Item Number: 10

NHS NORTH YORKSHIRE AND YORK **BOARD MEETING**	NHS North Yorkshire and York

Meeting Date: 28 June 2011

Report's Sponsoring Director:	**Report Author:**
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1. Title of Paper: Criteria-based commissioning in NHS North Yorkshire and York

2. Strategic Objectives supported by this paper:

1. To commission high quality safe effective patient care, seeking to improve the quality of care wherever possible and including delivery of all key standards (Goal 1, 5 and 6)
2. To ensure that the PCT delivers a clinically and financially sustainable healthcare system through delivery of the Quality, Innovation, Productivity and Prevention Programme (QIPP) to meet the needs of the people of North Yorkshire and York (Goal 4)

This paper outlines the approach that NHS North Yorkshire and York (NHSNYY) is taking to the commissioning of care pathways that are clinically effective, ensure appropriate patient management in primary care and referral to secondary care and reduce variation in surgical procedures, through 'criteria-based commissioning'.

3. Executive Summary

Since 2006, NHS NYY has developed an approach to ensuring that the care pathways it commissions are clinically effective, through the development of clinical criteria to ensure appropriate management of the patient in primary care and referral to secondary care. This helps to eliminate inconsistency in planned care referrals to secondary care, reduce variation in how planned surgical procedures are carried out across North Yorkshire and ensures that care pathways are evidence based and commissioned only where clinically appropriate.

This commissioning approach has been strengthened by work from the London Health Observatory, NHS Institute for Innovation and Improvement and the Yorkshire and the Humber Strategic Health Authority.

The NHS NYY commissioning policy outlines procedures and interventions that are not routinely commissioned due to being relatively ineffective or of low priority, and procedures that are commissioned only where specific clinical criteria are met because there is a close benefit/risk balance in mild cases or there are cost-effective alternatives which can be tried first. Criteria for referral to secondary care are determined by sources of clinical evidence such as National Institute for Clinical Excellence (NICE) guidance, in conjunction with local clinical expertise.

A robust Governance process ensures appropriate clinical consultation and engagement, and contractual implementation of the policy, whilst also ensuring that there is due consideration given to 'exceptional cases' where the commissioning criteria are not met, but the patient may require the procedure or intervention for exceptional reasons.

Since it's implementation, the criteria based commissioning policy has had a significant impact on reducing referrals to secondary care. It is estimated that a cost saving of £1 million will have been achieved for the year 2010/11.

It is important that this commissioning approach is maintained in order to ensure that appropriate, evidence-based referrals continue and to maximise clinical and cost effectiveness. In particular, effective monitoring needs to continue and appropriate action be taken to address inconsistencies in implementation of the policy. Also, consideration needs to be given to ways of supporting GPs in informing and managing patient expectation in order to implement commissioning policy for procedures where there is a close benefit/risk balance.

The Board is asked to:

- Note the approach NHSNYY is taking to 'criteria-based commissioning'
- Support the continued implementation and monitoring of this commissioning policy

4. Risks relating to proposals in this paper

Not applicable

5. Summary of any finance / resource implications

Not applicable

6. Any statutory/regulatory / legal / NHS Constitution implications

The PCT has a statutory responsibility to commission services within its financial allocation. The NHS constitution states that whilst the availability of some healthcare services is determined nationally, for example, under National Institute for Clinical Excellence Technology Appraisals, in most cases, decision-making on whether to fund a service or treatment is left to the local PCT. It also states that local decision-making should be made rationally, following a proper consideration of the evidence, and that patients have a right to have the rationale for funding decisions explained to them.

7. Equality Impact assessment for the proposals

Not applicable

8. Any related work with stakeholders or communications plan

Not applicable

9. Recommendations / Action Required

The Board is asked to note the approach NHSNYY is taking to 'criteria-based commissioning' and to support the continuing implementation and monitoring of this commissioning policy.

10. Assurance

Not applicable

For further information please contact:

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NHS NORTH YORKSHIRE AND YORK

Board Meeting: 28 June 2011

Criteria-based commissioning in NHS North Yorkshire and York

1. Criteria-based commissioning: definition and background

1.1 Primary Care Trusts have a duty to commission care that is 'clinically effective'. Clinical effectiveness is defined as 'the extent to which specific clinical interventions do what they are intended to do, i.e. maintain and improve the health of patients, securing the greatest possible health gain from the available resources' (NHS Executive,1996).

1.2 The London Health Observatory (LHO) published a report in 2007 in which it described different categories of clinical interventions or procedures for which there may be limited clinical effectiveness, as determined by the nature of the procedure and the underpinning clinical evidence. These were:

- Relatively ineffective interventions
- Effective interventions with a close benefit/risk balance in mild cases
- Effective interventions where cost-effective alternatives should be tried first
- Largely cosmetic interventions

1.3 Based on work undertaken in Croydon PCT, the LHO report recommended the adoption across London of 'common access criteria' for 34 surgical procedures, in order to reduce significant variation in hospital admission rates and save costs.

1.4 Subsequent to this, the NHS Institute for Innovation and Improvement published the 'Better Care Better Value' (BCBV) indicators which identified potential areas for improvement in efficiency. The 'managing variation in surgical thresholds' indicator identified specific procedures which are clinically effective in only a limited number of cases, with the need for implementation of specific criteria to ensure they are undertaken only when clinically indicated.

1.5 The Yorkshire and the Humber Strategic Health Authority (SHA) has also recently developed clinical criteria, or 'referral thresholds' for a number of commonly undertaken procedures, with the recommendation that these are implemented across the region.

2. Approach in NHS North Yorkshire and York

2.1 Since 2006, NHSNYY has developed and implementing a robust, evidence-based approach to the commissioning of procedures which fall into the categories that the PCT has defined as 'not routinely commissioned' or 'commissioned subject to criteria'. The London Health Observatory, Better Care Better Value and SHA work supports and strengthens the approach that the PCT has taken.

2.2 Procedures that are 'not routinely commissioned' are those which clinical evidence has demonstrated are relatively ineffective, or which have been agreed within NHSNYY as being of low priority (e.g. cosmetic interventions). These are listed in Appendix 1.

2.3 Procedures that are 'subject to criteria' are those with a close benefit/risk balance in mild cases, or where there is evidence that cost- effective alternatives (including conservative

management in Primary Care) should be tried first. The PCT has commissioned these procedures (listed in Appendix 2) only where specific clinical criteria are met. The criteria are determined by sources of clinical evidence such as National Institute for Clinical Excellence (NICE) guidance, Map of Medicine (an online tool which describes evidence-based care pathways), guidance from professional organisations and Royal Colleges, other national and regional initiatives and local clinical expertise.

2.4 This commissioning policy is supported by the Governance process outlined in Appendix 3, which ensures appropriate clinical consultation and engagement, and contractual implementation of the policy via Acute Trust's Contract Management Boards. The commissioning criteria are made available on the PCT's intranet site and on the North Yorkshire view of the Map of Medicine.

