NHS England

Paper: PB.04.07.2018/04

NHS ENGLAND – BOARD PAPER

Title: Developing the NHS long term plan: evidence based interventions
Lead Director: Professor Stephen Powis, National Medical Director Ian Dodge, National Director: Strategy and Innovation
Purpose of Paper: The NHS is already one of the world's most efficient health services, but like all other countries, we still have unjustified variation and waste. Over the next five years, the NHS budget will now be growing by 3.4% a year in real terms. But any savings we make on top of that can be reinvested in better frontline patient care. This paper therefore seeks approval to consult on the Evidence-Based Interventions programme, developed and jointly led by NHS England, NICE, NHS Improvement, the Academy of Medical Royal Colleges, and NHS Clinical Commissioners. This will protect patients from interventions likely to offer limited or no benefits while on plausible assumptions freeing up around £200m a year to reinvest in expanding and improving NHS care.
Patient and Public Involvement: We have liaised with patients and Healthwatch in the development of these proposals. We intend to publicly consult on the full proposals between 4 July and 28 September 2018.
The Board invited to: • Note progress; and • Approve the launch of the public consultation.

Evidence-Based Interventions Programme

Purpose

1. Earlier this year, NHS England and NHS Clinical Commissioners launched a new programme focusing on *items that should not be routinely prescribed in primary care*. The Board recommended in November 2017 that a similar approach be taken to interventions with no or limited clinical effectiveness.

2. We have partnered with NHS Clinical Commissioners, the Academy of Medical Royal Colleges (AoMRC), NHS Improvement and the National Institute for Health and Care Excellence (NICE) to develop a joint Evidence-Based Interventions programme. This follows discussions with the Board in November 2017.

3. We are seeking the Board's approval to publicly consult on the design principles for the programme, the interventions we should target initially, the proposed clinical criteria, the activity goals we should set, and twelve delivery actions, including proposed new terms in the NHS Standard Contract. The proposed consultation document is annexed to this paper.

Introduction

4. At both national and local levels, there is a general consensus that the NHS could get better at ensuring that the least effective interventions are not routinely performed, or only performed in more clearly defined circumstances. There are five reasons to turn this consensus into action:

   i. **Reduce avoidable harm** to patients. With surgical interventions, there is always a risk of complications and adverse effects which could be avoided.

   ii. **Save precious professional time,** when the NHS is severely short of staff.

   iii. **Help clinicians maintain their professional practice** in line with the changing evidence base.

   iv. **Create headroom for innovation**. If we want to accelerate the adoption of new, proven innovations, we need to reduce the number of least effective interventions performed.

   v. **Maximise value and avoid waste.** Ineffective care is poor value for money for the taxpayer and the NHS.

5. We propose the programme has a tight initial focus on seventeen interventions where there is clinical consensus and evidence that they should either not be routinely commissioned or should only be commissioned when certain criteria are met. We intend to make rapid and appropriate progress in reducing their volume in 2019/20, so that the practice better reflects the research evidence. If we do not take action now, and the trend over the past five years continues, it would take up to twenty-five years to reduce activity to the level we propose to aim for.

6. To identify the seventeen inventions for inclusion in phase one, we initially compiled a long list of interventions with no or limited clinical effectiveness, based on clinical evidence and research including NICE guidelines, *Choosing Wisely* recommendations, academic studies and NHS Clinical Commissioners' work on Procedures of Limited Clinical Effectiveness (PoLCE).

7. We prioritised changes that we could test our approach on and implement relatively quickly on a large scale. We focused on surgical interventions commissioned by CCGs, where there was high variability in the application of clinical guidelines.

8. We worked with the relevant Royal Colleges and clinicians to refine the list, ensuring there was clinical consensus and buy-in. We also worked closely with NHS Clinical Commissioners and patient representative groups like Healthwatch to test the proposals and understand their priorities.

9. We intend to make this a much wider, on-going programme, subject to making sufficient progress in the first phase. We will consult on further interventions in phase two, which will be launched in early 2019. We will keep the list of interventions under periodic review as the evidence base grows in future years. Phase two will also include specialised services, which are commissioned by NHS England.

The seventeen interventions

10. We propose to consult on:

    - Four interventions that should no longer be routinely commissioned by CCGs unless a successful Individual Funding Request is made, either because they are ineffective or have been superseded by a safer alternative (Category 1 interventions).

    - Thirteen interventions that should only be commissioned by CCGs or performed when specific clinical criteria are met (Category 2) – this is because they have only been shown to be effective in certain circumstances.

11. We have undertaken a data analysis exercise on the equalities characteristics of age and ethnicity to test whether our proposals for each intervention would have a disproportionate effect. Most of the eighteen interventions have a similar age profile to elective interventions overall and where these differ, such as for tonsillectomies, menstrual bleeding and knee arthroscopy, they are consistent with age groups at which the underlying problem is most prevalent. For ethnic groups, there are no substantial differences between the proportion of these interventions in the White British group, after taking account of the difference in the proportion of ethnic groups in different age groups. The exception is for Dupuytren's contracture, which is a more common problem amongst people of white European descent.

