NHS
Eastern Cheshire
Clinical Commissioning Group

GOVERNING BODY MEETING in Public

29 March 2017 **Agenda Item 5.1**

Paper Title	Procedures of Lower Clinical Priority Commissioning Policy

Purpose of paper

The paper presents the findings from the recent 90 day consultation relating to service review changes across Cheshire and Wirral. This includes changes to commissioning arrangements within Cosmetics, Dermatology, ENT (Ear, Nose and Throat), Fertility and Sterilisation, Trauma and Orthopedics and Urology/Uro-gynaecology.

Outcome Required:	Approve	☑	Ratify		Decide		Endorse		For information	

Recommendation(s)

Following a public consultation and further evidence review, identified that the CCGs of Cheshire and Wirral should implement a range of changes to our existing Procedures of Lower Clinical Priority Commissioning Policy.

The Governing Body is asked to:

- **Approve** the recommendations of the CCG Executive and Clinical Leadership to update our clinical policy in line with the recommendations contained in the report but with specific reference to:
  - reducing the number of IVF treatment cycles from 3 to 1 which will be consistent with the recommendation to Governing Bodies of the other Cheshire CCGs, most neighbouring CCGs, and the majority of CCGs nationally, but differing from NHS Wirral CCG who have decided to commission 2 cycles.
  - continue to commission IUI (Intra Uterine Insemination) for up to six cycles of treatment, prior to IVF, identifying people who likely to benefit from this treatment using NICE guidance; which is consistent with the Cheshire CCGs but differs from Wirral who have decommissioned this treatment.
  - delegation of approval to liaise with NHS Wirral CCG and agree the final wording of the Cheshire and Wirral policy to the Clinical Lead (Dr Mike Clark) and Commissioning Director (Neil Evans).
- **Note for information** that a robust process has been followed in consulting and developing the proposals.

Benefits / value to our population / communities

The application of this policy across Cheshire and Wirral will allow us to ensure a relatively consistent approach to commissioning these services across our local delivery system, whilst also helping us ensure more efficient utilisation of our limited commissioning resources.

Key Implications of this report – please indicate ☑				
Strategic	☑		Consultation & Engagement	☑
Financial	☑		Equality	☑
Quality & Patient Experience	☑		Legal / Regulatory	☑
Staff / Workforce			Safeguarding	

Governing Body Assurance Framework Risk Mitigation:
GB AF 247

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Date of report	**22 March 2017**

Procedures of Limited Clinical Priority Policy

1. Executive Summary

1.1. This paper makes recommendations to the Governing Body in relation to the outcomes of the consultation which has taken place to determine changes to the CCG "Procedures of Limited Clinical Priority" (PLCP) Policy. The existing policy was developed by Cheshire and Merseyside Commissioning Support Unit on behalf of all the CCGs in Cheshire and Merseyside and which was subsequently ratified by each CCG Governing Body.[1]

1.2. The basis of the review was to ensure that the CCG adopted national best practice in commissioning in those areas covered by the policy; recognising that the local CCGs are all faced by significant financial challenges and need to make efficiencies.

1.3. As was discussed at the September 2016 Governing Body the consultation was coordinated by NHS Wirral CCG and has taken place across Cheshire and Wirral with the aim of maintaining a consistent commissioning policy across our local delivery system. NHS Wirral CCG engaged with a variety of individuals and groups to assess existing policies and received input from the Cheshire CCGs into this process.

1.4. On behalf of the CCGs of Cheshire and Wirral, NHS Wirral CCG undertook an evidence review using a range of evidence including NICE, Royal College Guidance and other evidence reviews, including the approaches being taken by peer CCGs. This evidence was reviewed locally through the NHS Wirral CCG Clinical Operations Group and discussions with GPs with Special Interests and secondary care clinicians. Dr Mike Clark (GP) and Julia Curtis (Registered Nurse) provided input to this process from Eastern Cheshire CCG. All other clinicians had the opportunity to provide feedback to the consultation.

1.5. Equality and Quality Impact Assessments have been completed prior to consultation and then reviewed following the consultation to validate whether any changes were required

1.6. The CCGs have taken regard of the commissioning policies of other neighbouring CCGs in order to maintain relative consistency. The proposals included in this paper are consistent with those being presented to Governing Bodies at NHS South Cheshire, Vale Royal and West Cheshire CCGs.