2.5 Although the criteria based commissioning policy is expected to be applied in the majority of cases, for any patients considered by the GP or secondary care clinician to have 'exceptional clinical need' a process is in place to ensure consideration of these cases. The referring clinician sets out the case for exceptionality, which is then assessed by the PCT's Individual Funding Request (IFR) Panel, in accordance with the principles of exceptionality (Medicines and Technology Policy 2009) which are:

- Only evidence of clinical need will be considered. Factors such as gender, ethnicity, age, lifestyle or other social factors such as employment or parenthood cannot be considered as clinically relevant.
- In order to demonstrate exceptionality the patient must be significantly different from the reference population and there must be good grounds to believe that this patient is likely to gain significantly more benefit from this intervention than might be expected for the average patient with that particular condition. The fact that the treatment might be efficacious for the patient is not, in itself, grounds for exceptionality.

3. Impact of NHSNYY criteria-based commissioning policy

3.1 The criteria based commissioning policy described falls within the PCT's Quality and Productivity plan and the impact of the policy has been monitored in this context since April 2010. Appendix 4 shows the number of procedures undertaken that are not routinely commissioned for the period April 2009 – March 2011. Appendix 5 shows numbers of procedures performed that are subject to criteria for the period April 2009 – March 2011. Data are presented overall and by GPCC.

3.2 The drop in overall activity for York and Selby GPCC in early 2010 for procedures not routinely commissioned reflects revisions to the commissioning policy for epidural injections and facet joint injections for chronic low back pain, which were made as a result of new evidence from the National Institute for Clinical Excellence and the American Pain Society. These guidelines formed the basis of a refinement of the PCT's commissioning policy for patients with chronic spinal pain, with a 'not routinely commissioned' policy being applied to both new patients referred to pain services as well as patients currently under the care of the pain teams (previously, patients in the latter category were not included in this commissioning policy). Activity for these procedures is displayed in Appendices 6 and 7 respectively, both overall and by GPCC, for the period April 2006 – March 2011.

3.3 Reduction in numbers of procedures commissioned which are subject to criteria (Appendix 5) is not demonstrated overall for the period April 2009 – March 2011 because

much of the criteria based commissioning policy relating to these has been in place since as early as 2006, and the impact of this has already been realised.

3.4 As an example, Appendix 8 displays the reduction in varicose veins procedures over the period April 2006 – March 2011, with the main impact being realised by the end of the year 2006/7. Some level of activity would always be expected for these procedures as there are some circumstances, outlined in the criteria, when the procedures are known to be clinically effective, and are therefore commissioned.

3.5 In contrast, there should be very little activity for procedures not routinely commissioned. Any activity that is undertaken should be for exceptional cases only, with approval at the IFR panel having been given for all patients undergoing these procedures. Monitoring of the Quality and Productivity plan involves matching data on procedures performed against data from the IFR panel. This information is presented in Appendix 9 for cases accepted and declined by the panel for a sample of procedures performed April 2010 – March 2011. There are a large number of 'no matches', which indicate that the procedure has been undertaken without IFR approval. The PCT is in the process of raising contract challenges about these with Acute Providers.

3.6 It should be noted that all the graphs displayed in the appendices contain 'flex' data for March 2011, rather than 'freeze' data, which means that they are subject to minor change. This will not significantly affect the overall trends demonstrated.

3.7 The projected cost saving related to criteria based commissioning procedures (mainly 'not routinely commissioned' procedures) for the year 2010/11 was £1.4 million. Freeze data has yet to be obtained for March 2011, and contract challenges are still in progress, however it is estimated that a £1 million saving will have been achieved.

4. Implications for the future

4.1 Whilst much of the savings related to the implementation of criteria based commissioning have been realised, or will be realised this year, it is important that this approach continues. New or revised evidence is continually emerging on the effectiveness of procedures and, with it, the potential for developing criteria for further procedures. During 2011/12, the SHA will be publishing new criteria for hernia repair, cholecystectomy and cystoscopy, and updated criteria for tonsillectomy, which the PCT plans to implement.

4.2 It is also important to continue monitoring adherence to the commissioning policy. Monitoring adherence to policy on procedures not routinely commissioned is relatively straight forward, although there needs to be effective action taken to address inconsistencies in implementation of the policy identified through the monitoring process. Monitoring adherence to procedures subject to criteria is more complex. To effectively monitor these requires review of GP referrals and clinical audit, which is resource intensive. There is no specific capacity for this work within the PCT, but this is an area of possible development within commissioning consortia

4.3 Implementation in primary care of policy for 'subject to criteria' procedures where there is a close benefit/risk balance presents a challenge. The onus falls on the GP to assess the severity of the patient's condition and the potential impact a procedure may or may not have in terms of outcome, to explain the risks and benefits of this to the patient and to manage patient expectation accordingly. Fully informing patients of all these issues can be time-consuming and is not always easy during a busy surgery. Consideration needs to be given to how this can be addressed to minimise impact on GP workload.

4.4 GP Commissioning Consortia will be taking on the implementation and monitoring of this Quality and Productivity plan for 2011/12 and are currently planning the approach they will use.

5. Conclusion

5.1 NHSHYY has since 2006 implemented a 'criteria based commissioning' approach to the commissioning of procedures and interventions undertaken in secondary care. This approach is supported by national work programmes.

5.2 Commissioning criteria are underpinned by clinical evidence from sources such as the National Institute for Clinical Excellence on the effectiveness of procedures and interventions, together with local clinical agreement on how commissioning criteria and lower priority procedures are determined.

5.3 Since it's implementation, the criteria based commissioning policy has had a significant impact on reducing referrals to secondary care. It is estimated that a cost saving of £1 million will have been achieved for the year 2010/11.

5.4 It is important that this commissioning approach is maintained in order to ensure that appropriate, evidence-based referrals continue and to maximise clinical and cost effectiveness. In particular, consideration needs to be given to ways of supporting GPs in implementing commissioning policy for procedures where there is a close benefit/risk balance. There also needs to be continued monitoring of adherence to the policy and action taken to address inconsistencies in implementation.

6. Recommendation/Action Required

The Board is asked to note the approach NHSNYY is taking to 'criteria-based commissioning' and to support the continuing implementation and monitoring of this commissioning policy.

7. References

Better Care Better Value Indicators. NHS Institute for Innovation and Improvement. http://www.institute.nhs.uk/quality_and_value/high_volume_care/bettercare_better_value_indicators.html

Promoting Clinical Effectiveness – A Framework for Action in and through the NHS NHS Executive, Department of Health, 1996.

