ENCLOSURE: T

Agenda Item: 86/13

NHS Bexley Clinical Commissioning Group

Governing Body (Public) Meeting

DATE: 25 July 2013

Title	Expanding the Treatment Access Policy for Bexley
Recommended action for the Governing Body	That the Governing Body: **Approve** a Bexley CCG amendment to the 2013 South East London Treatment Access Policy (TAP) in relation to: 1. Surgery for Asymptomatic Gallstones 2. Investigations of Single Bright Red Rectal Bleed in patients under 45 years old
Executive Summary	This paper provides an update for the Governing Body following its approval of the South East London Treatment Access Policy at its 30th May 2013 public meeting. Within that paper was also a potential amendment recommendation to include the above, and although the implementation of these amendments was discussed, the notes of the meeting say it was "noted". On this basis clarity is required from the Governing Body to enable a formal decision to be made to implement these amendments. It is proposed that the minutes for the meeting of the Governing Body (May 28th) could then be amended to show that it was "discussed and approved". There are two areas of discussion that require approval prior to implementation in the Treatment Access Policy and these are: 1. Surgery for Asymptomatic Gallstones – amendment to current policy by moving to the Part 1 Prior Approval section 2. Investigations of Single Bright Red Rectal Bleed in patients under 45 years old – insertion of new clause in the Prior Approval section If the above are approved by the Governing Body, then the policy will require that Prior Approval is sought to ensure that both inappropriate referrals and treatments are minimised. The paper also describes improvements which have been made to systems and processes to offer the CCG assurance that procedures requiring Prior Approval have received such approval or alternatively will not be paid.

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Which objective does this paper support?	**Patients:**	Improve the health and wellbeing of people in Bexley in partnership with our key stakeholders	x
	People:	Empower our staff to make BCCG the most successful CCG in (south) London	
	Pounds:	Delivering on all of our statutory duties and become an effective, efficient and economical organisation	x
	Process:	Commission safe, sustainable and equitable services in line with the operating framework and which improves outcomes and patient experience	x

Organisational implications	Key Risks (corporate and/or clinical)	
	Equality and Diversity	None
	Patient impact	Treatment Access Policy is designed to ensure the CCG commissions only appropriate care for Bexley residents though may be seen as a restrictive process.
	Financial	Reducing inappropriate activity better enables the CCG to meet its statutory financial obligations
	Legal Issues	None
	NHS constitution	Reducing levels of inappropriate activity in acute hospitals will better enable patients to be seen within the 18 Weeks Referral to Treatment standard.
Consultation (Public, member or other)		
Audit (Considered / Approved by Other Committees / Groups)	SEL Treatment Access Policy agreed at 30 May Governing Body meeting, these are amendments to that agreed policy	
Communications Plan	To be agreed following Governing Body determination	
Author	Neil Hales	
	Clinical Lead No clinical lead, but currently under discussions with Nada Lemic Director of Public Health	Executive Sponsor Sarah Valentine Director of Commissioning
Date	19 July 2013	

1.0 Background

The South East London Treatment Access Policy (SEL TAP) was approved by the Governing Body at its meeting on 30th May 2013.

The Governing Body noted:

- The addition of 2 areas for changing the policy on Asymptomatic Gallstones, and Single Bright Red Bleeds in the under 45s.
- The need to address with providers poor compliance with existing Prior Approval processes

2.0 Operating the current 2013 South East London Treatment Access Policy (SEL TAP)

The current South East London Treatment Access Policy (SEL TAP) is split into 2 parts:

- Part 1 – Procedures with restricted access criteria requiring prior agreement
- Part 2 – Procedures with restricted access criteria not requiring prior agreement

For the purpose of this report Part 1 is referred to as the Prior Approval section. It is this section which is of most significance in terms of an effective mechanism to minimise the level of inappropriate referral and subsequent activity. Bexley's NHS Acute Contracts with hospital providers state that the CCG is not liable to pay for treatment for any procedure which requires Prior Approval where such approval has not been sought.

Section 3.1 below describes how the CCG has undertaken measures to ensure the existing Prior Approvals process, i.e. the Individual Funding Requests or IFR process, is operated more effectively.

Procedures listed in Part 2 of SEL TAP, where Prior Approval is not required, are subject to clinical audit between CCGs and Providers during each financial year. The purpose of the audit is to establish, from what may be a relatively small sample of patients, whether or not the restrictive criteria noted in the policy has been adhered to. Should the joint audit determine a level of non-compliance with the restrictions noted in the TAP policy Part 2 procedures a percentage reduction is agreed to the CCGs contractual payments, e.g. if there's 40% non-compliance, treatment costs will be reduced by 40%. Audits are difficult to undertake and may not have been undertaken in recent years.

The disadvantage for Providers is they may be undertaking treatment for which they may not be paid for. The disadvantage for Patients is this may undergo treatment which may be of little or not benefit to them. This arises as 'Part 2' procedures typically describe treatments which *may* have *some* benefit to *some* patients.

