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NHS
Merton
Clinical Commissioning Group

Merton Clinical Commissioning Group
Governing Body

Date of Meeting: 29th September 2016

Agenda No: 7.2 **Attachment:** 14

Title of Document: Review of Commissioned Services	**Purpose of Report:** For approval
Report Author: David Boothroyd - Head of Contracting	**Lead Director:** Karen Parsons – Director of Commissioning

Executive Summary:

The review of Effective Commissioned Services forms a significant part of Merton CCGs Financial Recovery Plan. A paper was submitted and agreed by the Governing body in July to review all commissioned services and procedures within an equitable, open and transparent process that realises benefits for the whole population of Merton matched against need and the available budget.

Three work streams have been developed under the Review of Commissioned Services programme.

- Prior Approvals
- Effective Commissioning Initiative Criteria
- Review of Acute and Non Acute Services/Procedures

Prior Approvals

CCGs across South West London, working with the CSU, are currently using the 2014/15 SWL) that provides the criteria for some referrals classed as 'Prior Approval' before proceeding with the procedure.

Prior Approvals have been prioritised by the Merton CCG Clinical Reference Group (CRG) and the process is being rolled out through the use of DXS software in GP Practices. A letter will be sent to the Acute Trusts over the next 4 weeks informing them that we expect them to follow our Prior Approval process.

Expected savings are difficult to estimate, however, it is very unlikely everyone uses the threshold criteria and therefore we have estimated a 10% reduction in referrals.

Effective Commissioning Initiative Criteria

The SW London CCGs have worked with the South East Commissioning Support Unit (CSU) to examine the current ECI policy list. The existing policies are due for review and are arguably in some cases not specific enough and require a review using the most recent available clinical evidence. This process will commence shortly and may require the SWL CCGs to engage with stakeholders.

These reviews should follow the usual process for making changes to thresholds – unless there is a substantial change that requires additional engagement and consultation.

This project is being led through the SWL Directors of Commissioning group and the South East Commissioning Support Unit.

Review on Acute and Non Acute Services/Procedures
The SWL STP Chief Officers have set up a number of delivery groups. The ECI work will be developed and delivered through the STP Contract Delivery Group, led by Sutton Chief Operating Officer and Croydon Chief Finance Officer.

The STP working groups have yet to be mobilised, therefore, Merton CCG continues to progress the work so as not to lose momentum.

The Merton CCG process was signed off at the July Governing Body. This paper provides the details of the progress since that date, including the Benefit Realisation Tool and services prioritised by EMT.

The paper also includes a list of procedures Richmond CCG Governing Body has approved for increasing thresholds and disinvestment. The Governing Body are asked to review and decide if Merton CCG can follow decisions made by Richmond CCG without running through our process.

Key sections for particular note (paragraph/page), areas of concern etc.:

The Governing Body should be aware of the implications of agreeing to follow Richmond CCGs decisions.

Recommendation(s)/Approval:

That the Governing Body:

1. Agree with the CCGs approach to Prior Approvals and ECIs
2. Agree to align our process with our neighbouring CCGs in SWL
3. Agree to support one of the two options:

Option 1:

Review Richmond's efficiency options and agree to allow EMT to implement the thresholds and disinvestment given in Table 1. EMT will review the impact in relation to our pathways and assess risks to our current pathways i.e.MSK pathway)

Option 2:

Continue with our own process for areas reviewed and agreed by Richmond CCG and take them through our agreed Decision Tree.

We intended to bring to the September board a number of services we consider a priority to review but now would like the GB to consider this report.

Committees which have previously discussed/agreed the report:
None but the contents have been discussed

Financial Implications: There are financial savings from this programme of work which are identified in the document.

Other Implications: (including patient and public involvement/Legal/Governance/ Risk/ Diversity/ Staffing) All implications are indicated in the document.

How has the Patient voice been considered in development of this paper:
Patient representatives have been involved in reviewing services. Public engagement will be part of a project plan.