Save to Invest. Developing criteria-based commissioning for planned healthcare in London, London Health Observatory, 2007. http://commissioning.pbworks.com/f/Save+to+Invest+(Executive+Summary).pdf

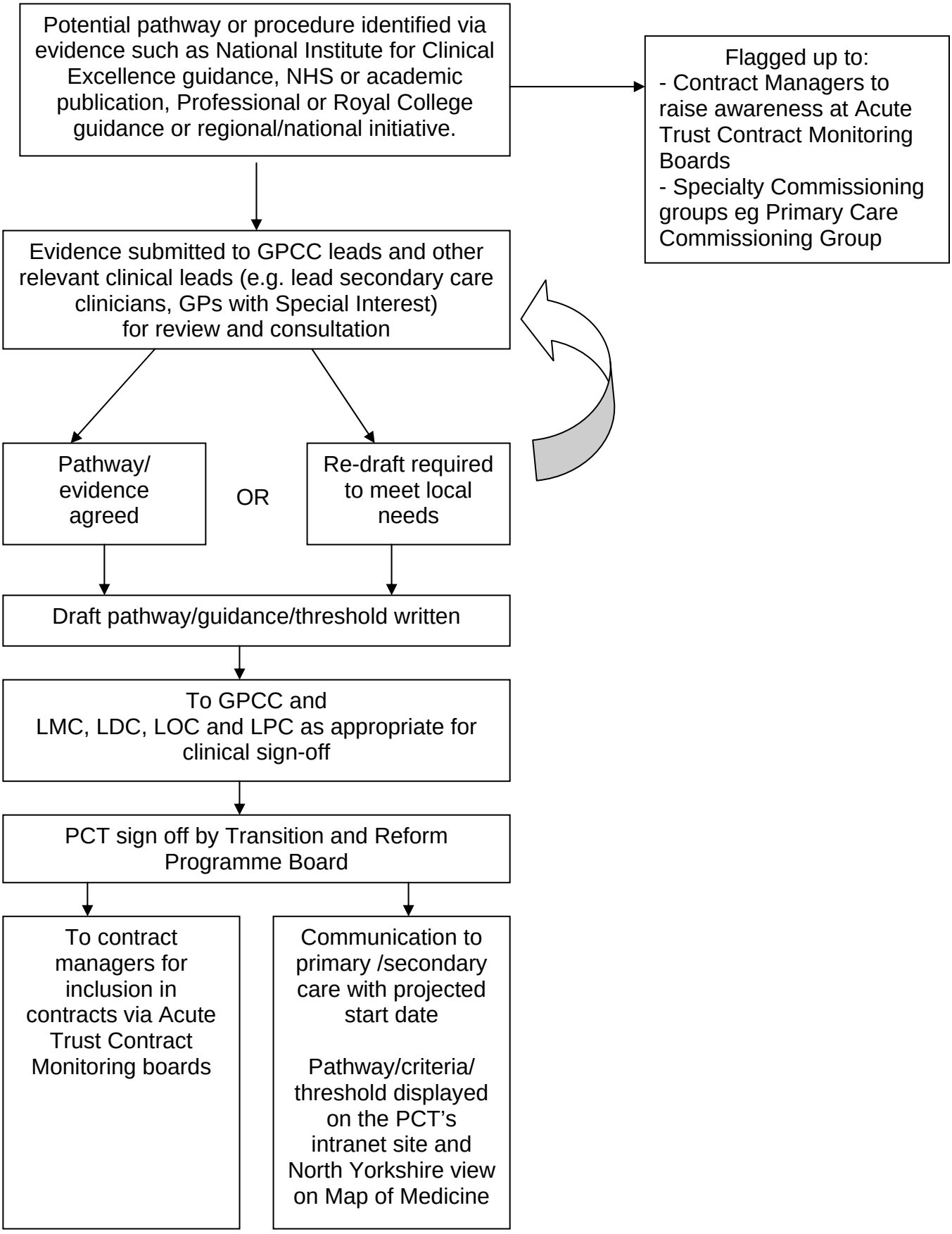
Appendix 1: Summary of procedures / interventions not routinely commissioned

Procedure / intervention	Reason
Dilatation and Curettage	Relatively ineffective intervention
Facet joint injections and epidural injections for chronic spinal pain	Relatively ineffective intervention
Ganglion surgery	Relatively ineffective intervention
Oculoplastic surgery for eye problems – see below	
• Watery eyes – can refer for advice/wash, not surgery	Relatively ineffective intervention Low priority procedure
• Ptosis	Relatively ineffective intervention Cosmetic intervention (low priority)
• Ectropion	Relatively ineffective intervention Cosmetic intervention (low priority)
• Meibomian cyst	Relatively ineffective intervention Cosmetic intervention (low priority)
Cosmetic plastic surgery for aesthetic reasons	Cosmetic intervention – low priority procedures
Anal skin tag surgery	Relatively ineffective intervention (low priority)
Hip arthroscopy	Relatively ineffective intervention
Sympathectomy surgery for axillary hyperhidrosis (heavy sweating)	Cost-effective alternatives should be tried first (botox) low priority procedure
Vasectomy under General Anaesthetic	Effective intervention but commissioned under local anaesthetic only
Reversal of sterilisation – male or female	low priority procedure
Assisted conception treatment including IVF	Effective intervention but lower priority procedure

Appendix 2: Summary of procedures / interventions commissioned subject to criteria