1.7. The savings from the changes proposed are estimated to be approximately £400K.

1.8. Having had a further clinical review of views of the public, discussed this feedback the recommended approach from the CCG Clinical Leadership and Executive Teams (see section 4.8 for a more detailed assessment of these recommendations) is to:

[11] https://www.easterncheshireccg.nhs.uk/Your-Views/service-consultation-review.htm

1.8.1. **Stop Funding:**

1.8.1.1. Surgery for the correction of asymmetrical breasts
1.8.1.2. Surgery for breast reduction
1.8.1.3. Surgery for gynaecomastia
1.8.1.4. Hair removal treatments for hirsutism (e.g. laser or electrolysis)
1.8.1.5. Stop all funding requested primarily for cosmetic purposes
1.8.1.6. Stop routine funding of surgical sperm recovery, individual funding request for patients with genetic conditions
1.8.1.7. Stop routine funding of donor oocyte cycle
1.8.1.8. Stop routine funding of donor sperm

1.8.2. **Amend Existing Treatment Thresholds:**

1.8.2.1. Surgery to remove benign skin lesions
1.8.2.2. Desensitising light therapy
1.8.2.3. Secondary Care ear was removal including microsuction
1.8.2.4. IVF (In-Vitro Fertilisation) – reduce from 3 to 1 cycle
1.8.2.5. Intrauterine insemination (IUI) unstimulated – limit to 6 cycles in advance of IVF
1.8.2.6. Shoulder arthroscopy
1.8.2.7. Dupuytren's contracture
1.8.2.8. Hip injections
1.8.2.9. Erectile Dysfunction treatment.

1.8.3. **Retain Existing Treatment Thresholds:**

1.8.3.1. Knee replacements
1.8.3.2. Percutaneous posterior tibial nerve stimulation (PTNS) for urinary and faecal incontinence
1.8.3.3. For patients already on the treatment pathway it is proposed that they will continue to be seen/treated in line with the existing criteria.

1.8.4. In the case of IVF it is recommended to move to one cycle of fertility treatment. This is based upon benchmarking which shows, all of our national peer CCGs and the majority of neighbouring CCGs offer one cycle. NHS Wirral CCG has decided to commission two cycles of IVF but not IUI.

1.8.4.1. The findings of our public consultation supported reducing the number of IVF cycles, although a majority favoured reducing to 2 cycles rather than 1 (59% to 41%)
1.8.4.2. The findings of our public consultation supported maintaining IUI

1.8.5. All other recommendations in this paper are consistent with the findings expressed by Eastern Cheshire respondents to the consultation.

1.8.6. Where a decision to stop funding is recommended it should be noted that clinicians can refer exceptional cases for an "Individual Funding Request" review.

1.8.7. Full details of the proposals used within the consultation can be viewed on the CCG website.[2]

1.9. **The Governing Body is asked to:**

- **Approve** the recommendations of the CCG Executive and Clinical Leadership Teams to update our Clinical Policy in line with the recommendations contained in this report (1.6 above) but with specific reference to:
  - Reducing the number of IVF treatment cycles from three to one
  - Continue to commission IUI (Intra Uterine Insemination) for up to six cycles of treatment identifying people who likely to benefit from this treatment using NICE guidance; which is consistent with the Cheshire CCGs but differs from Wirral who have decommissioned this treatment.
  - Delegation of approval to work with NHS Wirral CCG to agree the final wording of the policy to the Clinical Lead (Dr Mike Clark) and Commissioning Director (Neil Evans).

- **Note for information** that, **c**oordinated by NHS WIrral CCG, a robust process has been followed in developing the proposals and consulting with the public.

2. Peer Group Area/Town Area Affected

2.1 All peer group areas would be impacted by this policy change.

3. Population Affected

3.1. The policy focuses on a wide range of treatments each treatment will have a different characteristic in terms of whom is affected. As part of the Equality Impact Assessments this impact has been considered.

3.2. Where possible a consistent approach to treatment will be maintained across Cheshire and Wirral. It should be noted that there has historically been some minor variations between local areas e.g. Wirral have continued to commission some aspects of male circumcision.

4. Context

4.1. NHS Wirral CCG coordinated a process to review the current Cheshire and Merseyside policy against evidence of best practice, clinical effectiveness and cost effectiveness. Following this a list of procedures to be potentially added or amended within the policy were identified.

4.2. Following the PLCP review described above, a list of potential changes to the policy was taken to Wirral CCG's Clinical Operations Group for initial consideration and review. Further to this, additional conversations were held with lead clinicians including GPs with special interests and secondary care clinicians to refine the proposals. This consultation included liaison and discussion with the other CCGs of Cheshire and

[2] https://www.easterncheshireccg.nhs.uk/Downloads/Your-Views/Commissioning%20Policy%20Review/Service%20Review%20Consultation%20Procedure%20and%20Definition%20supporting%20matrix.pdf

Wirral; in the case of Eastern Cheshire proposals were reviewed and commented on by Julia Curtis and Dr Mike Clark.

