spend on interventions, the focus should be upon those that are of limited clinical effectiveness.

All clinical interventions should be carefully considered with the involvement of the person with the condition. Surgical interventions should be avoided if possible and clinicians will predominantly focus on less intrusive interventions in the first instance. We believe that this is increasingly being implemented across the country, with referrals only being made for those individuals with a specific need on the basis of clinical judgement. However, this is an area where there is a data gap and as part of these proposals, NHS England should support providers to collect this information so that the impact can be scrutinised.

Although the interventions in this proposal are evidence based, we have concerns that considerations for their removal have taken a narrow focus on clinical judgement and cost-effective elements, and we recommend that NHS England takes a wider, more holistic view of the patient-focussed factors which go into clinical decision-making.

As an example, the Government has previously supported clinicians to use Patient-Reported Outcome Measures (PROMs) across the NHS as the key to providing excellent patient-centred clinical care. These measures demonstrate an example in which the inclusion of patient-focussed evidence is an important factor in assessing the acceptability of proposals as an additional criteria alongside clinical judgement and cost effectiveness.

The impact of the proposed changes

If this proposed programme is ‘successful’ and expanded, there is a likelihood that interventions will be included where the only alternative to intervention is ‘to monitor’ the patient. This could be immensely frustrating and demoralising for people suffering with a particular condition and the system would not be addressing the needs of that individual. Where there are no other treatment options available, we urge NHS England to take a wider account of holistic views rather than focusing on financial measures.

We are concerned that the failure to meet criteria which would justify any proactive intervention could see unintended impact elsewhere in the system. For example there is potential for increased need in mental health or primary care services which would inevitably eat into the projected released capacity. Front-line staff working in the community are likely to be vulnerable to regular attendances from frustrated patients without the ability to deliver an intervention.

These issues will impact on patient acceptability, and there is a risk that processes may be discredited if an appropriate patient acceptability criterion is not taken on board initially.

The design principles appear to be underpinned by the assumption that practices can and will change as a result of commissioner and clinician engagement and adoption. This assumption does not appear to be underpinned by evidence or take account of the complexities of bringing about these changes in practice. A more nuanced approach would acknowledge geographical variation and recognise a range of approaches to realising change in practice to reduce unnecessary or potentially harmful variation.

We are concerned that the implementation phase focuses on the approach taken, but does not expand on understanding whether the initial phase will have been successful. If the data return indicates whether an intervention was or was not clinically relevant or necessary, this would only be a crude measure of 'compliance' and of 'variance' but the assumption is that the rates of specified procedures will fall.

Preventing unintended consequences

Health inequalities could occur within the population if some of these interventions positively evaluate as improving quality of life for some patients, but do not meet cost-effectiveness criteria. The exclusion of these interventions from the NHS could drive patients to seek private provision creating equity of access imbalance.

Unintended consequences pose a risk for the health care profession. There is a risk of 'skill fade' for health care professionals with the projected decrease in interventions. Consideration for this potential training gap would need to be managed going forward for those individuals for whom individual funding requests (IFRs) are sanctioned and medical interventions necessary. This is particularly important for the nursing workforce given the reduction in Health Education England's budget for continuing professional development, and with nursing shortages inhibiting ability for services to provide cover whilst individuals attend training sessions. Advanced Nurse Practitioners are performing increasingly expanded roles in the surgical sphere. Those who perform interventions included in this consultation are already limited in number given the nursing shortages and will face challenges retaining competence if this programme commences.

Involving professionals and patient groups

Nurses are often the point of contact in a variety of settings for patients to openly discuss concerns or seek clarification on all aspects of medical care. The decision to include Healthwatch and local patient groups in providing a clear 'experience as evidence' link should guard against decisions being made without attention to context.

Alongside the top-down modes of levers and sanctions from regulatory bodies and commissioning groups, Healthwatch and local groups could spearhead a bottom-up approach. This would go some way to explaining the process and its intended benefit for local populations, humanising and making accessible the changes to a wider audience. This would enable the evidence to be interpreted and presented for a broader audience that could support the system wide change that is desired.

The language suggests IFRs can only come from GPs. Given the evolving nature of the workforce and advancement of roles, requests could come from other clinicians as well as GPs. The IFR should include the assessment from the wider team if appropriate. The IFR process seems bureaucratic with regards to CCG approval processes, suggesting clinical judgement lesser to fund-holders.

This needs to be considered and IFR should be streamlined to ensure those who clinically need referral and treatment to benefit their health receive it in a timely manner. An unintended consequence of reducing variation could be increased bureaucracy. This has the potential to delay interventional treatment for the few that need it. When clinical assessment indicates that there is a need for intervention, there is currently no mention of the costs of negotiating for IFRs.

With regards to aligning incentives to the evidence, the administrative costs associated with preparing an IFR needs to be considered. Illustrative activity goals suggest capacity will be released with the introduction of this EBI programme but it is not clear if evidence supports this assumption when such 'opportunity costs' are not acknowledged.

About the Royal College of Nursing

The RCN is the voice of nursing across the UK and the largest professional union of nursing staff in the world.

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