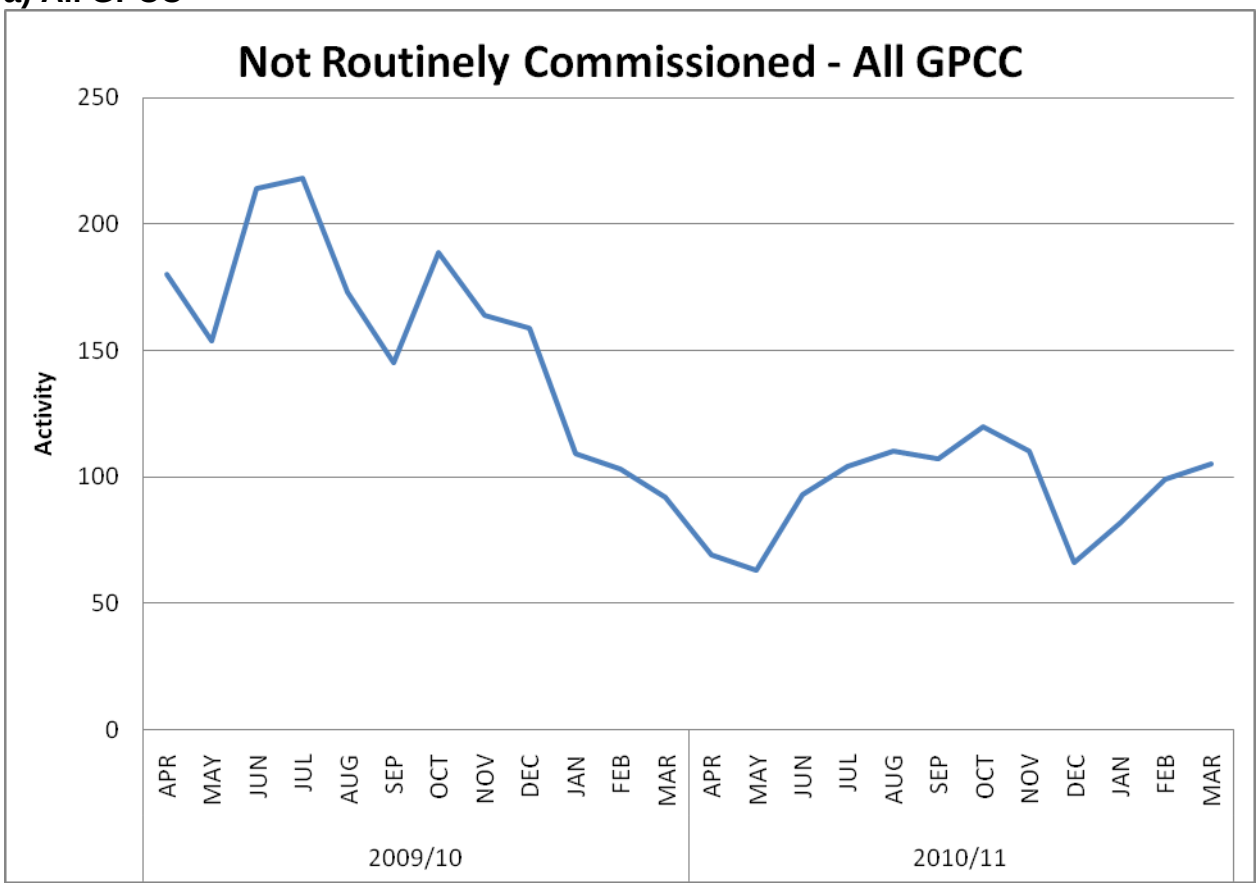
Procedure / intervention	Reason
Oculoplastic surgery for eye problems – Entropion	Effective intervention with a close benefit/risk balance in mild cases
Cataract surgery	Effective intervention with a close benefit/risk balance in mild cases
Anal fissure	Effective intervention with a close benefit/risk balance in mild cases
Haemorrhoidectomy	Effective intervention with a close benefit/risk balance in mild cases Effective intervention where cost-effective alternatives should be tried first
Varicose vein surgery	Effective intervention where cost-effective alternatives should be tried first
Hysterectomy for menorrhagia (heavy menstrual bleeding)	Effective intervention where cost-effective alternatives should be tried first
Urinary incontinence surgery – female	Effective intervention where cost-effective alternatives should be tried first
Circumcision	Relatively ineffective intervention
Tonsillectomy	Effective intervention with a close benefit/risk balance in mild cases
Myringotomy	Effective intervention with a close benefit/risk balance in mild cases
Bunion surgery	Effective intervention with a close benefit/risk balance in mild cases Effective intervention where cost-effective alternatives should be tried first
Carpal Tunnel surgery	Effective intervention where cost-effective alternatives should be tried first
Palmer Fasciectomy	Effective intervention where cost-effective alternatives should be tried first
Trigger Finger surgery	Effective intervention where cost-effective alternatives should be tried first
Wisdom teeth extraction	Effective intervention with a close benefit/risk balance in mild cases
Curly toes (paediatric foot problems)	Effective intervention with a close benefit/risk balance in mild cases
Metatarsus varus/aductus (paediactric foot problem)	Effective intervention with a close benefit/risk balance in mild cases
Botox injections for hyperhidrosis (heavy sweating)	Restricted to two injections per year as low priority procedure
Bariatric (morbid obesity) surgery	Effective intervention with a close benefit/risk balance in mild cases Effective intervention where cost-effective alternatives should be tried first

Appendix 3: Governance process for commissioning of pathways, procedures or interventions 'not routinely commissioned or 'subject to criteria'

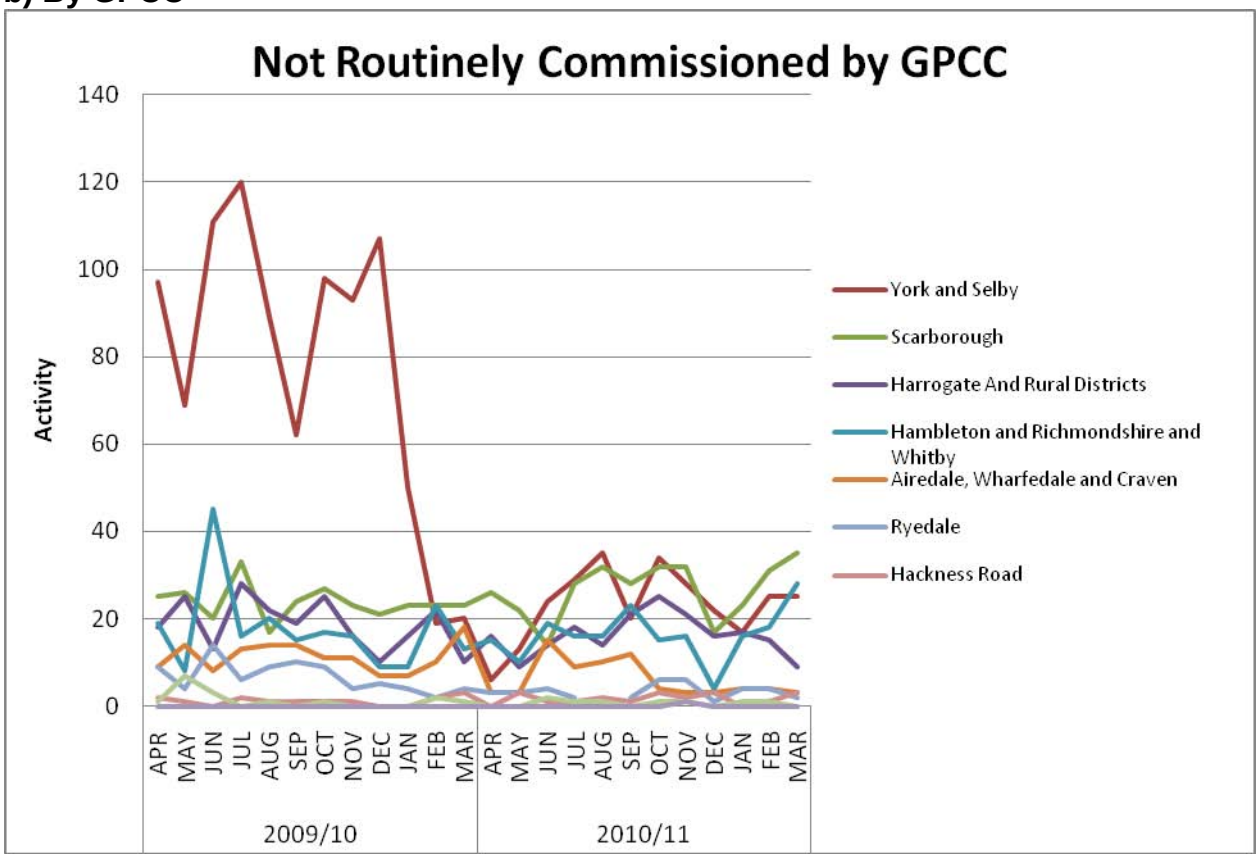


Appendix 4: Elective activity for procedures not routinely commissioned April 2009 – March 2011 – *(Top 5 Providers – York, Scarborough, Harrogate, South Tees and Airedale).*

