right care
right place
right time
right outcome

NHS
Merton
Clinical Commissioning Group

MERTON CLINICAL COMMISSIONING GROUP
GOVERNING BODY

Date of Meeting: 15 December 2016

Agenda No: 3.1 **Attachment:** 02

Title of Document: Evidence Based Commissioning	**Purpose of Report:** Decision Requested
Report Author: Andrew Moore: Programme Director- Financial Recovery	**Lead Director:** Andrew Moore
Contact details: andrew.moore16@nhs.net	
Executive Summary: The report sets out a number of areas for the governing body to consider in relation to changing the thresholds for particular types of elective care.	
Key sections for particular note (paragraph/page), areas of concern etc: Nil	
Recommendation(s): That the governing body: • Note the process which is on-going to work with the South West London (SWL) CCGs to develop revisions to clinical thresholds • Endorse the principles adopted • Await the final form of the policies for approval at a future meeting	
Committees which have previously discussed/agreed the report: Executive Management Team, Clinical Reference Group, Finance Committee	
Financial Implications: If the recommendations are adopted, there are likely to be material savings in 2017-18 as a result of both the policy changes and the associated system and process improvements.	
How has the Patient voice been considered in development of this paper: Yes, an early outline of this paper was presented to the Merton Patient Engagement Group (PEG) and key principles discussed.	
Other Implications: (including patient and public involvement/Legal/Governance/Risk/Diversity/ Staffing) There is no particular legal implication of commencing a review. The final recommendations for change will include examination of legal and governance risks.	
Equality Assessment: As the paper is seeking approval to commence a review of current policy an equality impact assessment has not been carried out.	

Information Privacy Issues: N/A
Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution): See section in the body of the paper

right care
right place
right time
right outcome

NHS
Merton
Clinical Commissioning Group

Evidence based commissioning in Merton- a review of existing arrangements and proposal for the future

Context and introduction

NHS England has invested in the **RightCare programme** with the expectation that it should be the 'business as usual' way of carrying out **evidence-based and clinically-engaged change**. It is a programme committed to improving people's health and outcomes which makes sure that the right person has the right care, in the right place, at the right time, making the best use of available resources.[1] It is applicable across the whole health care system and is national policy; therefore Merton CCG needs to embed this approach into its programme of review of commissioned services and transformation of out of hospital care.

Like its neighbouring CCGs, Merton CCG is financially challenged and needs to prioritise its spending and commissioning decisions to ensure maximum value for money whilst improving the health of the population and reducing longstanding health inequalities in the borough. This is summed up by our responsibility under the Equality Act 2010 and Health and Social Care Act (2012)[2] to:

> *"Give regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities".*

Additionally Merton CCG needs to consider its position within the local health care system and its commitment to work with local partners. The South West London Sustainability and Transformation Plan[3] (the STP) has highlighted that the whole of SWL Healthcare system has considerable financial challenges over the period covered by the STP. Development of the STP has already encouraged commissioners, hospitals and non-hospital providers to work together. It is important for the development of new policies to take account of the needs of all parts of the system. By defining agreed thresholds for access to elective treatment together, and identifying those procedures where there are alternatives to hospital care, this will ensure the system as a whole is sustainable and delivers for all the patients it serves.

There are a number of advantages in working with our colleagues in all six CCGs in SWL and keeping the threshold policies in the SWL Effective Commissioning Intentions common to all CCGs as far as possible:

[1] https://www.england.nhs.uk/rightcare/

[2] The Health and Social Care Act 2012

[3] http://www.merton.gov.uk/health-social-care/sw_london_stp.htm

- All SWL patients have common access to evidence based treatments and we don't expose patients to a 'post-code lottery', where changing GP could lead to a having different access to particular elective treatments.
- Providers are not exposed to having to apply different sets of rules to patients from within SWL, depending on which CCG is responsible for the patient as this could add complexity and compliance costs.
- The six SWL CCGs are increasingly working together within the STP footprint and can share the work of maintaining the thresholds and ensuring the whole system acts fairly to ensure consistent access for patients.
- Referrers have a widely shared understanding of what the latest evidence says and apply the same thresholds. This is important as many GPs work across different practices and borough boundaries.
- Risk sharing across the patch may assist in case of challenge relating to a clinical policy decision.