From a contractual perspective the position regarding 'Prior Approval' procedures is very clear, i.e. the CCG is not liable for any costs relating to treatment where Prior Approval has not been sought. It is therefore imperative that procedures which are not routinely funded should be detailed in the Part 1 'Prior Approval' section. Where this is the case clinicians, via the Individual Funding Request (IFR) process, must satisfy the exceptionality of patients treatment, on a case by case basis, to determine whether or not treatment for Part 1 Prior Approvals treatment is authorised to proceed.

3.0 Expanding the Treatment Access Policy (TAP) for Bexley CCG

The Governing Body May discussion "noted" how the South East London Treatment Access Policy could be enhanced to ensure inappropriate referral or activity is minimised. A review of similar 'TAP' policies in operation in other health economies has been undertaken and the following areas are requested as amendments for Bexley CCGs Treatment Access Policy.

These are:

- Surgery for Asymptomatic Gallstones
- Investigation of Single Bright Red Single Bleed in the under 45s

3.1 Asymtomatic Gallstones Surgery

These are currently listed within Part 2 of the policy, the Governing Body are asked to approve moving these into Part 1 of the Policy (see Section 2.0 above that shows the difference between Part 1 and Part 2 of the South East London Treatment Access Policy). Surgery for Asymptomatic Gallstones is already listed within the current policy, in Part 2, as follows:

Extract SEL Treatment Access Policy April 2013, P20:

"2.12 SURGERY FOR ASYMPTOMATIC GALLSTONES[1]

> Approximately 10-20% of people in western countries have gallstones, and some 50-70% are asymptomatic at the time of diagnosis. Asymptomatic disease has a benign natural course and progression to symptomatic disease is relatively low, ranging from 10-25%. The majority of patients rarely develop gallstone-related complications without first having at least one episode of pain.
>
> **There is no evidence, and in particular no evidence from randomized controlled trails that surgery for asymptomatic gallstones is beneficial and it will not therefore be routinely funded."**

Asymptomatic gallstones are usually diagnosed incidentally when they are seen on imaging which is done for unrelated reasons. As such referral for treatment is ordinarily via consultant to consultant referral. As the CCG does not routinely fund Surgery for Asymptomatic Gallstones it is more appropriate that such procedures are detailed in the Part 1 'Prior Approvals' section of the policy.

As there is no evidence that surgery for asymptomatic gallstones is beneficial it is unlikely that such surgery would be funded. However, by moving this element to the Prior Approval section clinicians may use the Individual Funding Requests process to seek authority to treat patients should they be able to demonstrate any exceptionality which would merit such treatment on a case by case basis.

Based on 2012/13 data Bexley CCG spent £625k on Surgery for Asymptomatic Gallstones, or £52k per month. It is imperative that further contractual control, via the Prior Approvals process, is exercised in relation to this procedure to ensure inappropriate treatment for Bexley residents is minimised.

The reduction in inappropriate Surgery for Asymptomatic Gallstones can be most effectively achieved via amending the current Treatment Access Policy to include such treatment as a Part 1 Prior Approval procedure.

3.2 Investigation of Single Bright Red Rectal Bleed in the under 45s

A comparison with other health economies policies has been undertaken regarding exclusions and restricted criteria for a range of treatments. Investigation of Single Bright Red Single Bleed in the under 45s is noted in several policies including Staffordshire and Birmingham & Solihull. Appendix 1 details the Birmingham & Solihull policy in respect of this which highlights that although rectal bleeding may be a symptom of Colorectal Cancer, the likelihood in a patient under 45 years is very rare. The likelihood of a patient 40 years with rectal bleeding (and no other adverse symptoms) having cancer has been estimated as 1 in 400.

The Governing Body are asked to approve the adoption the Birmingham and Solihull commissioning policy with regard to Rectal Bleeding by including this as a Part 1 Prior Approval procedure as a Bexley amendment to the South East London Treatment Access Policy.

During 2012/13 the CCG spent £284k in relation to such Rectal Bleed investigations.

4.0 Improving the Prior Approval Process

The CCG has developed a mechanism to identify all activity undertaken within the existing South East London Treatment Access Policy, i.e. a filter on specific OPCS procedure codes which are listed in the policy as either being an excluded or restricted procedure. At time of writing, the CCG are awaiting a refresh of data for April and May activity which will automatically highlight those patients who have received either an excluded or restricted procedure.

The CCG will then verify with the Commissioning Support Unit which patients had received appropriate Prior Approval. The CCG will challenge payment for any activity that has been undertaken without Prior Approval. The CCG is not contractually liable for costs of any treatment as defined in the Treatment Access Policy as requiring Prior Approval but where no such approval was sought.

The previous paper to the 30th May Governing Body meeting noted only 182 of 1,177 procedures had received appropriate Prior Approval, via the Individual Funding Request or IFR process. Hence this filter mechanism is key in challenging providers for any activity undertaken which has in essence not been commissioned by the CCG, i.e. has not been subject to the appropriate approval process.

