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NHS Clinical Commissioners response to the consultation on Evidence-Based Interventions

Friday 28 September 2018

I. NHS Clinical Commissioners

NHS Clinical Commissioners (NHSCC) is the membership body of Clinical Commissioning Groups (CCGs). Established in 2012, we have over 91% of CCGs in membership. We offer a strong national voice for our members on specific policy issues and support them to be the best they can to commission services effectively for their local populations.

NHSCC was actively involved in a counterpart to the Evidence-Based Interventions (EBI) programme, when we worked with NHS England to publish '*Conditions for which over the counter items should not routinely be prescribed in primary care: Guidance for CCGs*' as part of joint work to improve outcomes and value from medicines.

Following on from this, we have worked with NHS England, alongside other partners including the Academy of Medical Royal Colleges, NICE, and NHS Improvement to develop proposals for the EBI programme. It remains vital that we continue to represent our members' views as proposals are developed. To inform our response we have therefore sought the views of our members through a series of webinars, hosted jointly with NHS England, to provide a forum for our members to hear about, and comment upon, the proposals within the EBI consultation. We also engaged with our members through a virtual reference group, comprised of NHSCC board members and CCG leaders from our wider membership, including Chairs and leads of work relating to EBI and Procedures of Low Clinical Effectiveness (POLCE).

II. Overarching comments

Our members report broad support for the consultation's aims

Our members are highly supportive of the EBI programme's aims to provide a national steer to reduce the number of procedures performed by the NHS that are of low or no clinical effectiveness to prevent avoidable harm and free up clinical time and capacity. Every procedure carries risk and it is right that procedures that are being carried out should be scrutinised in terms of clinical effectiveness. In addition to reducing unnecessary risk for patients, it is also important to reduce clinical time that is spent on unnecessary procedures in order to free up the limited time of clinicians to focus on interventions that are clinically effective.

With responsibility for meeting the needs of their populations, and with limited financial resources to do so, CCGs also need to ensure that the money they spend delivers the best value from the NHS pound. With the estimated spend on activity for the 17 interventions amounting to £439m last year, there is significant scope to reorient this funding toward more effective treatments and deliver more treatment within the national access standards, in order to enable CCGs to deliver better value for their local populations. The current levels of activity for the 17 listed procedures vary significantly



across CCGs, as the variation graphs in the consultation document appendix illustrate. As our members are increasingly having to make difficult decisions about where they prioritise funding, a clear national steer helps CCGs to allocate funding to the most clinically effective interventions, while reducing unwarranted variation. Having a national steer also improves the efficiency of the process of reviewing and developing policies for individual interventions, as this can be done once centrally and then shared with all CCGs, as opposed to each CCG independently undertaking these activities.

The minimum nature of clinical thresholds must be clear

Many of our members have already undertaken comprehensive work to reduce procedures of low clinical effectiveness, having reviewed the evidence base and consulted with their local populations. Adherence to the EBI programme should not penalise such CCGs, where they have determined policies for procedures within the list of 17 interventions that already go beyond the proposals set out in the consultation, for example by setting additional criteria that must be met in order for the procedure to be considered. One example of this, highlighted by our members, is the removal of benign skin lesions (category two, F), where many CCG policies already go beyond the scope of restrictions proposed in the consultation. We have fed examples of this local work done by CCGs back to NHS England, so that existing learning is drawn upon. While the minimum nature of the set thresholds is stated in the consultation document, there is a need to build upon this statement to ensure that CCGs and the providers who deliver care for their populations receive this message clearly to ease existing concerns that have been expressed. This also needs to be clear in patient-facing communication and engagement activities, so that expectations are aligned.

The scope of the EBI consultation should be considered as proof of concept, to be followed by further work

While we are supportive of the 17 interventions proposed in the consultation, which will act as proof of concept, our members would like to see the scope of the EBI programme go further – both in the thresholds set and the number and range of interventions that are identified. For many of the listed interventions, there are other reasons why they are performed in addition to the specified example. One instance of this is knee arthroscopies; many CCG policies on knee arthroscopies already include thresholds for several other clinical conditions.

Furthermore, this programme clearly focuses on interventions where there is an evidence base about effectiveness, or lack of, and has not focused at all on ‘low value’ interventions. Our members would also welcome further, ambitious proposals to identify and reduce activity of **both** low clinical effectiveness and relative value for use of the NHS pound. We look forward to working together on the next steps for EBI, to continue to feed in the views of our members in this regard.

The success of this programme will depend on widespread support

A range of efforts have been made to engage with members of the public on the content of the consultation, including public events and a range of online engagement, however the nature of the proposals and clinical thresholds may not be readily understood by many members of the public. Equally, engagement is also ongoing with the clinical community whose behaviour and practice may be impacted by the EBI proposals. There is a need to ensure that engagement on the consultation is broad enough to build the basis of support and mutual understanding that is needed to successfully implement the proposals.

Implementation challenges need to be worked through

There are a number of implementation challenges that must be worked through as the EBI programme progresses if it is to be successful. Examples highlighted by our members include: whether the proposals are mandated or guidance; refining implementation mechanisms, including referral processes; the need for clear patient-facing communications; ensuring continued clinical input; addressing coding issues; and determining the most appropriate monitoring and adherence processes. It is highly likely that there will be different ways of tackling implementation that are already in place and it is imperative that where these are working locally, across the system for commissioners and providers, that they are not then undermined by a strict national approach.