The current situation in Merton and the South West London Perspective

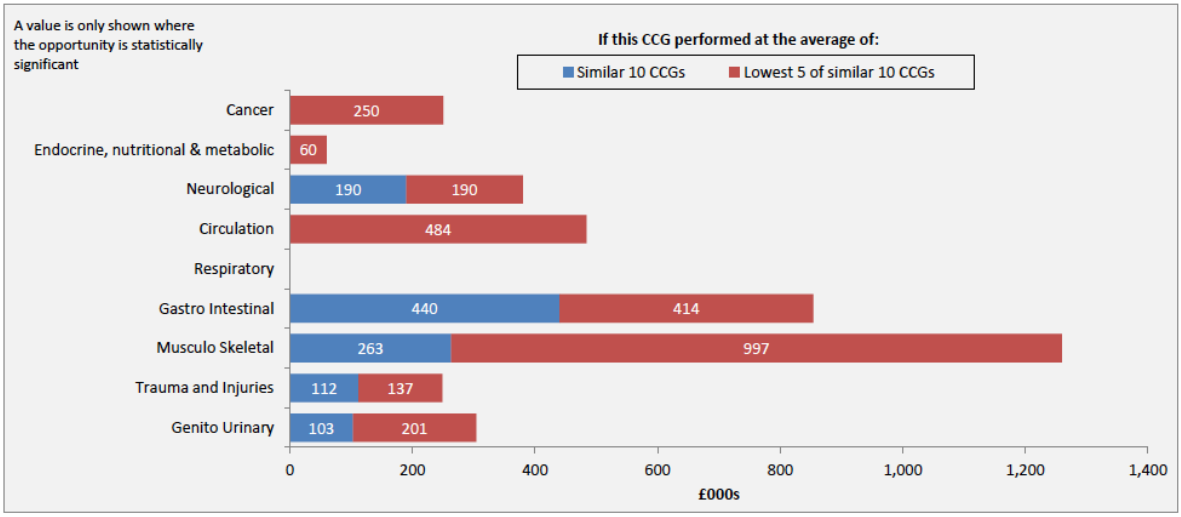
Merton CCG is a member of the SWL collaborative and as such has signed up to the SWL Effective Commissioning Initiative. This document identifies agreed thresholds for treatments for which restricted access has been agreed and has been in place in its current form since 2014[4]. The access criteria are based on evidence of clinical effectiveness and have been developed by the South West London Public Health Network.

In trying to understand the current base line impact of these policies it has become evident that there is little systematic implementation of these polices across the Merton CCG population or the wider SWL area. It is therefore the case that there is differential application by individual clinicians of the existing policies and at an organisational level there is incomplete contractual enforcement.

It is recognised that by enforcing the existing policies more effectively there would be benefit in improving the application of evidenced based treatment thresholds, and subsequently a reduction in the level of elective activity undertaken by acute trusts. However, the current policies approved in 2014 would still require review to ensure they are up to date, that they are constructed in a way that supports consistent clinical application. The CCG would also need to agree with partners how monitoring of the policies could systematically occur.

[4] http://www.wandsworthccg.nhs.uk/newsAndPublications/Publications/Documents/Effective_Commissioning_Initiative%202014-2015.pdf

Elective care benchmarks for Merton CCG –RightCare data



The spend data presented above uses Secondary User Services Extract Mart (SUS SEM) and is from financial year 2015/16.

As the Rightcare data indicates, there is evidence that Merton CCG is an outlier in the expenditure on elective care and this has guided the selection of the initial areas for review.

As a partner to the South West London STP, Merton CCG is also affected by the approach being taken in the wider health community. Croydon CCG is the lead within the SWL STP for developing a SWL approach to clinical priorities, access thresholds and Procedures of Limited Clinical Value. As Croydon CCG is also in formal financial turnaround, they have been completing this work at pace and subsequently have started the process of implementation in advance of SWL agreement.