a) All GPCC

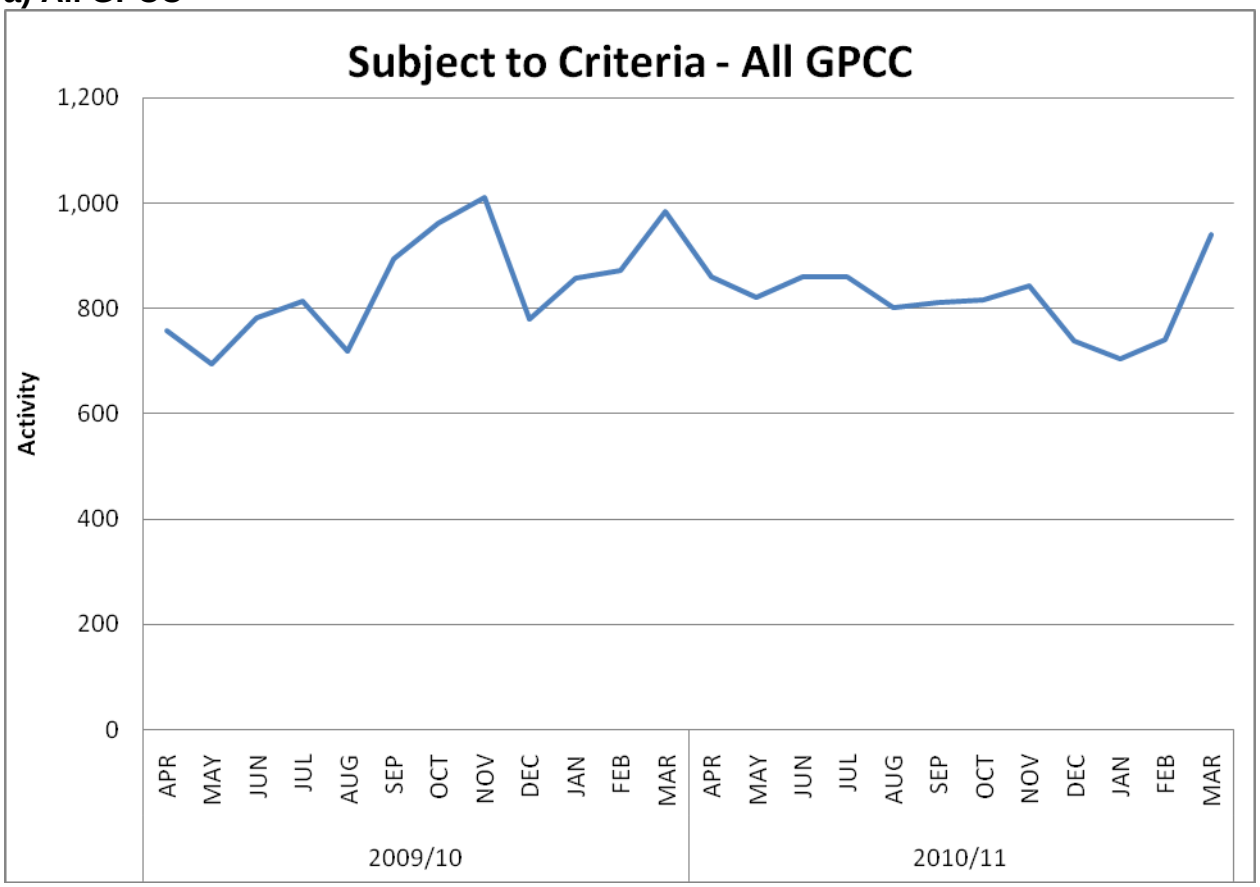


b) By GPCC

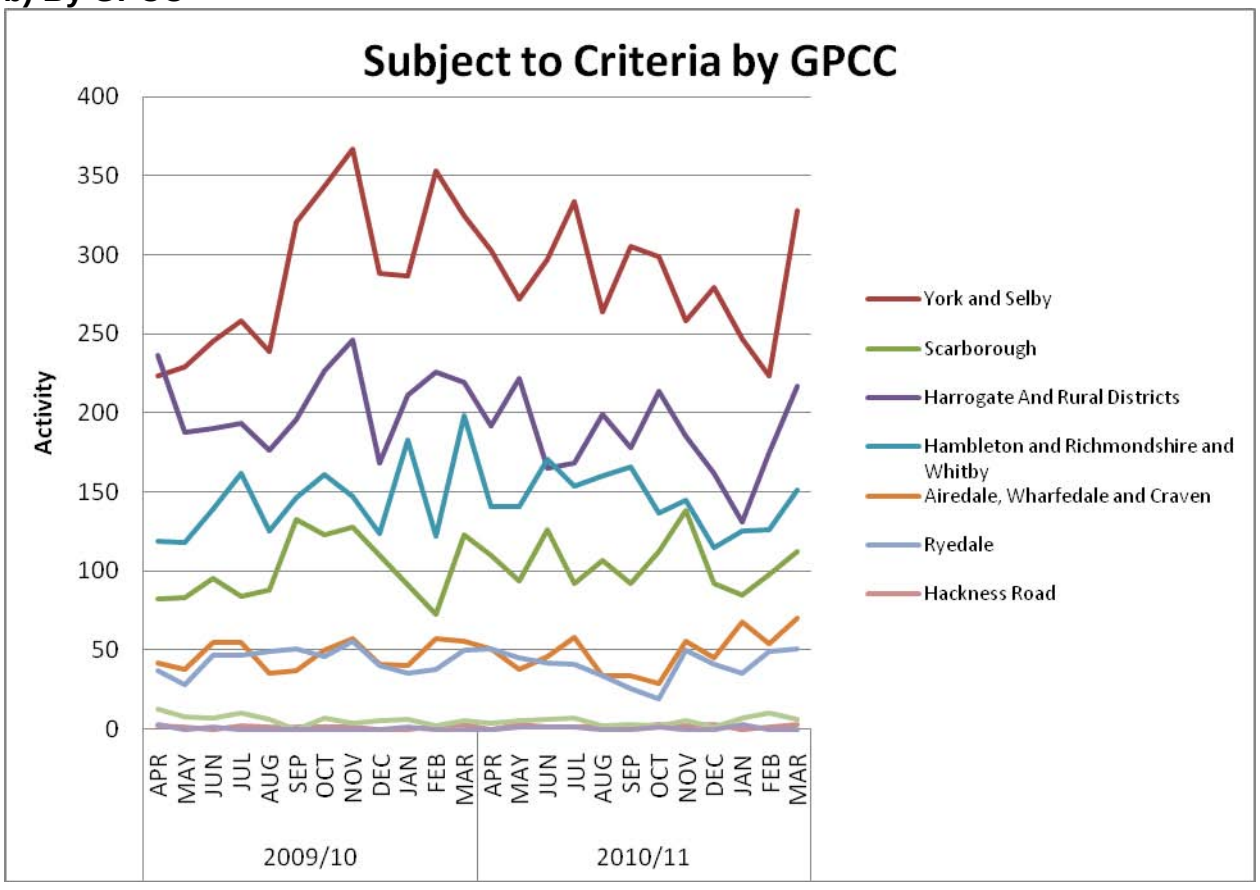


Appendix 5: Elective activity for procedures commissioned subject to criteria April 2009 – March 2011 *(Top 5 Providers – York, Scarborough, Harrogate, South Tees and Airedale)*

