Report to:	**PROFESSIONAL REFERENCE GROUP**
Date:	17 January 2017
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**PROPOSAL FOR AN INTERCEPTOR FOR KEY EUR PROCEDURES**

Report Summary:

A benchmarking exercise across GM highlighted that the level of patients who receive some of the EUR procedures is much higher than other CCGs. Ten key procedures have been identified where a more robust process to intercepting referrals/decisions to undertake the procedure could deliver significant reductions and bring the activity in line with other CCGs.

Two options are set out; - the first utilises the CSU GM EUR process and changes the Monitored Approval activity to Individual Prior Approval. The second utilises an internal Interceptor which retains the existing criteria but will allow all GP referrals to be intercepted and Other referrals from Tameside and Glossop Integrated Care Foundation Trust, GM EyeCare, Hyde Physio, Pioneer and NWCATS.

The cost benefit analysis takes into account the additional costs at CSU or the SCF to manage the referrals, additional capacity at T&G ICFT to support additional admin and the reduction in spend for the activity. It is recognised that it may not be possible to release all of the costs at T&G ICFT and a conservative estimate has been used.

Option		**Annual Net Saving to the economy**
1	All ten managed through CSU EUR as IPA or IFR	£290,544
2	All ten managed through the Interceptor	£311,746

Recommendations:

PRG are asked to recommend to SCB the implementation of the proposed Internal EUR Interceptor for the ten specified procedures and the recruitment of the additional Band 3s for a 12 month period at both the Trust and the CCG.

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

The approach outlined in the paper is welcomed, where depending on which option is approved there is a minimum saving to the economy after accounting for loss of income to the ICFT is between £245k and £266k (from the wider aligned ICF). In delivering those savings, CCG performance for those EURs in scope would improve to the average across GM.

Given the size of the financial challenge faced by the Health and Care economy there is a strong case to be made that as a minimum, improvement targets should aspire to deliver performance at the top quartile compared to a peer group or at the average performance of the best three CCG's in GM whichever is the better and at the same time maximise

	opportunities for efficiencies with providers. On that basis the options in this paper should be more ambitious and set out the potential benefits in achieving top quartile performance against comparable CCGs or the average of the top 3 GM CCGs.
Legal Implications: **(Authorised by the Borough Solicitor)**	The policy should be applied fairly and kept under review.
How do proposals align with Health & Wellbeing Strategy?	Prompt access to Dermatology conditions will support children and adults to live well.
How do proposals align with Locality Plan?	Elective services that support people in the community and enable people to self-manage their conditions and maintain their independence is part of the Locality Plan.
How do proposals align with the Commissioning Strategy?	The service will increase support within Neighbourhoods and reduce the use of specialist services when not clinically indicated.
Recommendations / views of the Professional Reference Group:	PRG approved the implementation of the internal EUR Interceptor as set out in option 2 for 12 months. which would require capacity for band 3 post in both the ICFT and SCB ,both would look to see if this can be found across the whole economy, if this is not possible then there would be backfill funding as outlined in the business case, to offer a secondment type offer as an invest to save as highlighted in the paper There will be a four month evaluation of impact as part of a wider paper that includes options for the future commissioning /decommissioning of all EUR procedures.
Public and Patient Implications:	The pilot will involve explicit patient consent to share the referrals and will enable more patients to receive care closer to home. The desire to be treated closer to home has been tested through several engagement exercises and this pilot will help identify any concerns or patient identified benefits when plans are put into action.
Quality Implications:	An initial draft Quality Impact Assessment suggests positive improvements in patient access with no increased risks for clinical effectiveness, patient safety or safeguarding.
How do the proposals help to reduce health inequalities?	The improved access within the Tameside and Glossop Locality will support people with limited access to private transport. Increased support in the familiar surroundings of Primary Care may enable some patients to engage more fully in their treatment.
What are the Equality and Diversity implications?	The services are not expected to have negative impacts on any protected group.
What are the safeguarding implications?	The clinical pathways have no additional safeguarding implications.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The pilot uses explicit patient consent to allow the sharing of the patient information. Strict protocols will be in place regarding storage of images and referrals and audits will be used to ensure compliance.