In addition, Merton CCG and Richmond CCG have prioritised their approach to this agenda and the Richmond CCG Governing Body has agreed a paper setting out further work to strengthen their commissioning in this area. Richmond CCG and Merton CCG have been working together with a single management lead overseeing their approach and as part of this, commissioned external expert support to review the local policies and make recommendations.

Merton CCG has carried out an initial estimate of the potential impact of making changes to the policies and the number of people potentially effected. This work will be included in the impact analyses when the final agreed policies are presented for approval.

While there are some consistencies to the approaches taken by Croydon and Richmond/Merton there are also differences that should be resolved where possible in advance of any final recommendations being made to ensure clinical consistency. Sutton CCG, Wandsworth CCG and Kingston CCG have now agreed that they would take papers that are agreed at a SWL STP level through their Governing Bodies to support approval in advance of the 2017-19 acute trust contracts.

All six CCGs Director of Commissioning covered by the SWL STP have agreed that in addition to the Policy Review, work should be undertaken to ensure a SWL Clinical Priorities Committee including General Practitioner, secondary care consultant and

Director of Public Health membership exists to carry this work forward. In addition there is also a commitment to consider use of the Lead Provider Framework to secure the most effective partners in supporting implementation and monitoring of the policies.

Merton CCG-a clinically led organisation

Merton CCG has a strong ethos of being a clinically led organisation. Its structure and governance ensures that clinicians are consulted about its commissioning decisions as widely as possible. The routes for this engagement include locality meetings, practice commissioning leads forums, the clinical quality committee, the clinical reference group and the clinical cabinet. Additionally all key decision making committees within the CCG have GP membership. Within the governance arrangements of the CCG the clinical reference group can make recommendations to the executive management team and the Governing Body about issues of clinical importance.

As part of its financial recovery plan and also as part of work with neighbouring CCGs, Merton has identified the need to review all of its commissioned services for clinical quality and effectiveness and value for money. This process is already underway and is supported by a governance framework that has been agreed within the CCG. With respect to the review of the existing ECI policy, Dr Vasa Gnanapragasam, our Clinical Director for planned care has been working with CCG managers to identify whether the thresholds in the ECI policy are still fit for purpose and to make suggestions for procedures or clinical situations where a re-evaluation may be desirable. The list of these is also being discussed more widely in SWL to try to agree a consensus position as far as possible.

The clinical directors of the CCG and the Director of Public Health for Merton have given senior clinical scrutiny to proposed changes in commissioning and will ensure that appropriate engagement with the wider membership, and patients and the public take place. Clinical leaders have undertaken an initial review of the list of procedures below that are also under consideration by Croydon and Richmond CCGs in preparation for the CRG workshop on 1/12/16.

1. Arthroscopic Knee Surgery
2. Dupuytren's Fasciotomy surgery
3. Pain Management- lumbar epidurals
4. Hallux Valgus Osteotomy (Bunion Surgery)
5. Carpal Tunnel Surgery
6. Hip replacement
7. Knee replacement
8. Cataract surgery provision for second eye operations
9. Increasing patient fitness for elective care
10. Reversal of Female and male sterilisation
11. Minor Skin Lesions (treatment of)
12. Asymptomatic Gallstones
13. Circumcision
14. Grommets
15. (Adeno) Tonsillectomy

The Senior Clinicians and CRG adopted the following **principles** for this crucial piece of work:-

- The promotion of evidence based commissioning whilst seeking to evaluate both the quality and content of the evidence provided.
- Decisions should be ethically robust based on the four ethical principles[5] of beneficence, *non-maleficence*, promotion of autonomy in decision making for patients and justice. Largely this means that commissioned services should benefit the health of patients, they should be protected from procedures that the evidence suggests offer limited or no clinical value, support for patient decision making should be strengthened and there should be equality of access to care.
- The process is clinically led and encourages as much clinical engagement as possible within the time constraints.
- It supports the enforcement of currently agreed ECI guidelines.
- It strives to reduce health inequalities in Merton.
- It promotes partnership working across SWL CCGs and supports transformation of care.
- Any proposed changes will be assessed from the perspective of benefits to patients, risks to patients and impacts on any other part of the system.
- Where risks are identified steps will be taken to mitigate them that may include developing new community pathways of care.
- That policy implementation will utilise efficient processes minimising bureaucratic impacts on patients, clinicians and organisations at all stages of the decision making process.
- Stakeholder engagement should be as wide as possible and the process should be transparent to patients.
- A robust and timely IFR process should support the process to deal with genuine cases of exceptionality. There should also be a process whereby feedback and complaints from IFRs can be captured and learnt from. This could be monitored via the clinical quality committee of the CCG.