a) All GPCC

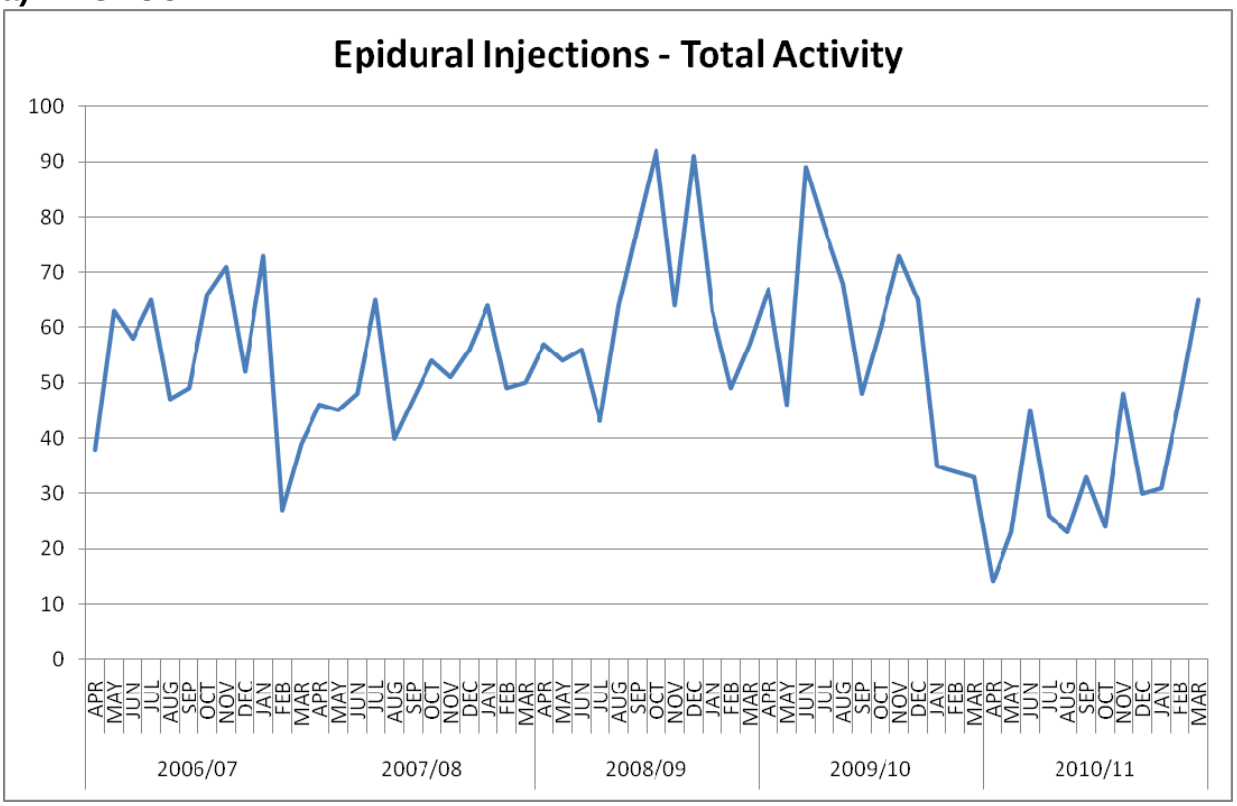


b) By GPCC

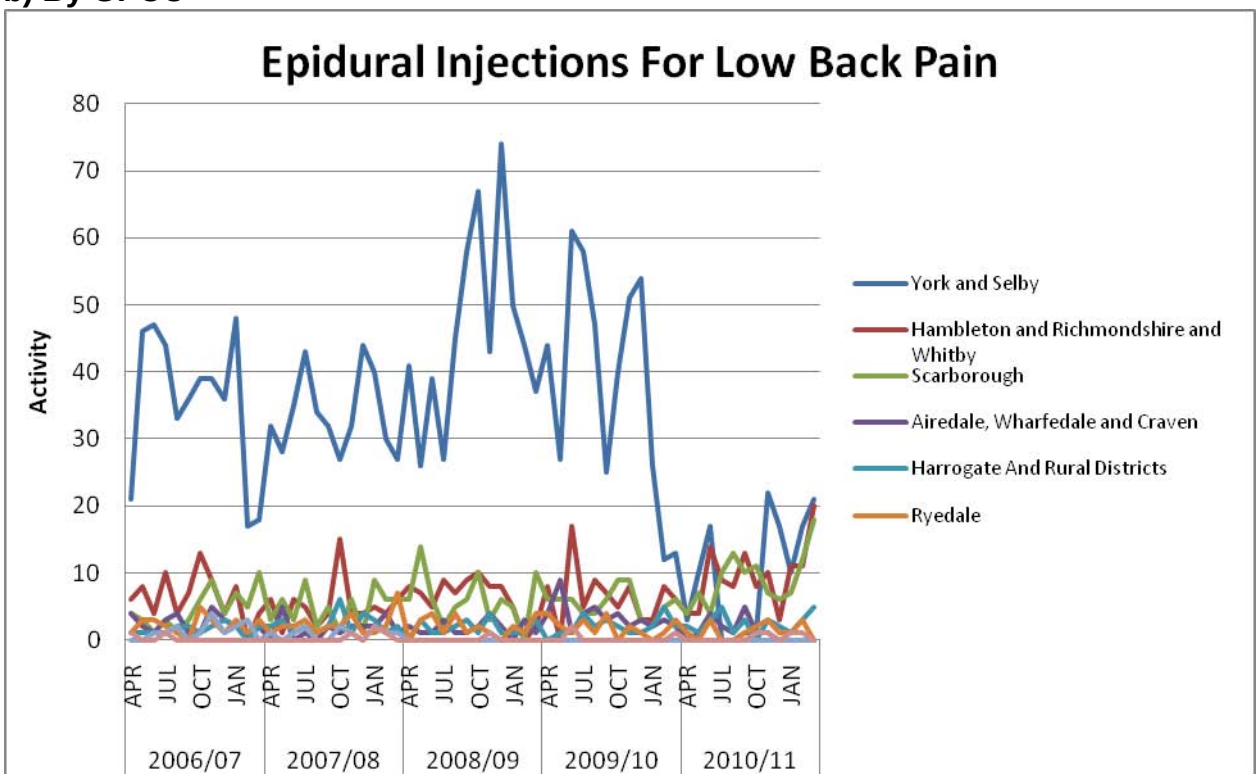


Appendix 6: Elective activity for epidural injections April 2006 – March 2011 ***(Top 5 Providers – York, Scarborough, Harrogate, South Tees and Airedale)***

