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NHS ENGLAND – BOARD PAPER

Title: Developing the NHS long term plan: reducing inappropriate clinical procedures

Lead National Directors:

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Purpose of Paper:

This summer, the Academy of Medical Royal Colleges, NICE, NHS Clinical Commissioners and NHS England and NHS Improvement joined forces to consult on how we best reduce the number of inappropriate interventions provided on the NHS.

Our main goals were to avoid needless harm to patients, and free-up scarce professional time for performing other interventions - including creating headroom for proven innovations. The time and resources saved will all be reinvested in patient care.

This Board paper now presents the results of the consultation. Overall, we found strong support from clinicians, NHS commissioners, providers, and national bodies. National patient representative bodies were also broadly supportive, in contrast to individual patients and members of the public who responded.

With the insights and practical suggestions from respondents, we have revised and strengthened our proposals. We have updated the clinical criteria for the 17 interventions and agreed these with the relevant medical royal colleges and specialist societies. With input from the NHS, we have also adjusted our implementation mechanisms, including expected activity reduction volumes for 2019/20. These are issued as part of new statutory guidance for CCGs, which will help ensure that a more equitable approach is taken across England.

Patient and Public Involvement:

The public consultation exercise took place between 4 July and 28 September 2018. We received 707 online responses and 97 individual submissions. We also spoke to 397 individuals by hosting or attending many events across the country.

The Board invited to:

- approve the response to the consultation, agree that NHS England issues statutory guidance to CCGs, and with our national partners, proceeds to implement the programme.

Evidence-based interventions programme

Background

1. In July 2018, we launched a consultation on the design and implementation of a new programme designed to reduce the volume of inappropriate interventions.

2. The evidence-based interventions programme runs alongside NHS England and NHS Clinical Commissioners' programme focused on *items that should not be routinely prescribed in primary care.*

3. The programme was conceived and developed as a joint enterprise between 5 national partners: the Academy of Medical Royal Colleges (AoMRC), NHS Clinical Commissioners, the National Institute for Health and Care Excellence (NICE) as well as NHS England and Improvement.

4. During the 12-week consultation, we received 707 online responses and 97 individual submissions. We also spoke to 397 individuals by hosting or attending a number of face to face and on-line events including:
   - patient and public events in Birmingham, London and Leeds.
   - workshops with individuals who have learning disabilities in Leeds and London
   - seven online webinars with: the Health and Wellbeing Alliance; Healthwatch England; NHS Clinical Commissioners; the NHS Youth Forum; and Voluntary Sector and Community Enterprise
   - the Patients Association facilitated focus group with patients.
   - the Academy of Medical Royal Colleges' conference with clinicians, patients and practitioners in London
   - the NHS Expo conference in Manchester
   - NHS Improvement costing forums in Leeds, Birmingham and London
   - the Guidelines International Network conference in Manchester.

5. Our proposals covered 17 interventions - whether delivered as day-cases or inpatients.

6. The differing evidence base meant we grouped them into two categories:

   - four interventions that should no longer be routinely commissioned by CCGs unless a successful Individual Funding Request (IFR) is made, either because they are in most cases inappropriate 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) because they have only been shown to be appropriate in certain circumstances.

7. The attached consultation response outlines in detail the feedback we received and how these comments have influenced our proposals.

8. Some CCGs wanted to add additional interventions to the list of 17. We concluded that these should be considered as part of a further public consultation, on a second phase of the programme.

9. We have sought to improve our clinical criteria to ensure that they fully reflect the clinical evidence developed by NICE, NICE-accredited or specialist society guidance, upon

which the proposals were based. **We have made numerous improvements to the clinical criteria**, including:

- expanding the wording in the recommendations for Carpal tunnel syndrome release, Dupuytren's contracture release, Ganglion excision and Trigger Finger Release to align with proposals from the British Society for Surgery of the Hand;

- excluding children from the criteria related to Trigger Finger Release, Dupuytren's contracture release and Snoring Surgery as these conditions present differently in children and may indicate more serious underlying conditions;

- clarifying that those children who cannot undergo normal assessments are still able to access specialist advice for Grommets for Glue Ear.

10. **These and other improvements to the clinical criteria have been carefully tested with, and approved by, the relevant medical royal college and specialist societies**.