	A Privacy Impact Assessment will be completed by the provider prior to go live.
Risk Management:	There are no additional risk management implications.
Access to Information :	The background papers relating to this report can be inspected by contacting Elaine Richardson, Head of Delivery and Assurance:  Telephone: 07855469931  e-mail: elaine.richardson@nhs.net

1. INTRODUCTION

1.1. Tameside and Glossop CCG along with others in GM have identified a number of procedures that have limited clinical value and should only be used for the specific patients that will derive clinical benefit. These are subject to the Effective Use of Resources (EUR) system which agrees policies that set out the circumstances when a patient will derive clinical benefit and manages the route by which the treatments will be approved.

1.2. A benchmarking exercise across GM in 2015/16 highlighted that the level of patients who receive some of these procedures (using an agreed set of GM treatment codes) is much higher than other CCGs. This exercise has continued and whilst we have moved to be closer to the GM average in quarter 1 2016/17 we are still in the highest four CCGs for several.

	2015/16			Forecast 2016/17		
Procedure	**Number per 100k population**		**Rank**	**Number per 100k population**		**Rank**
	T&G	**GM**		**T&G**	**GM**	
Benign Skin Lesion of Eyelid	29	27		56	42	9
Breast (Correction of Nipple)	1	0		2	1	1
Breast (Gynaecomastia Male)	0	0		0	0	
Breast (Mastopexy)	0	1		0	0	
Breast Augmentation Revision	0	0		0	0	
Breast Reduction	1	0		0	0	
Bunion Removal	50	29	12	38	27	8
Cataract Surgery	881	654	11	775	640	9
Common Benign Skin Lesions	131	115	9	97	93	9
Correction of Eyelid Ptosis	8	5		8	5	4
Dupytrens Contracture	40	27	10	33	26	9
Ganglion Cyst Removal	21	20	9	20	21	6
Hyperhidrosis	33	14	11	40	16	11
Non-Specific Low Back Pain/Facet Injections	355	129	12	267	201	10
Pinnaplasty	2	2		3	2	7
Revision of Scarring	3	5		2	3	1
Sacral Neuromodulation	0	1		0	0	
Snoring	12	6		1	1	10
Tonsillectomy	124	75	12	23	20	9
Varicose Veins	68	53	10	59	49	10
Grand Total	**1,761**	**1,162**				

Table 1 GM Benchmarking Position

1.3. The activity levels in 2016/17 suggest that we have reduced activity for some procedures already. There are likely to be several reasons for the improvement including greater awareness by GPs of the EUR procedures, processes put in place by the ICO and the increased use of non-surgical community providers. The two providers who provide community based services have already been reminded that there should be no onward referrals unless patients meet the appropriate EUR policy and are reporting on the activity.

1.3.1. NWCATS have identified that some spinal injections are being onward referred and are auditing whether these cases come under the Facet Joint Injection for back and neck pain policy. They have instigated an MDT to review onward referrals and ensure adherence to IPA and IFR processes.

1.3.2. GM EyeCare onward referred 165 patients for cataracts out of 173 in Quarter 1 and 173 out of 182 in Quarter 2. They have been asked to ensure all their optometrists are accurately interpreting the criteria and to make it clear that a second eye must

not be operated on unless explicitly requested. GPs have also been asked not to directly refer patients who have not been through the cataract refinement service

1.4. Based on the benchmarking the Single Commissioning Function has decided to focus on ten procedures, nine of which are highlighted above plus Hyaluronic Acid Injections for Osteoarthritis. It is difficult to benchmark the latter as the coding is not straight-forward however local activity appears to be higher than expected hence it has been included in the ten priorities.

1.5. The need for a process that intercepts the referrals for these procedures before activity is undertaken has been highlighted and the following summarises two options for the proposed arrangements and potential impact.

2. CURRENT EUR ARRANGEMENTS

2.1. Each of the ten procedures is only commissioned under certain specific criteria but there are three types of approval across the ten as it is dependent on the procedure (table 2).

2.1.1. **Monitored Approval (MA)** – Referrals may be made or accepted for these procedures in accordance with the criteria set **without** the need to secure prior funding approval. It is the responsibility of the CCG to monitor the activity for these procedures.