12. We intend to ask specific questions about equalities in the consultation. We are also targeting specific representative groups of protective characteristics (age, gender, disabilities and race) as part of the consultation exercise to help inform our final approach.

Illustrative activity goals

13. The main reason for introducing this programme is to prevent avoidable harm to patients and free up clinical time and capacity. This means reducing activity for these seventeen interventions. Last year, based on an initial assessment, we estimate the seventeen interventions were performed 348,201 times, amounting to £439m spend, although this figure will be subject to further review.

14. We have modelled three illustrative scenarios of the potential reductions in activity we could expect to achieve. Our moderate estimate is a reduction of 168,005 procedures in 2019/20, amounting to £203.3m spend. This is based on reducing activity for Category 1 interventions by 95% on the basis that they should rarely be performed. For Category 2 interventions, this is on the basis of reducing activity to the 20th percentile of the age-sex standardised rate of CCGs, as it is more difficult to judge the impact of the changes when the clinical criteria are still being agreed. We intend to test our assumptions as part of the consultation exercise, before confirming the actual figure later this year.

Delivery actions

15. We are aware that numerous prior initiatives have tried to eliminate ineffective practice with partial or limited success. Working together with our partners, we will ensure that change is delivered by taking twelve actions:

Engaging the system

i. A new **national collaboration**, comprising NHS England, NHS Clinical Commissioners, NHS Improvement, NICE, AoMRC and the relevant Royal Colleges, will steer the programme and support delivery.

ii. We will take a **systematic, multi-channel approach to communications and engagement with patients, clinicians and commissioners**. Clinical champions will be identified for each intervention to build clinical engagement. We also propose to issue statutory guidance to CCGs on Evidence-Based Interventions under Section 14Z8 of the NHS Act 2006.

iii. In the next few weeks, in parallel to the consultation, we will identify a small number of **exemplar geographies**, which are furthest advanced in implementing the clinical recommendations for the seventeen interventions. We will invite these geographies to form a reference group to further test our proposals and to share learning and provide peer-to-peer support to other systems.

Aligning incentives to the evidence

iv. We propose to ask providers to seek clinical approval to perform these interventions where they can demonstrate exceptionality – for Category 1 interventions via an **Individual Funding Request** and Category 2 interventions via a **prior approval process**.

v. We propose to set a default position of "**zero tariff"** (at sub-HRG level) in the National Tariff rules for Category 1 interventions, meaning providers would not be paid for delivering these interventions without a successful IFR.

vi. We propose, with effect from 1 April 2019, to amend the terms of the **national NHS standard contract** to require both commissioners and providers to comply with the policy, and to enable the commissioner to withhold payment for the relevant procedure without evidence of IFR approval (for Category 1 interventions) or other prior approval.

vii. Engagement with GPs, as well as hospital clinicians, will be key to successful implementation of the new policy. We will explore how the **e-referrals system** could be amended to flag these interventions to GPs.

Applying a rigorous approach to assess implementation

viii. We will set **activity based targets** for 2019/20. In financially challenged systems, accelerated progress on implementing the Evidence-Based Interventions policy will be an integral part of recovery plans.

ix. We will produce an **integrated monthly dashboard** to monitor how this programme is being implemented across the country and to ensure any issues are rapidly addressed.

x. We will expect local systems (commissioner and providers) to undertake an **annual audit** to ensure that they are not paying for interventions that should not be routinely commissioned.

xi. We will consider inclusion of an **indicator** of progress in delivering the Evidence-Based Interventions policy in the evolving CCG and STP frameworks.

xii. We are working with the **Care Quality Commission** (CQC) to consider how we can incorporate information about how effectively providers are applying the policy into their inspection methodology and quality ratings.

16. Modest additional resources will need to be identified to deliver these actions. We intend that a small dedicated team is established to oversee delivery of the programme. Within NHS England, the programme is a joint endeavour between the Medical and Strategy and Innovation Directorates. Professor Steve Powis is providing clinical direction, leadership and engagement. Ian Dodge is overseeing the programme coordination, implementation actions and delivery.

Next steps

17. Subject to the Board’s approval, the consultation will run from 4 July to 28 September 2018, during which time we will hold a number of events to gather further clinical, professional and patient views. We have taken advice from legal on the consultation process and will ensure appropriate public engagement in compliance with NHS England’s statutory duties under Section 13Q of the Act.

18. Following the close of the consultation, we will review and analyse all responses received and take them into account in finalising the approach.

19. We will seek the Board’s approval of the final policy post consultation and incorporate the requirements into the 2019/20 planning process.

Recommendation

20. The Board is invited to:
    - Note progress; and
    - Approve the launch of the public consultation.

Authors: **Ivan Ellul, Johannes Wolff and Stefanie Rutherford**