Equality Analysis: Equality Impact has been completed in the risk assessment; however, a complete Equality Impact Assessment will be completed for services that are deemed to require them.

Information Privacy Issues: N/A

Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution) A communication plan is running concurrently with this work.

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Introduction
All CCGs are responsible and accountable for ensuring all commissioned services are based on need, quality driven and affordable. An integral part of Merton CCGs QIPP programme over the next 2 years is an undertaking to review all its commissioned services under the umbrella of Effective Commissioning Initiatives.

1. Context

The review of Effective Commissioned Services forms a significant part of Merton CCGs Financial Recovery Plan. A paper was submitted and agreed by the Governing body in July to review all commissioned services and procedures within an equitable, open and transparent process that realises benefits for the whole population of Merton matched against need and the available budget.

Since its inception Merton CCG has worked across a South West collaborative with varying levels of success. There is already an Effective Commissioning Initiative in place run by our Commissioning Support Unit (CSU) which Merton CCG is fully engaged with.

Merton CCG is an integral member of the emerging South West London Sustainability and Transformation Plan (STP) which sets the strategic commissioning plan for the local footprint from 2017/18 to 2020/21. The plan is being developed through genuine collaboration between all NHS commissioners and providers in South West London, working with the six Local Authorities and GP federations. Our FRP is cognisant and complementary of the direction of travel set out within the STP

In developing our review of commissioned service initiatives there has been a genuine interest across SWL CCGs to develop the Effective commissioning agenda together, however, with CCGs varying financial positions, there is a requirement to escalate this work to achieve our financial forecasts over the next 2 years.

Richmond and Merton's ECI plan and process is very similar and more advanced than other SWL CCGs. The difference between Merton and Richmond CCG is the pace. Richmond CCG has recently approved a paper to take a number of services forward for review.

Merton CCG recently conducted as part of its QIPP programme a 'Coding and counting' exercise looking at variances of activity and payments across our Acute services. This work has further highlighted the need to progress this work urgently to get a grip on our activity against agreed service thresholds.

2. Current Progress

Since the July Governing Body meeting the programme has been split into three work streams under the umbrella of 'Review of Commissioned Services':

- Prior Approvals
- Effective Commissioning Initiative Criteria
- Review of Acute and Non Acute Services/Procedures

Our progress to date is as follows:

2.1 Prior Approvals

CCGs across South West London, working with the CSU, are currently using the 2014/15 SWL ECI Policy (Version 1.7.2). The policy provides the criteria for referrals for a number of procedures, some classed as 'Prior Approval' to check that the patient matches the criteria for referral before proceeding with the procedure. If they don't then they are referred through the 'Individual Funding Request' route which involves determining the rationale for treatment where it otherwise wouldn't be funded.

We know from the coding and counting exercise that this policy is not being routinely followed by referring clinicians and therefore the CCG is funding procedures above the agreed thresholds.

Prior Approvals have been prioritised by the Merton CCG Clinical Reference Group (CRG) and the process is being rolled out through the use of DXS software in GP Practices. A letter will be sent to the Acute Trusts over the next 4 weeks informing them that we expect them to follow our Prior Approval process.

Initially the Prior Approval process will be tested within a number of selected practices and then rolled out over the coming months as we test the DXS software. The system will produce a Prior Approval from that will pop up on the screen when the GP prepares the referral.

2.2 Effective Commissioning Initiative Criteria

Merton CCG continues to take part in the South West London Effective Commissioning Initiative (SWL ECI). The SWL ECI provides a set of patient criteria to underpin the commissioning of a range of clinical interventions.

As part of MCCG's Financial Recovery Plan (FRP) we have identified the need to:

1. review existing ECI thresholds to ensure they are clear, unambiguous, current and enforceable;
2. increase MCCG's effort in communicating and ensuring compliance with the existing policies
3. withdraw funding in all areas of spend where, on review, MCCG's patients are receiving little or no value for money

There is a proposal currently being considered to review the thresholds further.