2.1.2. **Individual Prior Approval (IPA)** – Funding approval is required **prior to** initiating treatment. This is obtained via a request to GM EUR that demonstrates that a patient meets the specific criteria.

2.1.3. **Individual Funding Request (IFR)** – when treatment is not routinely commissioned or may only be commissioned under certain specific criteria approval is required **prior to** initiating treatment. This is obtained by submitting an individual patient request to GM EUR detailing why the patient should receive the treatment.

2.2. Funding outside of the criteria may be considered on an individual patient basis if there is evidence of clinical exceptional circumstances and this follows the Individual Funding Request route.

2.3. CSU administers the system for Individual Prior Approval (IPA) and Individual Funding Requests (IFR) on behalf of the CCG and either the referrer or the treatment providers (whoever identifies the procedure as the required outcome) are expected to follow the process of gaining approval shown in **Appendix 1**.

2.4. No one intercepts Monitored Approval Referrals but as a CCG we monitor activity and raise concerns through the contracting route when activity appears high. A CCG can instigate an audit and discussions are ongoing with the lead commissioner around cataract levels at one provider.

Procedure	Type of Approval		
	Monitored Approval	Individual Prior Approval	Individual Funding Request
1. Tonsillectomy	Adults and Children		
2. Dupuytrens Contractures	All		
3. Bunion Surgery	All		
4. Ganglion Cyst	All		

Removal			
5. Hyperhidrosis	All		
6. Benign Skin Lesions	All		
7. Cataracts	All		
8. Varicose Veins Surgery	Severe varicose veins	Moderate varicose veins	
9. Facet Joint Injections	Existing patients with demonstrable improvement in quality of life measures following each treatment assessed using a validated research tool. No more than 2 injections a year.	All New Patients	
10. Hyaluronic Acid Injections			All

Table 2 Current Approval Arrangement

2.5. The type of approval that operates for each provider relates to the Lead Commissioner with all patients being treated at that provider following that Lead Commissioner criteria e.g. if Stockport CCG use Monitored Approval for Tonsillectomies all our patients referred for Tonsillectomies at Stockport Foundation Trust will be listed without going to CSU regardless of the criteria set by Tameside and Glossop CCG. However, if Stockport were IPA and T&G monitored Approval CSU would automatically approve the request as T&G have a lower criteria

3. PROPOSED APPROVAL ARRANGEMENTS

3.1. There are two options for the arrangements that will enable referrals to be intercepted and reviewed to ensure only those patients who meet the criteria are accepted for surgery.

3.2. Both will involve a request for approval either from a GP or a treating clinician as set out below:

3.2.1. When a **GP has a reasonable expectation that one of the ten procedures** will be the treatment then **they will be responsible for the request** by completing the referral proforma that sets out the criteria the patient must meet and sending it to the Internal EUR Service.

3.2.2. When a **GP makes a referral for assessment and or treatment but does not specify one of the ten procedures** then the **provider who decides that the procedure is required are responsible for the request** by completing the proforma that sets out the criteria the patient must meet and sending it to the Internal EUR Service.

3.3. It is expected that as part of agreeing a management plan with a patient, the GP or the treating clinician will have discussed the possibility of the procedure to enable a patient to make an informed decision around potential management plans and will explain that the procedure is only effective in specific circumstances. Having explained that they are required to discuss the clinical effectiveness with colleagues before finalising it as an option, patients must explicitly consent to this in order to enable the process to be followed. If patients refuse consent then they cannot be offered the procedure.

Option 1

3.4. The seven procedures that are Monitored Approval become Individual Prior Approval and the Severe Varicose Veins and existing patients for facet joint injections also become Individual Prior Approval in the same way as Moderate Varicose Veins and New Patients. The Hyaluronic acid injections will remain IFR.

3.5. The review of referrals and reporting to the CCG of approved activity will then follow the process shown in **Appendix 1**.

3.6. The arrangements will only apply in providers who have a direct contract with Tameside and Glossop CCG i.e. the ICO and GM EyeCare in 2016/17.

3.7. Current experience is that the three procedures that should go through the IPA/IFR do not do so which suggests that other arrangements will also need to be put in place at the ICO to ensure that no patient is listed for surgery without the necessary approval.

