Evidence Based Interventions Consultation

Frequently Asked Questions

THE CONSULTATION

1 What we are consulting on?

The Evidence Based Interventions programme, specifically: the design principles for the programme, the interventions we should target initially and proposed clinical criteria, the goals we should set and the delivery actions including proposed new terms in the NHS Standard Contract.

2 Which organisations were involved in the developing the consultation document?

We have partnered with NHS Clinical Commissioners, the Academy of Royal Medical Colleges, NHS Improvement's GIRFT programme and NICE to develop the proposals, working in collaboration with the relevant Royal Colleges and patient groups including Healthwatch.

3 How people can respond to the consultation?

There are a number of ways you can respond to the consultation:

- *Via an **online web-form** at: https://www.engage.england.nhs.uk/consultation/evidence-based-interventions/*
- ***Written responses** can be submitted to: england.EBinterventions@nhs.net*
- *In addition we are holding a number of **events** to gather further clinical, professional and patient views. Please see the NHS England website for further information.*

*Please send your responses by **Friday 28 September 2018.***

4 What will happen after the consultation closes?

Following the close of the consultation on Friday 28 September 2018, we will analyse and consider all responses received to inform our final approach, which will be announced later this financial year. Any wording which, following consultation, we determine should be added to the NHS Standard Contract will

be included in the 2019/20 version of the Contract, to be published later this financial year.

THE INTERVENTIONS

5 Which interventions are included in the consultation?

We propose that the following four interventions should no longer be routinely commissioned by CCGs unless a successful Individual Funding Request is made, either because they are ineffective or have been superseded by a safer alternative:

- *Snoring Surgery (in the absence of Obstructive Sleep Apnoea)*
- *Dilatation and curettage for heavy menstrual bleeding in women*
- *Knee arthroscopy for patients with osteoarthritis*
- *Injections for nonspecific low back pain without sciatica*

We propose that a further thirteen interventions should only be commissioned by CCGs or performed when specific clinical criteria are met – this is because they have only been shown to be effective in certain circumstances:

- *Breast reduction*
- *Removal of benign skin lesions*
- *Grommets for Glue Ear in Children*
- *Tonsillectomy for recurrent tonsillitis*
- *Haemorrhoid surgery*
- *Hysterectomy for heavy menstrual bleeding*
- *Chalazia removal*
- *Arthroscopic shoulder decompression for subacromial shoulder pain*
- *Carpal tunnel syndrome release*
- *Dupuytren's contracture release*
- *Ganglion excision*
- *Trigger finger release*
- *Varicose vein surgery*

6 Will all seventeen interventions be completely stopped?

No.

We are proposing that the following four procedures are not routinely performed unless a clinician can demonstrate exceptionality: snoring surgery (in the absence of Obstructive Sleep Apnoea), dilatation and curettage for heavy menstrual bleeding in women, knee arthroscopy for patients with osteoarthritis and injections for nonspecific low back pain without sciatica. For example, when the clinician is able to demonstrate that the individual is different in some way from all patients with the condition AND they can provide the evidence for why

this individual might benefit more from the procedure than other similar patients. In such exceptional cases clinicians would need to submit an Individual Funding Request to their CCG on behalf of the patient.

The 13 procedures listed above would only be offered by the NHS in specific circumstances in line with research and evidence based criteria. We are proposing that GPs should seek prior approval from the relevant CCG to refer patients for these interventions.

7 How were these seventeen interventions chosen?

We initially compiled a long list of interventions with no or limited clinical effectiveness, based on clinical evidence and research including NICE guidelines, Choosing Wisely recommendations, academic studies and NHS Clinical Commissioners' work on Procedures of Limited Clinical Effectiveness (PoLCE). We prioritised changes that we could test our approach on and implement relatively quickly on a large scale. We focused on surgical interventions commissioned by CCGs, where there was high variability in the application of clinical guidelines. We worked with the relevant Royal Colleges and clinicians and some patients to refine the list, ensuring there was clinical consensus and buy-in. We also worked closely with NHS Clinical Commissioners and patient representative groups like Healthwatch to test the proposals and understand their priorities.

8 What happens if I have been referred for one of the seventeen interventions?

Prior to the final policy being announced, we will encourage clinicians to ensure that their patients are fully informed of the risks of proceeding with these interventions. You should talk to your GP or surgeon about this programme if you have been referred for one of the procedures.

9 What about people who have recently had one of the seventeen interventions?

If someone has received one of the seventeen interventions recently, there is no need for concern. But patients should talk to their GP if they are worried.

10 Why are you only focussing on seventeen interventions?

We will first develop proof of concept, by having a relatively narrow initial focus on a few interventions, rather than pursuing all possible opportunities at once. One of the reasons similar initiatives have failed in the past is because they aimed too wide too soon.

However, we intend to make this a much wider, on-going programme, subject to making sufficient progress in the first phase. We will consult on further interventions in phase two, which will be launched in the new year. We will keep the list under periodic review as the evidence base grows in future years. Phase two will also include specialised services, which are commissioned by NHS England.

11 What should I do if I think further interventions should be added to the list?

We would welcome your recommendations on further interventions that we should target. Should you wish to press for additional interventions to be included in the initial list, we ask that you share suggestions by 31 July 2018, along with the supporting clinical evidence and criteria, to enable them to be considered. Recommendations received after 31 July 2018 would still be welcomed and may be used in future rounds.

GENERAL QUESTIONS

12 Is this rationing?

No. The aim of the programme is to:

- *Reduce avoidable harm to patients. With surgical interventions, there is always a risk of complications and adverse effects which could be avoided.*
- *Save precious professional time, when the NHS is severely short of staff.*
- *Help clinicians maintain their professional practice in line with the changing evidence base.*
- *Create headroom for innovation. If we want to accelerate the adoption of new, proven innovations, we need to reduce the number of least effective interventions performed.*
- *Maximise value and avoid waste. Ineffective care is poor value for money for the taxpayer and the NHS.*

Any savings generated will be reinvested in expanding and improving NHS care.

13 What savings will be made by reducing these interventions?

The main reason for introducing this programme is to prevent avoidable harm to patients and free up clinical time and capacity. Based on our initial assumptions, the changes could free up around £200m a year to reinvest in expanding and improving NHS care. We want to test our assumptions as part of the consultation exercise, and will confirm the actual figure later this year.

14 How would any savings be spent and redistributed?

We expect CCGs and providers to work collaboratively on implementing these changes and agreeing how any released capacity is deployed for the benefit of patients.

We would expect that the freed up capacity will be used for other elective activity, for example to improve performance against the Referral to Treatment (RTT) standards, as part of plans agreed with CCGs.

This freed up capacity may also reduce the need for NHS providers to outsource procedures

15 What progress do you expect to see?

Pace is a core design principle of the programme. We will establish clear, quantified national and local goals based on analysis of unwarranted variation across the country. The final goals will be informed by feedback from the consultation, and widely communicated.

16 How will you ensure change is delivered?

Previous attempts to decommission interventions on the basis of clinical evidence have faltered through lack of sustained national and local drive and the absence of formalised levers to support implementation. We propose to take twelve actions to enable delivery – as set out in the consultation document.

17 What if local systems are going further than the proposals set out in this document?

Some local systems have already developed and implemented plans to address the issues set out in this document, engaging and consulting local clinicians, providers and their local populations. We have no desire to reverse legitimate local decision-making and encourage those local systems to continue to make progress in line with their plans. It will be important for the national programme to learn from those furthest on with implementation. We will encourage sharing of learning and peer-to-peer support to other local systems.