2.3 Review of Acute and Non Acute Services/Procedures

The SWL STP Chief Officers have set up a number of delivery groups. The ECI work will be developed and delivered through the STP Contract Delivery Group, led by Sutton Chief Operating Officer and Croydon Chief Finance Officer.

Merton CCG has continued to develop its local process (***Appendix 1***) signed off at July's Governing Body meeting. At the 15th September EMT members approved the 9 key principles that make up the Benefit Realisation Tool **(*Appendix 2***) and agreed to prioritise a number of services to go through the Merton CCG process, these include:

- IVF - £620k
- Wimbledon Guild - £50k
- Carers Support - £50k
- Low Vision - £12k
- Meds Management Self Care - £256k
- Gluten Free Produces - £49k

Richmond has also started this process and the procedures given in Table 1 below have been signed off by their Governing Body to recommend making changes to thresholds to reduce expenditure. These procedures are shown below in table 1.

Table 1 – Richmond CCG's increased thresholds and disinvestments recommended in the FRP. (Source: Richmond CCG Governing Body paper 20/09/2016)

MSC surgical management -Arthroscopic Knee Surgery	Inappropriate referrals - reduction of 30% in total referrals by introducing new clinical policy
MSC Surgical Management - Dupuytren's	Inappropriate referrals - reduction of 50% by implementing new clinical policy
MSC Surgical management - Pain Management	30% reduction in lumbar epidurals through MSC referral management and replacement with other treatments
Gastroenterology- Diagnosis management	Inappropriate referrals for endoscopy - 14% reduction by new IBS diagnosis and treatment pathway, that includes the availability of faecal calprotectin testing
MSC Surgery- Hallux Valgus Osteotomy (Bunion Surgery)	Increased thresholds to be applied to this treatment option, based on NICE guidance which suggests, due to variance in surgical technique, outcome and efficacy is limited. Referral for surgery should be on a case basis and only if functional mobility impairment results
MSC Surgery -Carpal Tunnel	Threshold update - review and update MSC pathway for CTS management, patient journey should include hand therapy and advice on managing ADLs; static volar splinting, appropriate analgesic management for a minimum of six months. Should symptoms not subside or Thenar atrophy becomes apparent, only then should surgery be considered.
Hip replacement deterrence	Implement Patient Decision Making Aids to reduce Hip replacement by : Look to limit by selection, those patients receiving primary hip replacement surgery per 1000, weighted population by and through the use of PDAs reducing surgical conversion by 100% - 209 fewer procedures
Knee replacement deterrence	Roll out use of PDAs for patients considering total hip replacement surgery, establish criteria of functional deficit impairment, EQ5D score, Oxford score and VAS. By implementing patient decision aids, and encouraging informed choice, we anticipate that a cohort of patient will decide not to pursue surgical treatment, therefore reducing the volume of additional waiting lists or the number of new patients added to the waiting list. 274 fewer procedures

The list above is anticipated to be implemented with some impact in the current financial year to 31 March 2017, but will have full effect in next financial year

Merton CCG has the option of continuing the internal agreed process or making decisions in line with Richmond CCG. ***Appendix 3*** shows Richmond CCGs decision making process.

The internal work will continue alongside the Richmond work with our own services and procedures being reviewed for efficiencies. The current list is split into Acute and Non-Acute Services as shown in ***Appendix 4***.

- ***Acute Services***
  The Acute Services/Procedures have been reviewed and narrowed down to a reasonable list that could be presented at Clinical Reference Group (CRG).

  CRG has selected a number of Services/Procedures for further detailed work as to whether these can be decommissioned, restricted or redesigned.

  This work will be developed over a longer timescale and notice will be given to providers as part of the contract negotiations for 17/18.

  CRG and EMT will receive updates on areas we decide to prioritise and the decisions made. This work should continue with services continuously reviewed and becoming part of business as usual.

- ***Non Acute Contracts/Services***
  The Non-Acute contracts are in the process of being reviewed. The process requires services presented at the weekly Review of Commissioned Services Group for agreement. Due to complex discussions on the risks this process is taking longer than planned and the process is now not expected to be completed until the end of September.