3.8. Any referral from a GP for a procedure that does not have the CSU approval letter attached will be rejected by the ICO but internal monitoring will be required to ensure Other referrals e.g. Consultant to Consultant are also sent to CSU.

3.9. The SCF will need a mechanism for linking the report from CSU with the activity submitted by providers.

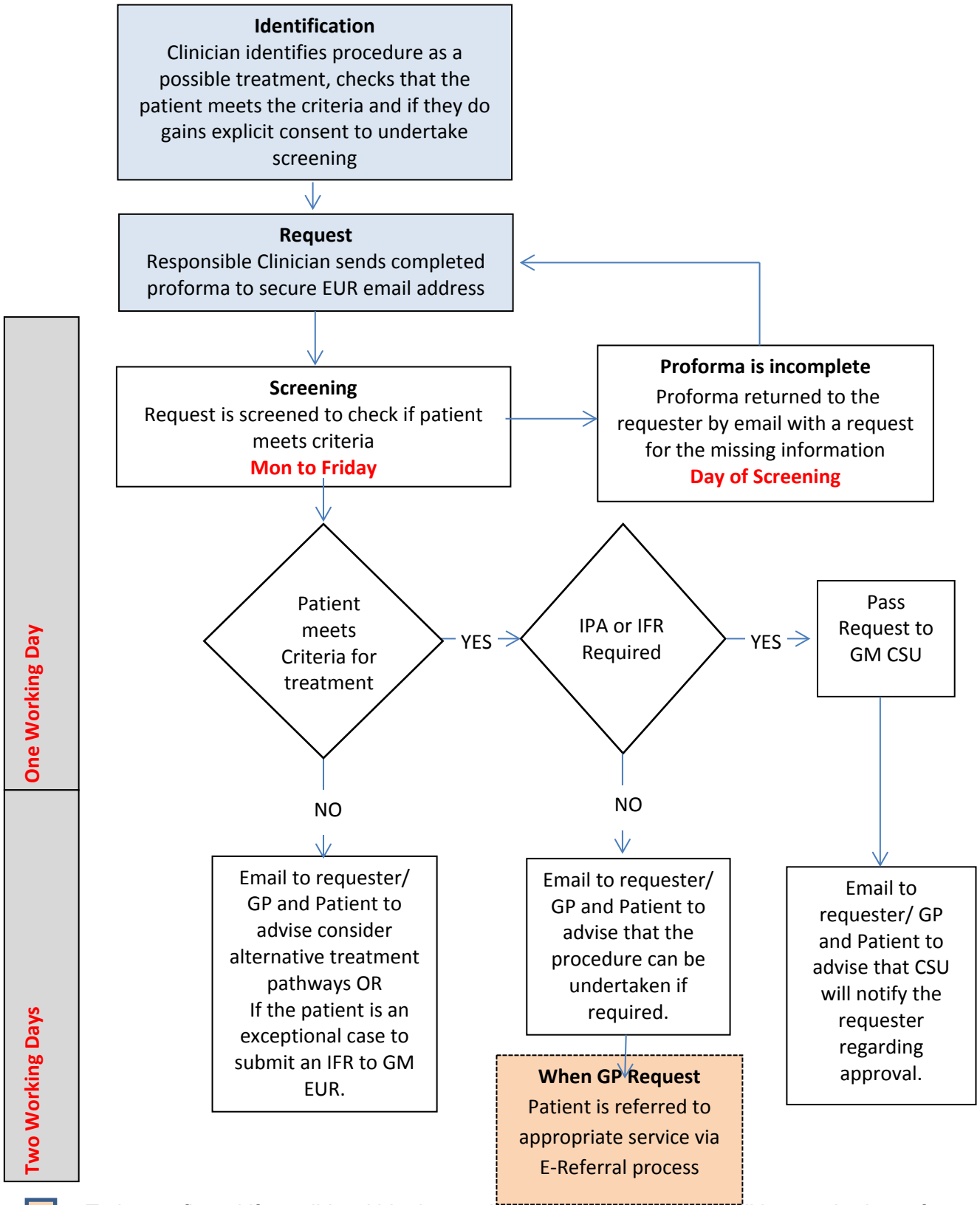
Option 2

3.10 Referrals for all ten procedures come to an Internal EUR Interceptor service that will screen them to ensure all criteria are met. For Moderate Varicose Veins, New patients for facet joints and Hyaluronic acid injections if the patient meets the screening criteria the IPA or IFR request will be passed on to CSU to follow the GM EUR process (**Appendix 1**).