a) All GPCC

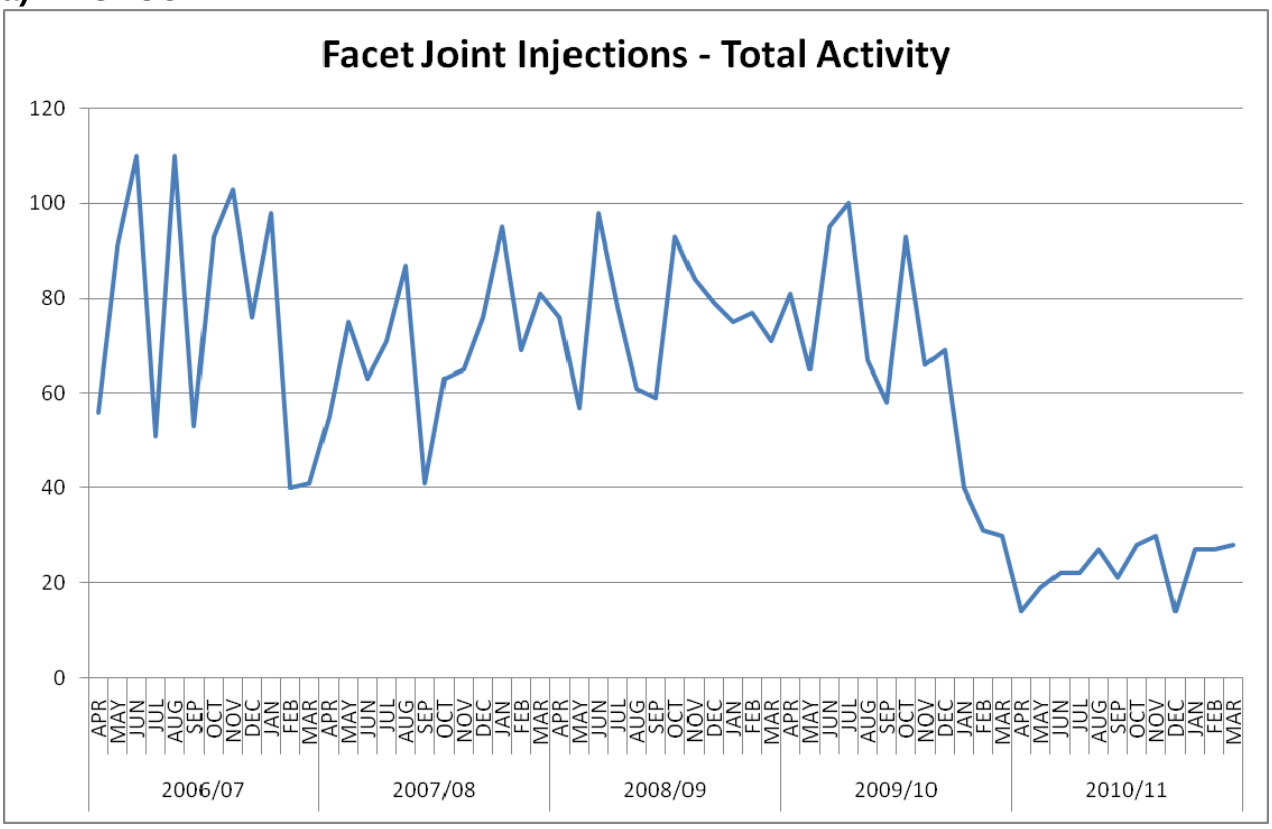


b) By GPCC

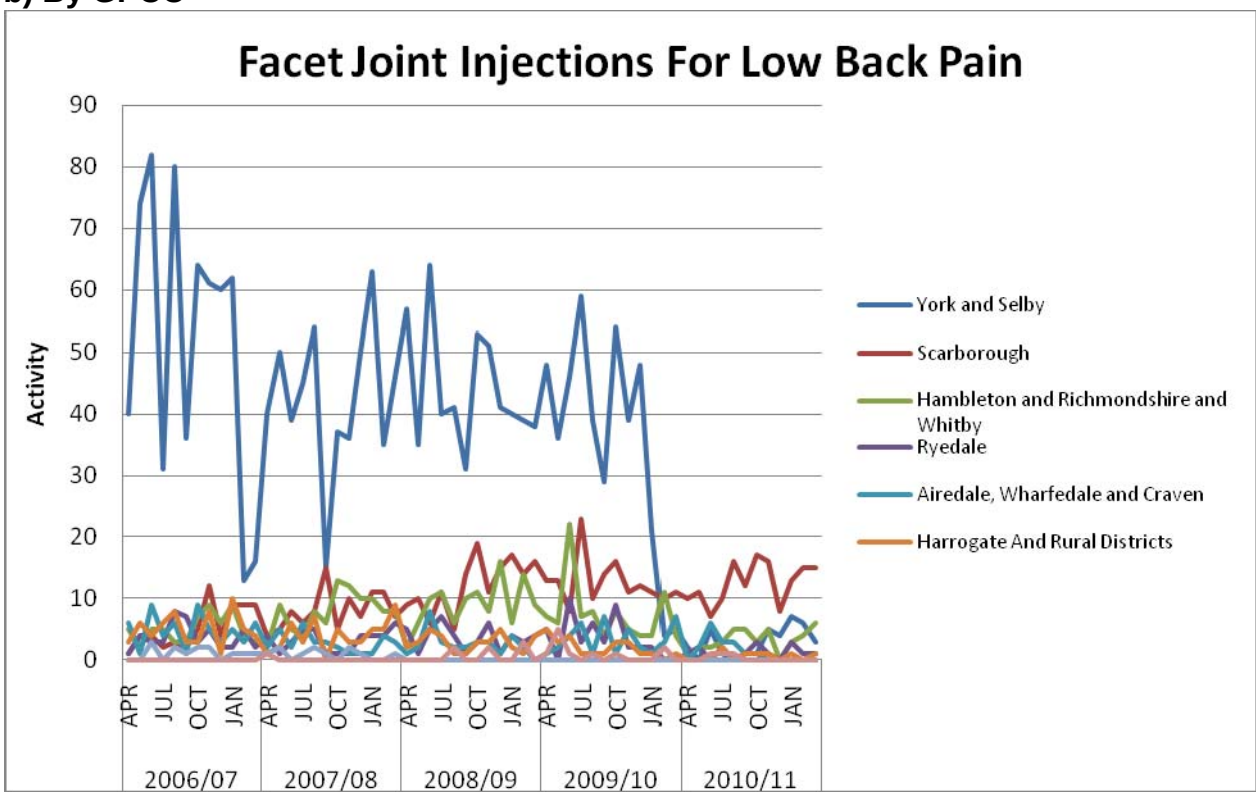


Appendix 7: Elective activity for facet joint injections April 2006 – March 2011 ***(Top 5 Providers – York, Scarborough, Harrogate, South Tees and Airedale)***