  Following this process an options paper will be sent to the Clinical Panel and EMT for each service/procedure.

  The original ask was that all services are reviewed together however, due to timescales, it has been agreed to complete the review process and make decisions on individual services/procedures before all the services have gone through the process.

  In addition Richmond identified other procedures which have been added to the list. It is expected that a small number of these services will have finished for the next Governing Body.

We intended to bring to the November Governing Body a number of services we consider a priority to review...

Recommendation(s)/Approval:

That the Governing Body:

4. Agree with the CCGs approach to Prior Approvals and ECIs
5. Agree to align our process with our neighbouring CCGs in SWL
6. Agree to support one of the two options:

Option 1:

Review Richmond's efficiency options and agree to allow EMT to implement the thresholds and disinvestment given in Table 1. EMT will review the impact in relation to our pathways and assess risks to our current pathways i.e.MSK pathway)

Option 2:

Continue with our own process for areas reviewed and agreed by Richmond CCG and take them through our agreed Decision Tree.

Appendix 1: Merton CCG agreed Decision Tree for ECI's

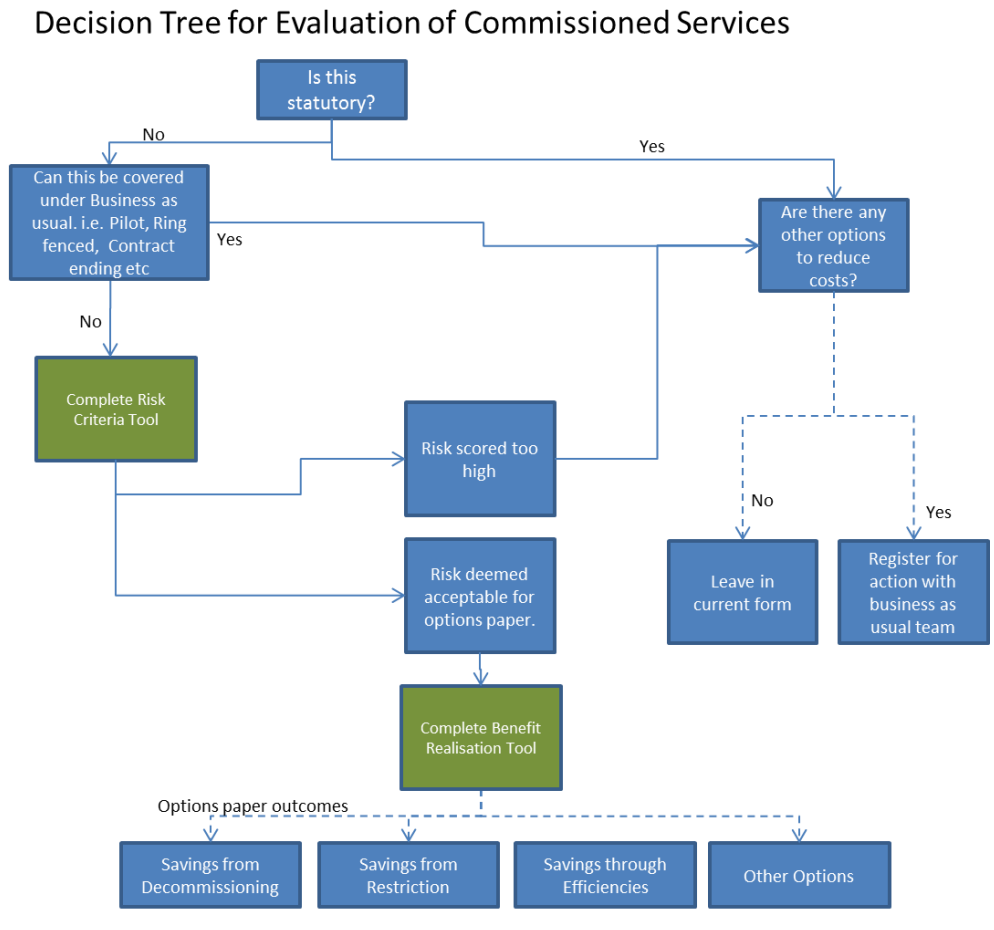
Appendix 1

The Clinical lead and Commissioning lead risk assess the service. Evaluation of Commissioned Services Group (ECSG) discuss the risk assessment with the leads and by deeming services too high a risk to the organisation rule out services from the process.