3.11 A report on approved and rejected activity will be used to validate activity submitted by providers to ensure compliance.

3.12 The flow chart for the approval process is set out below.

Internal EUR Process



To be confirmed if possible within the service or whether practices will be required to refer

3.13 The outcome of the screening will be communicated to the requester within 2 working days and the requester, the GP and the patient will be notified of the screening decision and next steps.

3.14 There will be no right of appeal but if a requester or patient is unhappy with the decision they are able to make a complaint to the CCG through the complaints system.

3.15 The internal process will take up to two working days and this must be factored in by providers working to 18 week standards. For procedures that are IPA and IFR the screening at GM CSU EUR will take up to a further 3 working days and if a decision is appealed that can take up to a month. Complete and high quality requests will reduce the risk of delays as they will enable comprehensive clinical review to take place early in the process.

3.16 As in option 1, arrangements will also need to be put in place at the ICO to ensure that no patient is listed for surgery without the necessary approval. Any referral from a GP for a procedure that does not have the Interceptor approval reference will be rejected by the ICO but internal monitoring will be required to ensure Other referrals e.g. Consultant to Consultant are also sent to the Interceptor.

4. COST BENEFIT ANALYSIS

4.1. The CSU element of Option 1 is likely to cost £45,000.

4.2. The internal Interceptor process in Option 2 will require full time (band 3) administrative support with oversight of the CCG EUR manager. The CCG EUR Manager will be released to provide the oversight and ensure effective reporting on activity. The band 3 is an additional post at a cost of £23,798. This will manage around 3,800 requests based on existing activity.

4.3. For both options the additional work at the ICO to ensure that when required requests are made, tracked and responses received and enacted so patients do not breach waiting times will also require a Band three at a cost of £27,100. It is expected that around 1,000 requests will be made by the ICO based on existing activity.

4.4. When an alternative management plan is required to meet the patient's need there may be a cost to that for activity or medication however it is impossible to quantify this at this stage and this will be included in the cost effectiveness evaluation.

4.5. The activity reductions required are indicated in table 3 below. For some procedures we cannot recover a GM rate e.g. Hyperhidrosis and are extremely unlikely to recover facet joint injections, or cataracts. Hyaluronic acid injections do not have a GM rate but these are not commissioned and only patients demonstrating exceptionality should be receiving them.

Procedure	T&G Activity							
	Current		Average Ambition				Top 3 Ambition	
	Apr to Sept	FYE	T&G No. @ GM Rate	Reduction Required	Activity Share at T&G ICFT	Activity Reduction at T&G ICFT	T&G No. if in top 3	Reduction Required
Bunion Removal	49	98	65	33	82%	27	44	54
Common Benign Skin Lesions	104	208	226		79%		121	87
Dupytrens Contracture	27	54	63		74%	0	44	10
Ganglion Cyst Removal	25	50	52		68%	0	39	11
Hyperhidrosis	48	96	38	58	58%	34	19	77
Tonsillectomy	39	78	48	30	61%	18	39	39
Cataract Surgery	967	1,934	1552	382	0%		1091	843
Varicose Veins	66	132	120	12	80%	10	73	59
Facet Joint Injections	322	644	488	156	95%	148	182	462
Total	**1,647**	**3,294**	**2,652**	**671**	**6**	**237**	**1,652**	**1,642**
Hyaluronic acid injections	222	444			76%	350		

Table 3 2016/17 Activity

4.6. If activity for those procedures shown in table 3 that are above GM average can be brought in line with the GM average there is the potential to save £630k in 2017/18 compared with 16/17. This would be increased to £1.356m if the activity was in line with the top 3 CCGs. The savings potential is detailed in the table 4 below.

