NHS Greater Glasgow & Clyde Paper

Policy for the Management of Zero and Low Health Gain Surgical Procedures in NHS Greater Glasgow and Clyde.

The Surgery and Anaesthetics Directorate in Greater Glasgow and Clyde have embarked upon an initiative, led by the AMD, to reduce the use of zero and low health gain procedures. Although when implemented this should contribute to CRES, the principal aim is to improve the quality of care delivered to patients. This will be achieved by ensuring that zero health gain procedures are abandoned and appropriate thresholds are achieved before patients are subjected to "low health gain" operations where the risk of significant complications outweigh any putative benefits.

Progress to date

A meeting led by the AMD was convened that included Clinical Directors and Lead Clinicians from the various sub- specialties. Lists of low gain procedures based upon NICE and other guidance were circulated prior to the meeting. Participant were asked to consider the low health gain procedures performed within their clinical areas and to identify two or three in the first instance that would be targeted. The following procedures have been suggested.

ENT Surgery

1. Insertion of Grommets
2. Tonsillectomy
3. All Operations for snoring disorders

General Surgery

1. Asymptomatic umbilical hernia
2. Asymptomatic small primary inguinal hernia
3. Benign skin conditions not affecting the face
4. Uncomplicated varicose veins.

Orthopaedics

1. Diagnostic arthroscopy and arthroscopic knee wash outs.
2. Thresholds for Knee Replacement Surgery
3. Injections for back pain

Ophthalmology

1. Review of the criteria for cataract surgery to the second eye.

Next steps

A

Having identified the initial target procedures the next step is to review the evidence base to support any recommendations that we make. This will be especially important in taking informed consent and in gaining the support of primary care colleagues. For example, chronic pain has been reported to occur in up to 20% of patients after a primary hernia repair. That becomes a major consideration for a patient when considering whether to have repair of a small asymptomatic hernia.

B

A crucial component of this plan is to consult with and to obtain the support of colleagues in primary care. Informal discussions have already taken place with a view to raising this formally through the established consultation processes.

C

Several of these interventions are low gain procedures unless offered to patients with severe symptoms. This raises the question of thresholds for interventions and the need to have "hurdles" in place to ensure that patients fulfil the criteria whereby the benefits outweigh the risks. We are considering how this might be implemented.

D

Finally, the use of "pooled" waiting lists has identified a wide spectrum for the level of threshold for surgical intervention between surgeons. Second surgeons seeing a patient from a pooled waiting list frequently consider the operation to be inappropriate. Our impression is that this occurs more frequently when the first surgeon is a junior doctor. We are at present considering whether we should only allow senior doctors to list patients for surgical intervention.

Although not directly within my remit in GG&C other procedures that could be subject to early review include:

Extraction of asymptomatic wisdom teeth.

Operations for uro/gynaecological prolapse where the symptoms are mild.

Hysterectomy for menorrhagia before exhausting conservative treatments.

Orthodontics for purely cosmetic reasons

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