Note. If other options are available they will be worked on throughout the year by the Commissioning Teams.

The Clinical lead and Commissioning lead develop options papers using a Benefit Realisation tool and their intelligence of the service.

The ECSG & Clinical Reference Group/Clinical Panel will assess the options paper and make recommendations to EMT.



Appendix 2: Benefits Realisation Criteria

1. **Principle 1: Equity**
   1.1. The Committee believes that people should have access to health care on the basis of need. There may also be times when some categories of care are given priority in order to address health inequalities in the community. However, the Committee will not discriminate, or limit access to NHS care, on grounds of personal characteristics including: age, race, religion, gender or gender identity, sex or sexual orientation, lifestyle, social position, family or financial status, pregnancy, intelligence, disability, physical or cognitive functioning. However, in some circumstances, these factors may be relevant to the clinical effectiveness of an intervention and the capacity of an individual to benefit from the treatment.
   1.2. The Committee abides by the Equality Act (2010) which protects people from being discriminated against because of: race, sex, sexual orientation, disability, age , caring responsibilities , religion or belief , being transsexual , being pregnant or just having had a baby , or being married or in a civil partnership
   1.3. The Committee values mental health equally with physical health in line with the NHS "parity of Esteem".

2. **Principle 2: Health care need and capacity to benefit**
   2.1. Health care should be allocated justly and fairly according to need and capacity to benefit. The Committee will consider the health needs of people and populations according to their capacity to benefit from health care interventions. As far as possible, it will respect the wishes of patients to choose between different clinically and cost effective treatment options, subject to the support of the clinical evidence.

   2.2. This approach leads to three important principles:
   - In the absence of evidence of health need, treatment will not generally be given solely because a patient requests it.
   - A treatment of little benefit will not be provided simply because it is the only treatment available.
   - Treatment which effectively treats "life time" or long term chronic conditions will be considered equally to urgent and life prolonging treatments.

3. **Principle 3: Evidence of clinical effectiveness**
   3.1. The Committee will seek to obtain the best available evidence of clinical effectiveness using robust and reproducible methods. Methods to assess clinical and cost effectiveness are well established. The key success factors are the need to search effectively and systematically for relevant evidence, and then to extract, analyse, and present this in a consistent way to support the work of the Committee. Choice of appropriate clinically and patient-defined outcomes need to be given careful consideration, and where possible quality of life measures should be considered.

   3.2. The Committee will promote treatments and services for which there is good evidence of clinical effectiveness in improving the health status of patients and will not normally recommend treatment and services that cannot be shown to be effective. For example, is the product likely to save lives or significantly improve quality of life? How many patients are likely to benefit? How robust is the clinical evidence that the treatment or service is effective?

   3.3. When assessing evidence of clinical effectiveness the outcome measures that will be given greatest importance are those considered important to patients' health status. Patient satisfaction will not necessarily be taken as evidence of clinical effectiveness. Trials of longer duration and clinically relevant outcomes data may be considered more reliable than those of shorter duration with surrogate outcomes. Reliable evidence will often be available from good quality, rigorously

appraised studies. Evidence may be available from other sources and this will also be considered. Patients' evidence of significant clinical benefit is relevant.

3.4. The Committee will also take particular account of patient safety. It will consider the reported adverse impacts of treatments and the licence status of medicines and the authorisation of medical devices and diagnostic technologies for NHS use.