	Potential Saving to SCF		
Activity Level	No change	At GM average	At level of top 3 CCGs
Bunion Removal	0	84,672	163,296
Common Benign Skin Lesions	0		55,071
Dupytrens Contracture	0		41,440
Ganglion Cyst Removal	0	1,834	10,087
Hyperhidrosis	0	28,914	36,498
Tonsillectomy	0		42,666
Cataract Surgery	0	276,660	670,185
Varicose Veins	0	3,318	65,254
Facet Joint Injections	0	234,724	326,634
hyaluronic acid injections	0		
Total	**0**	**630,122**	**1,411,131**

Table 4 Potential Saving to SCF

4.7. The activity share at the trust will mean that the loss of activity may be insufficient to release costs and if the capacity cannot be used effectively and reduce additional costs such as waiting list initiatives or use of external providers then there will be limited cost reduction to the economy as a whole. Table 5 shows the potential Health Economy savings.

Potential Savings			
Activity Level	At GM average	Income Loss to T&G IC FT	**Minimum Economy Tariff Savings**
Bunion Removal	84,672	69,120	15,552
Ganglion Cyst Removal	1,834	1,247	587
Hyperhidrosis	28,914	16,867	12,047
Cataract Surgery	276,660	0	276,660
Varicose Veins	3,318	2,664	654
Facet Joint Injections	234,724	223,061	11,663
hyaluronic acid injections			
Total	**630,122**	**312,959**	**317,163**

Table 5 Potential Savings 2017/18

4.8. Whilst not on a tariff based contract the potential income lost through tariff would be £316k with Tameside & Glossop Integrated Care NHS Foundation Trust. However, the SCF still has the potential to save £317k from activity going outside of the economy which would contribute towards the £70m economy financial gap. If the Trust can also make savings over the longer term this too will also help to support bridging the economy gap.

4.9. The EUR activity reduction along with other reductions through service redesign for Advice and Guidance, compliance with Consultant to Consultant protocols and reductions in Follow Up appointments may support the release of costs at the ICO and maximise income through delivery against National CQUIN Six Offering advice and Guidance (A&G). The ICO has identified £45,481 of costs that can be released these are not included in the savings below as the timing is to be agreed.

4.10. The net saving after taking account of investment at both the CCG and the Trust in order to implement the proposal would be as shown in Table 6.

Option		**Annual Net Saving to the economy**
1	All ten manged through CSU EUR as IPA or IFR	£290,544
2	All ten manged through the Interceptor	£311,746

Table 6 Net Saving

5. IMPLEMENTATION PLAN

5.1. For Option 1 the timeframe for implementation will depend on CSU and recruitment to the additional capacity, band 3 and band 4 to manage the requests.

5.2. For Option 2 the intention is the implement the process from 1 January 2017. It will be for 12 months in the first instance to enable detailed analysis of referral and request patterns, identification of training support for referrers and requester and identification of learning that can be taken into the ICO for further demand management. Recruitment to the Band 3 will be undertaken (on a fixed term contract initially) and the internal processes and monitoring set up.

5.3. The CSU guides to the policies and IPA/IFR proformas are planned to be uploaded to Practice Clinical Systems week of Dec 12th to support EUR procedures so this work will be ahead of any decision and will support both option 1 and option 2.

5.4. The initial implementation for both options will be with all Tameside and Glossop GPs and all providers who have a direct contact with Tameside and Glossop CCG. This includes:

- Tameside and Glossop ICFT
- GM EyeCare
- Hyde Physio
- Pioneer
- NWCATS – whilst only an associate to the bridging contract the provider will be included at stage 1.

5.5. Further to discussions across GM with Heads of Commissioning and Directors of Finance regarding GM adopting IPA for all policies it may be possible to extend across more providers.

5.6. There will be an initial review of usage after one month to measure compliance and the approval rate. Any improvements in processes within the service and across requesters will be agreed and implemented.

5.7. Activity and approval rates will be monitored monthly with an interim evaluation of cost effectiveness after three months to inform wider roll out/continuation of the service.

5.8. Following approval communication will take place with practice representatives through TARGET, Practice Manager's Forum and Neighbourhood meetings to ensure a full understanding of the new processes.

5.9. Providers will be asked to implement their own internal processes to ensure compliance with the process.

5.10. Discussions regarding the use of E-referral are ongoing and if possible we will look to refer from the service to maximise the use of E-referral which is a Quality Premium Indicator.

6. RECOMMENDATIONS

6.1. As set out on the front of the report.

APPENDIX 1

GM CSU EUR Process