a) All GPCC

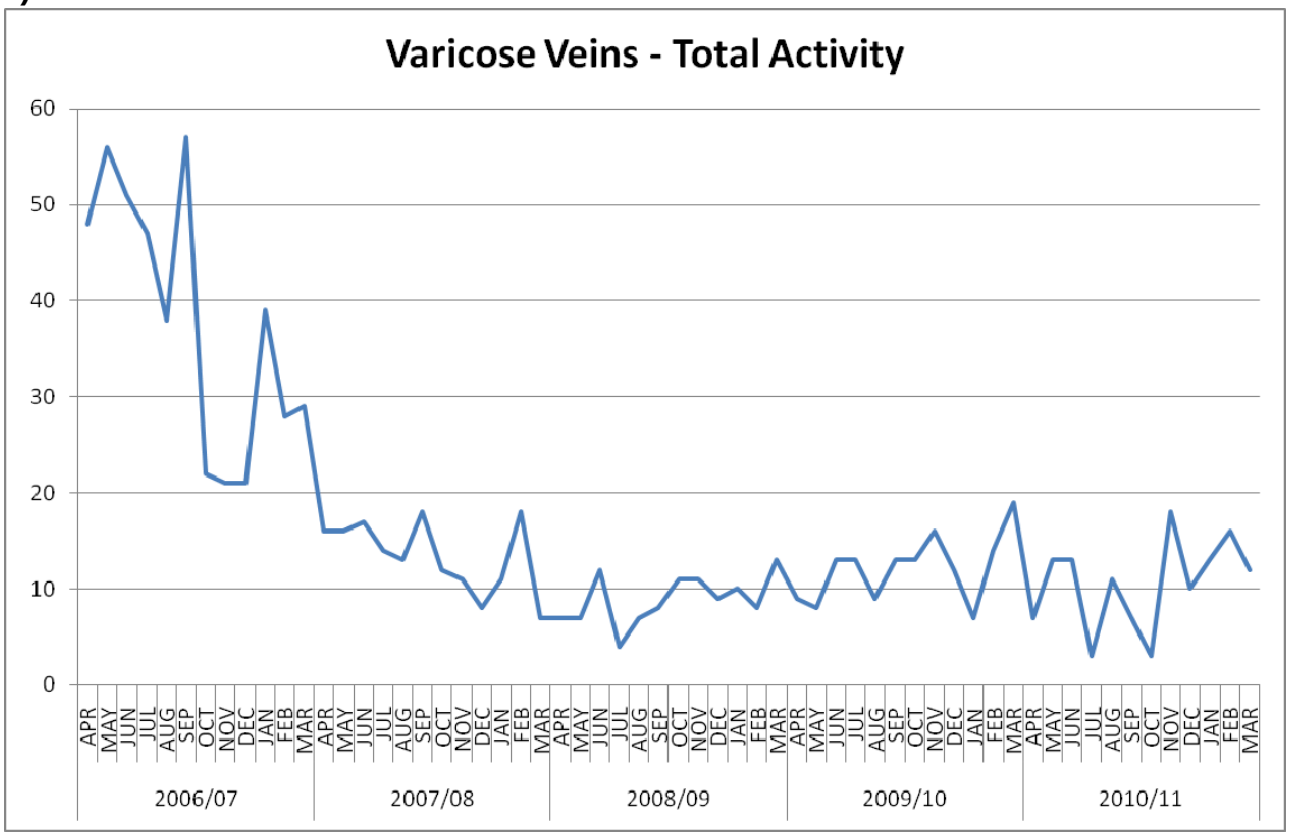


b) By GPCC

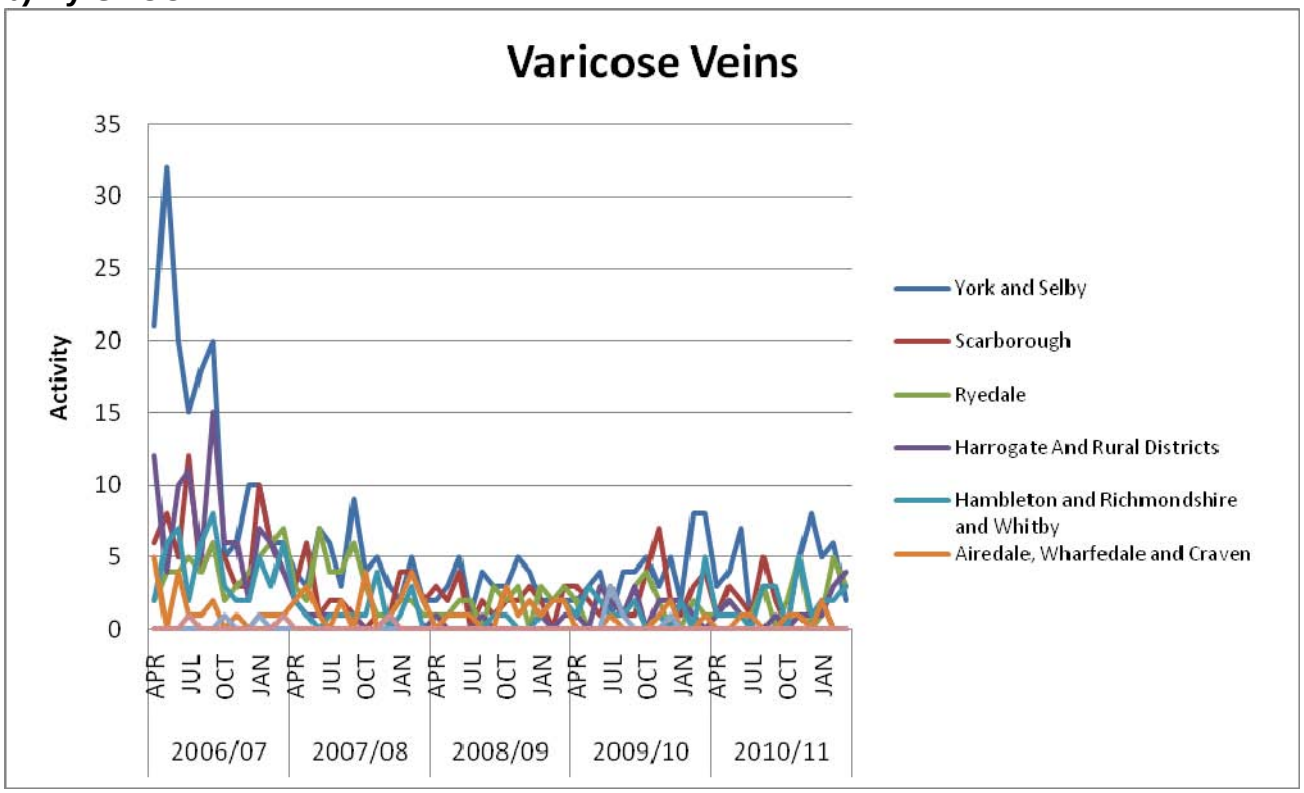


Appendix 8: Elective activity for varicose vein procedures April 2006 – March 2011
(Top 5 Providers – York, Scarborough, Harrogate, South Tees and Airedale)

a) All GPCC



b) By GPCC



Appendix 9

Summary of a sample of 'not routinely commissioned' procedures undertaken April – March 2011, compared with whether approved or declined by Individual Funding Request Panel. 'No match' indicates that the procedure was undertaken without IFR approval.
(Top 5 Providers – York, Scarborough, Harrogate, South Tees and Airedale).

	Approved		No Match		Declined		Total #	Total £
Procedure	#	£	#	£	#	£		
Dilatation And Curettage			19	£14,232			19	£14,232
Epidural Injections For Low Back Pain	30	£29,833	388	£359,448	4	£3,670	422	£392,951
Facet Joint Injections For Low Back Pain	28	£20,276	247	£163,421	6	£4,008	281	£187,705
Ganglion	1	£1,258	73	£79,018	1	£847	75	£81,123
Vasectomy	4	£2,348	231	£135,253	1	£587	236	£138,188
Grand Total	**63**	**£53,715**	**958**	**£751,372**	**12**	**£9,112**	**1,033**	**£814,199**