4. Principle 4: Evidence of cost effectiveness

4.1. The Committee will seek information about cost effectiveness in order to assess whether interventions represent value for money for the NHS. The Committee will compare the cost of a new treatment to the existing care provided and will also compare the cost of the treatment to its overall benefit, both to the individual and the community. The Committee will consider studies that synthesise costs and effectiveness in the form of economic evaluations (e.g. quality adjusted life years, cost-utility, cost-benefit. as they enable the relationship between costs and outcomes of alternative healthcare interventions to be compared, however, these will not by themselves be decisive.

4.2. Evidence of cost effectiveness assists understanding whether the NHS can afford to pay for the treatment or service and includes evidence of the costs a new treatment or service may release.

5. Principle 5: Cost of treatment and opportunity costs

5.1. Because each CCG is duty-bound not to exceed its budget, the cost of a treatment must be considered. A single episode of treatment may be very expensive, or the cost of treating a whole community may be high. This is important because of the overall proportion of the total budget: funds invested in these areas will not be available for other health care interventions.

5.2. The Committee will compare the cost of a new treatment to the existing care provided, and consider the cost of the treatment against its overall health benefit, both to the individual and the community. As well as cost information, the Committee will consider the numbers of people in their designation populations who might be treated.

6. Principle 6: Needs of the community

6.1. Public health is an important concern of the Committee and they will seek to make decisions which promote the health of the entire community. Some of these decisions are promoted by the Department of Health (such as the guidance from NICE and Health and Social Care Outcomes Framework). Others are produced locally. The Committee also supports effective policies to promote preventive medicine which help stop people becoming ill in the first place.

6.2. Sometimes the needs of the community may conflict with the needs of individuals. Decisions are difficult when expensive treatment produces very little clinical benefit. For example, it may do little to improve the patient's condition, or to stop, or slow the progression of disease. Where it has been decided that a treatment has a low priority and cannot generally be supported, a patient's doctor may still seek to persuade the CCG that there are exceptional circumstances which mean that the patient should receive the treatment.

7. Principle 7: National policy directives and guidance

7.1. The Department of Health issues guidance and directions to NHS organisations which may give priority to some categories of patient, or require treatment to be made available within a given period. These may affect the way in which health service resources are allocated by individual CCGs. The Committee operates with these factors in mind and recognise that their discretion may be affected by Health and Social Care Outcomes Frameworks, NICE technology appraisal guidance, Secretary of State Directions to the NHS and performance and planning guidance.

7.2. Locally, choices about the funding of health care treatments will be informed by the needs of each individual CCG and these will be described in their Local Delivery Plan.

8. Principle 8: Exceptional need

8.1. There will be no blanket bans on treatments since there may be cases in which a patient has special circumstances which present an exceptional need for treatment. Individual cases are considered by each respective CCG. Each case will be considered on its own merits in light of the clinical evidence. CCGs have procedures in place to consider such exceptional cases through their Individual Funding Request Process.

9. Principle 9: Personal responsibility

9.1. Individual patients have a personal responsibility for improving their health outcomes. By doing so they give themselves the best chance of a successful outcome prior to and during medical interventions (prevention).

Appendix 3: Richmond's process for reviewing services.

The suggested process combines a clinical threshold approach (based on clinical benefit) and the financial benefit for the whole population. The following process is suggested:

1. Background information will be gathered for each treatment under review including:
    a. Data on current activity and spend
    b. Evidence base for its effectiveness and any impact on patient safety if decommissioned
    c. Size of the patient cohorts whom disinvestment would disadvantage, and their characteristics
    d. An equality impact assessment, to establish whether disinvestment would disproportionately disadvantage any group with a protected characteristic or widen health inequalities
    e. Intended and unintended consequences in terms of other treatments that might be expected to show increased activity as patients are managed along alternative pathways
    f. Contracting implications
    g. Net likely financial saving as a result of disinvestment.
    h. Engage quickly where required with clinical experts and impacted patient groups

2. If the evidence indicated a change could be achieved by adjusting a threshold, that the change was low risk or that there was strong national precedent for the change – then an accelerated process be adopted to engage stakeholders and implement the change through existing processes.