A further update will be provided to the Governing Body in due course on the level of 'Prior Approval' activity that has been challenged by the CCG for Quarter 1 activity, April to June 2013.

4.0 Recommendations

In view of the above the Governing Body are requested to approve a Bexley CCG amendment to the current South East London Treatment Policy which will:

- Move the current exclusion of *Surgery for Asymptomatic Gallstones* into the 'Part 1 Prior Approval' section of the TAP policy
- Adopt a new clause applying *Investigation of Single Bright Red Single Bleed in the under 45s* as an excluded procedure governed by the 'Part 1 Prior Approval' process

Sarah Valentine
Director of Commissioning

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Appendix 1

Birmingham & Solihull Commissioning Cluster
Procedures of Lower Clinical Value

Ref No. 1b10.6

For information to Bexley CCG

COMMISSIONING POLICY

Rectal Bleeding in the Under 45's

April 2011

CONTENTS

Version: 6
Date: April 2011

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SUMMARY

Birmingham & Solihull Commissioning Cluster does not usually fund investigation for a single rectal bleed in the Under 45 age category.

1. Background:

An electronic copy of this Commissioning Policy is available on the Cluster's website at the following address:

https://www.sbpct.nhs.uk/bham-and-solihull-cluster/individual-funding-requests.aspx

Only 1% of colorectal cancers occur in patients under 40 years whereas rectal bleeding is commonest in the 30-40 year age group. The likelihood of a patient 40 years with rectal bleeding (and no other adverse symptoms) having cancer has been estimated as 1 in 400. This can be compared with a likelihood of 1 in 300 for an asymptomatic person of 60 years. It would seem illogical that people aged 40 years with rectal bleeding as their only symptom should be referred urgently to a specialist when we would not advocate this for an asymptomatic person aged 60. These considerations will, however, need to be carefully explained to patients (Source: DH Referral Guidelines for suspected cancer)

Rectal bleeding, although it is common, can be a symptom of colorectal cancer. About 40% of patients with colorectal cancer have rectal bleeding, but the risk of colorectal cancer for a patient with rectal bleeding is thought to be relatively low.

The risk of colorectal cancer in patients who present to primary care with rectal bleeding has rarely been studied. Most studies are retrospective: a Dutch study of 269 patients, nine of whom had cancer, found a positive predictive value of 3.3% (95% confidence interval 1.2% to 5.4%); a Belgian study of 386 patients, 27 of whom had cancer, found a value of 7.0% (4.6% to 10.0%); and a UK case control study of 2093 patients, 349 of whom had cancer, estimated a positive predictive value of 2.4% (1.9% to 3.2%). A recent UK study investigated 219 (69%) of 319 patients aged 34 or more whose main symptom was rectal bleeding. Eleven cancers were found, giving a positive predictive value of 3.4%. All patients with cancer in that study also had a change of bowel habit, mainly looser stools.

(Source: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489264/)

2. Eligibility Criteria:

Patients under 45 years of age who have had a single bright red rectal bleed, and have no other symptoms considered as being of high predictive value for or suggestive of malignancy should be considered low priority.

This policy does not apply to patients with HIV who have an increased risk of anal cancer.

Symptom/sign combinations with a high predictive value for colorectal cancer
Rectal bleeding with a change in bowel habit to looseness or increased frequency
Rectal bleeding without anal symptoms (soreness, discomfort, itching, lumps or pain)
Palpable abdominal mass
Palpable rectal mass
Intestinal obstruction

Symptom/sign combinations with a low predictive value for colorectal cancer
Rectal bleeding with anal symptoms
Change in bowel habit to decreased frequency and harder stools
Abdominal pain without signs of intestinal obstruction

Patients over the age of 45 years with <u>any</u> of the following symptoms over a period of six weeks should be urgently and appropriately investigated:

- **rectal bleeding with a change in bowel habit to looseness or increased frequency**
- **rectal bleeding without anal symptoms**
- **palpable abdominal or rectal mass**
- **intestinal obstruction.**

All patients with iron-deficiency anaemia (Hb<11g/dl in men or<10g/dl in postmenopausal women) without overt cause should be thoroughly investigated for colorectal cancer.
Source: SIGN 67 (2003).

3. Implementation:

Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process. This will be undertaken on the Cluster's behalf by HCS.

The agreed implementation process defined within the acute services contract for your trust should be followed.

4. Procedures Covered by the Policy:

Primary Operative Procedure	Primary Operative Procedure Description
H221	Diagnostic fibreoptic endoscopic examination of colon and biopsy of lesion of colon
H228	Other specified
H229	Unspecified
H251	Diagnostic examination of lower bowel and biopsy of lesion of lower bowel using fibreoptic sigmoidoscope
H258	Other specified
H259	Unspecified
H281	
H288	
H289	