III. Implementation challenges to be worked through

Whether proposals are mandated

Our members would find it useful to apply a national mandate for the category one interventions – those which should not be routinely commissioned or performed. There is a clear evidence base that these procedures have limited to no clinical effectiveness, and more effective or less risky intervention options exist. However, a number of areas are still reporting high levels of activity for category one interventions and it would therefore be helpful to have a clear national steer in terms of mandation to drive national parity and reduce unwarranted variation. The minimum nature of this mandation must be made clear through communications to CCGs and providers (irrespective of sector) and NHSCC will continue to engage with our members in this regard. Remaining issues will also need to be addressed to determine agreement that the correct interventions are placed in the appropriate category (for example feedback from our members questioned whether breast reduction should be a category one intervention rather than category two).

There was some diversity in member views as to whether category two interventions should be mandated and as a collaborating organisation involved in the EBI programme, we would welcome the opportunity to work through this option in more detail with our members. Some felt it would be useful for these thresholds to be mandated, while emphasising that there should be flexibility afforded for implementation mechanisms. Other members felt that mandation may be detrimental to those CCG who have gone further with more restrictive thresholds.

Implementation mechanisms, including referral processes

Several members question the proposal for GPs to seek individual funding requests, rather than the treating provider clinician. GPs may lack appropriate specialist knowledge to make these decisions. The consultation's proposal to place responsibility with GPs would also conflict with a number of existing CCG policies for individual funding requests that currently state that they must be completed by the treating clinician. Some of our members feel this detail should therefore be reconsidered, and a clear rationale for the decision needs to be provided. Any resulting challenges will need to be worked through with both CCGs and providers.

Across our members, there is variation in the level of development of existing prior approval systems within CCGs. Some members already have effective systems in place to implement clinical thresholds, for example one member is successfully managing category two interventions using 'trust and verify' (audit) arrangements, rather than prior approval. This system is working well, and the CCG is in the

bottom quartile of activity for most of the listed interventions. Another area has a prior approval process in place that is working well. Implementation mechanisms for category two interventions should therefore be broad enough to not restrict CCG freedom to agree local implementation processes. However, alongside this, other CCGs do not have well-established systems in place and have experienced challenges working with providers when they have tried to implement one. The publication of a best practice way of managing prior approval, as proposed in the consultation, or several good practice examples, would therefore be helpful, and NHSCC will work with partners and our members to develop this.

Other issues regarding e-referral systems have also been raised. One of our members questioned “moving away from e-referral systems”. This may need more clarity in terms of removing category one interventions (as per page 25) and we will continue to get more information from them on their concerns and a suggested approach.

A point was also raised regarding primary care provision of these interventions. This isn’t seen to be sufficiently covered by the proposals, so the detail of this requires further consideration, for example to include clarification over how the removal of benign skin lesions in primary care will be managed as it cannot be monitored through the referral system.

All of these details relating to implementation and referral processes will need to be worked through with CCGs and providers within demonstrator sites and then monitored to understand any possible unintended consequences and to ensure no adverse impacts.

Clear patient-facing communications

If the proposals move to implementation, it is important to develop clear public-facing communications that can support conversations with patients when discussing eligibility for the identified interventions. Patient decision aids for shared decision making would be helpful. Considerations should be given as to whether the completion of a patient decision aid should be mandated, prior to one of the listed interventions taking place, to ensure that patients are aware of the evidence, risks and benefits before consenting to one of these interventions.

Continued clinical input

It is right that the EBI programme is clinically led. Expert clinical input from across CCGs is needed in order to help shape the proposed criteria for the 17 interventions, and we expect that some of the consultation responses received will highlight adaptations required, on the basis of clinical knowledge. Our members have raised with us a number of issues to be addressed, details of which we have passed on the NHS England team. Some of the issues raised include:

- Clarification over the scope of the removal of benign skin lesions – to include whether the proposal relates only to surgery or if it includes laser treatment. Some of our members have highlighted that it would be helpful to have a clear evidence base on laser treatment.
- Clarification over why it is only noted that gynaecomastia is allowed following prostate surgery (referenced in the clinical criteria for breast reduction). A member raised the point that if this is due to gynaecomastia being drug induced in this instance, then the policy is not clear as drugs that induce it are used in a range of other conditions as well – further detail on this would therefore be welcomed.

- Clarification about the evidence base for shoulder decompression surgery, and whether it should be commissioned at all without being part of a randomised controlled trial to help establish a clear evidence base.

The above examples represent a snapshot of the clinical issues that should be worked through and adapted on the basis of expert input gathered through the consultation exercise. Moving to implementation, proposals should then be tested and adapted as appropriate based on findings from demonstrator sites. NHSCC has already passed on details of interested CCGs to the NHS England team.

Coding issues

A number of our members highlighted issues around coding – many relating to the point that coding is not specific enough to pick up the restricted procedures. If coding difficulties are not resolved, then our members feel that certain interventions for which there are a number of exceptions, such as pain injections, could be very resource-intensive to manage. To address these issues, the detail of coding needs to be reviewed following the analysis of all consultation responses, and then worked through in specific demonstrator sites with both commissioners and providers.

Monitoring and adherence

Monitoring and adherence processes should not place an undue burden on CCGs. This is aligned with two of the six design principles of the EBI programme being to save professional time and maximise value and avoid waste. Working processes through with both CCGs and providers will be essential and ensuring efficient monitoring and adherence mechanisms should be a focus of demonstrator sites.

IV. For more information

If you would like any further detail on our response please do not hesitate to contact our Head of Policy and Delivery, Sara Bainbridge at s.bainbridge@nhsc.org, or Senior Policy Officer, Emily Jones at e.jones@nhsc.org. In addition to our response, NHSCC will continue to work with NHS England and partners to take forward the EBI programme, informed by the views and insight gathered through this consultation exercise.