3. If the evidence suggested the change did not meet the test in (2) i.e. that the change was high risk, or without precedent that:
    1. An Governing Body meeting would be convened in order to consider each option for going forward to wider clinical and public consultation.
    2. Preliminary engagement takes place through standing patient engagement routes and with local authority and provider partners.
    3. If required, formal public consultation takes place. Preparation for implementation could be planned alongside this consultation.
    4. Results brought back to Governing Body for final decision on which changes to adopt.
    5. Implementation then be undertaken

This process represents a substantial volume of work, requiring input from almost every team in the RCCG.

There is a reputational risk to note. Other CCGs that have initiated disinvestment proposals have encountered challenges in progressing decisions. By following a robust process, emphasising the need to communicate widely to explain the nature of the challenges and proposed solutions, RCCG will work to mitigate this risk.

Appendix 4: List of Merton CCG services currently being reviewed

Service description	Value in £000's
Non Acute Services	
Wish Centre - Self-harm support	39
Merton Vol Service- Community navigation	39
Meds Mgmt - Self Care	256
Low vision	12
Minor surgery GPSI -Dr D Muktar / Dr M Mehra	91
Prescription of Gluten Free Food	49
Central &NW London FT - Interpreting service	20
IVF - AQP	620
Wimbledon Guild - Bereavement support	50
Skin laser care - Laser tx	50
Alzheimer society - Voluntary sector	68
Carers support	50
Hospice transport - HATS	15
DXA-bone scanning	48
EoL - Marie Curie	100
Walk-in centre for unregistered pts	958
Child sexual abuse support - NSPCC	15
Termination of pregnancy - BPAS	191
Termination of pregnancy - Marie Stopes	117
EoL - St Raphael Hospice & Trinity	609
Mental Health Tier 2 CAMHS Service	233
Merton Step Down Service	2,400
IAPT - Addaction	1,755
Home care - Air Liquide	82
NES - NEAR PATIENT TESTING	6
LCS - End of Life Care	27
LCS -Near patient testing	7
LCS - Removal of clips sutures	23
LCS - Menorrhagia Management	100
LCS - Phlebotomy (Ambulatory)	40
LCS - Phlebotomy (Domicillary)	13
LCS - Insulin Initiation	12
LCS - Gynaecology	60
LCS - Urology	39
LCS - Anti-coagulation	178
MM software - Scriptswitch	75
Collaborative commissioning	?
LBMICES section 75 Equipment provision	45
CSU	2,276
Podiatry	130
Wishmore Cross Academy - CAMH training	40
GP Support to Woodlands nursing home	-
Carter H. nursing home	8
CHC in care homes with nursing AQP	-
Personal health budgets admin	-
Care UK (Harmoni) - Out of hours/111	1,280
Connect - Community physio	1,278
Locked MH rehab	734
Tier 4 (mental health?) - Sussex partnership	222
IT for Nelson - Essentia Guy's	126
MM software - Eclipse	12
British pregnancy	4
CHC domicilary care - Pan London	-
Rehab Unit	200
St G @ Nelson - Outpatient and diagnostics	2,000
DESP Surveillance Clinic	TBC

Service description	Value in £000's
Acute Services	
Accupuncture	24
Emergency Department : Domestic Abuse Post : (SGH)	17
Alcohol liver disease development liaison nurse : : (SGH)	45
Recovery at Home : : (SGH)	181
Trauma & Orthopaedics : Landing Tariff (SGH)	55
Blood Pressure Unit (SGH)	135
Spirometry/Oximetry Assessment/Expiratory Flow Rate	136

Taken from Richmond's List.	
Arthroscopic Knee surgery for degenerative meniscal tears	TBC
Cease Dupuytren's Fasciotomy surgery	TBC
MSK - Hallux Valgus Osteotomy (Bunion Surgery)	TBC
Cease Carpal Tunnel decompression surgery	TBC
Female sterilisation and vasectomy	TBC