11. We have undertaken data analysis on the **equalities characteristics** of age and ethnicity to test whether our proposals for each intervention would have a disproportionate effect. **We can confirm that our analysis has not shown any significant concerns**. A number of the seventeen interventions have a similar age profile to elective interventions overall. Where these differ, such as for tonsillectomies, hysterectomy due to 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.**

Activity goals

12. The aim of the programme is to prevent avoidable harm to patients and free up clinical time. In our consultation we modelled three illustrative inpatient activity reduction scenarios:

- Category 1 interventions: a conservative target based on a 90% reduction in national activity, a moderate target based on a 95% reduction in national activity, and an ambitious target based on a 99% reduction in national activity.

- Category 2 interventions: conservative target based the 25th percentile of the age-sex standardised rate of CCGS, a moderate target based on the 20th percentile of the age-sex standardised rate of CCGs, and an ambition target based on a 15th percentile of the age-sex standardised rate.

13. Following feedback, for 2019/20 we are setting out a 'conservative' inpatient activity reduction figure for Category 2. This will be established as a minimum reduction target for CCGs, STPs/ICSs and providers. This represents the 25th percentile of the age-sex standardised rate of CCGs (rather than the 20th percentile as originally proposed in the consultation document). For Category 1 interventions, we have concluded that we cannot sensibly estimate the number of the 'exceptional' cases that will arise from successful Individual Funding Requests; by definition, the activity levels without IFRs will reduce to zero.

14. We have also made changes to around 20% of the 250 codes we used to generate the underlying data. **We calculate that the 17 interventions were provided 335,026 times as inpatient spells and day cases in 2017/18. From that baseline, we intend to reduce these by at least 128,038 by the end of 2019/20.**

15. Due to data limitations, we cannot calculate nationally the **volume of outpatient appointments that will also be saved** as a result of this programme.

Supporting delivery actions

16. We have established a **national steering group** to strengthen our collaborative approach. This comprises NHS England, NHS Clinical Commissioners, NHS Improvement, NICE, AoMRC and the relevant Royal Colleges, as well as the Care Quality Commission, British Medical Association, NHS Confederation, NHS Providers, National Voices, The Patients Association and patient representatives to help steer the programme. The steering group is providing advice to the **programme board**.

17. We are now issuing the clinical criteria for the 17 interventions as **statutory guidance to CCGs**, under Section 14Z8 of the NHS Act 2006. This national guidance will help ensure a more equitable approach across the country.

18. Our new statutory guidance for CCGs sets out **activity reduction figures for each of the 17 interventions by each CCG and by STP/ICS area.** We will also calculate 2019/20 goals for providers.

19. We are creating a **demonstrator community**. This builds on our early work with Frimley ICS and South West London STP. We will share learning and facilitate peer-to-peer support to other systems. Led by the Academy of Medical Royal Colleges, we are also increasing and strengthening clinical communications.

20. At this stage, we are implementing an IFR only process for category 1 interventions. **With effect from 1 April 2019, we have amended the terms of the national NHS Standard Contract to require both commissioners and providers to comply with the policy, and to enable the commissioner – subject to the statutory consultation on the 2019/20 National Tariff Payment System - to withhold payment** for the relevant procedure without evidence of IFR approval (for Category 1 interventions).

21. We are working to **identify IT solutions** that will make implementation easier. This includes **excluding Category 1 interventions from the e-referral system**, except where an IFR has been agreed. We will work to identify other electronic solutions to support the prior approval route.

22. In addition to setting out local activity goals for 2019/20, by the end of the year we will publish an **integrated dashboard** that is aligned with the programme seeking to reduce items that should not be routinely prescribed in primary care. Where local systems are struggling to make progress, we will seek to understand, challenge and support faster progress, as part of routine performance management. This will be through the 7 NHSE/I Regions.

23. We are developing an **indicator of progress** in delivering the Evidence-Based Interventions goals. We will consider its inclusion in the evolving **CCG and ICS/STP**

assessment frameworks from 2019/20. We are also working with the **Care Quality Commission** to incorporate information about how effectively providers are applying the policy into their inspection methodology and quality ratings.

24. We conclude that we are confident that the intended activity reductions will be achieved. The consultation process already appears to have contributed to an in-year 2018/19 volume reduction effect. All five partner organisations are committed to playing a full role in achieving the activity reduction goals.

25. Subject to satisfactory progress in relation to the 17 interventions, **we will consider an expansion of the programme in early 2019.**

Recommendation

26. The Board is invited to approve the consultation response, issuing of statutory guidance and implementation actions.

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