The need for patient engagement

Merton CCG is committed to fulfilling its responsibilities under Section 14Z2 of the Health and Social Care Act which states that:

> *'each CCG has a duty, in relation to health services provided (or which are to be provided) under arrangements made by the CCG exercising its functions, to make arrangements so as to secure that individuals to whom the services are being (or may be) provided are involved at various specified stages, including:*
>
> - *•In planning commissioning arrangements;*
> - *In the development and consideration of proposals for change;*
> - *In decisions affecting the operation of commissioning arrangements where implementation would have an impact on the manner in which services are delivered or the range of services available.*'

[5] BMJ. 1994 Jul 16;309(6948):184-8.Medical ethics: four principles plus attention to scope. Gillon R

The CCG is also bound by the NHS Constitution and the rights of all patients to be involved in decision-making processes which affect them.

As an NHS body, the CCG has a responsibility to put patients at the heart of everything we do and is accountable to the public, communities and patients we serve.

The development of options has been shared in public through a number of channels including reference in Part 1 of Governing body meetings in July, September and November. Most recently the plans were shared with the Patient Engagement Group on 28 November. The Governing Body also discussed the next steps as part of their recent away day. The Chair and Chief Officer met the Chair of the Oversight and Scrutiny Committee to discuss the CCG's current financial position and the ways in which it was looking to ensure it was able to bring it back into balance.

The comments and ideas raised through all of these have helped and will continue to help form the proposals as they stand and to inform the development of next steps in terms of wider public and stakeholder engagement.

The plan for initial clinical engagement

High level plans were shared with CCG clinicians and the wider membership via discussions at the monthly clinical reference groups, and most recently at the Practice Leads Forum in November 2016. Additionally some Merton clinicians attended a workshop hosted by Richmond CCG to promote wider clinical engagement and to support the continuation of a shared SW London approach.

Key dates:-

22/11/16	Richmond and Merton CCG workshop with secondary care providers (Dr Murray, Dr Worthington and Dr Chill attended)
28/11/16	Patient Experience Group attended by Liam Williams.
29/11/16	Clinical Cabinet
1/12/16	Clinical Reference Group-extraordinary meeting for this purpose with GP and nurse representation
6/12/16	GB seminar
15/12/16	GB public meeting

Following the CRG meeting all feedback was collated into this Governing Body paper.

Recommended actions from work to date

- A communication should be sent to all Practices advising them of the expectation that existing thresholds should be enforced without delay. The partnership managers will liaise with the Practice Leads and Practice Mangers to ensure all clinicians have the existing ECI policy on their desktop and that a link is incorporated into the Merton locum toolkit.

- Phase 2 of the clinical review will commence to ensure consistency of process. This will focus on the additional procedures recently added to the list and will follow the same principles as the earlier work. Existing clinical directors and new

clinical leads shortly to be appointed will undertake the work with a report to the January 2017 CRG.

Knee washout
Therapeutic facet blocks
Obstructive sleep apnoea surgery
Pinnaplasty
Rhinoplasty
Varicose Veins surgery
Hysterectomy for heavy menstrual bleeding

- Continue to work collaboratively with the aim of a SWL wide document being produced detailing amended and/or new thresholds.
- A SWL process needs to be formalised for the review and communication of changes as new evidence becomes available. Merton proposes that this is led at an STP level by Public Health in SWL to ensure hierarchies of evidence are considered by the clinicians with the appropriate expertise.
- The CRG highlighted the following areas for further scrutiny including possible amendments to access to cataract surgery