4.3. During a phase of pre-consultation NHS Wirral CCG met with their Local Medical Committee, their Member Practices, Wirral Healthwatch and Secondary Consultants from Wirral Hospital University Foundation Trust. NHS Eastern Cheshire CCG also shared draft proposals with the Cheshire East Health and Social Care Overview and Scrutiny Committee, our CCG Clinical Leadership Team and highlighted the consultation to our local providers and member practices. The final list of proposals consulted upon can be viewed on the CCG website.[3]

4.4. In October 2016 the CCGs of Cheshire and Wirral commenced a 90 day consultation asking our local population for their views on future commissioning of a range of conditions. Full details of the consultation findings can be found on the CCG website.[4]

4.5. NHS Wirral CCG took a paper to their Governing Body in early February 2017.[5] The four Cheshire CCGs agreed we should jointly review the consultation findings and the evidence in order to maintain a consistent approach across Cheshire. A teleconference was held to do this including the clinical and managerial leads for each CCG in order to agree a shared set of proposals.

4.6. On the basis of the findings of the consultation and further review of national best practice the recommended approach to updating our Procedures of Limited Clinical Priority is (figures exclude "unsure" responses):

4.6.1 **Cosmetic Procedures. T***he following treatments were already included within our existing policy but the proposal is to stop funding all of the following cosmetic procedures subject to the exclusions listed.*

Consultation Theme	Treatments in a year (*Note total activity is included not patients affected)*	What did the public say in response to the Consultation ? (number of responses shown)		What proportion of the public supported the proposal		Did the Eastern Cheshire respondents support the proposal
Cosmetic Service		Continue Funding	Stop Funding	% ECCCG	%CWW	
Breast Assymetry	21	108	239	69%	50%	✓
Breast Reduction		148	210	59%	42%>	✓
Gynaecomastia		173	176	50%	40%-	✓
Hirsuitism	2	157	209	57%	46%+	✓
Primarily Cosmetic	20	57	294	84%	72%	✓
*>41% said continue and 18% were unsure - 44% said continue and 17% unsure + 37% said continue and 17% unsure ^ 42% said continue and 12% were unsure *27% said continue with 27% unsure*						

[3] https://www.easterncheshireccg.nhs.uk/Downloads/Your-Views/Commissioning%20Policy%20Review/Service%20Review%20Consultation%20Procedure%20and%20Definition%20supporting%20matrix.pdf
[4] http://www.easterncheshireccg.nhs.uk/Downloads/Your-Views/Commissioning%20Policy%20Review/SRP%20consultation%20results%20FULL.pdf
[5] https://www.wirralccg.nhs.uk/Downloads/Governing%20Body/WCCG%20Governing%20Body%20PUBLIC%20Agenda%20and%20Papers%20re%2007.02.2017.pdf

4.6.2 Our proposals are:

- Stop routine funding of surgery for asymmetrical breasts
- Stop routine funding of surgery to reduce breast size
- Stop routine funding of surgery for enlarged breast in men
- Stop routine funding of surgery for hair removal treatments for hirsutism
- Stop funding any procedures requested primarily for cosmetic purposes

4.6.3 Exclusions will be included for:

- Condition(s) associated with cancer or cancer treatment
- Condition(s) associated with Burns/accident victims
- Birth defects
- Polycystic Ovaries Syndrome for hirsutism – eligibility criteria will apply
- Musculoskeletal conditions – eligibility will apply
- Severe psychological impact – eligibility will apply

4.6.4 Rationale for proposal

- to stop funding for the cosmetic procedures mentioned above. If approved, the only option to obtain funding would be via an Individual Funding Request in exceptional circumstance.
- in summary cosmetic surgery is not routinely provided on the NHS. Decisions are made based on clinical need and public funds are devoted solely to the patients the NHS serves.[6,7,8,9]

4.6.5 Equality Impact Assessment

- Age - certain cosmetic procedures e.g. Gynaecomastia, may be more common in younger adults, however all age groups will be affected. Disability - in rare circumstance, a patient may feel their disability is worsening due to lack of treatment as part of this policy. If a clinician deems their case to be clinically exceptional, they can apply for funding via an Individual Funding Request.
- People with mental health issues relating to the way they look may be affected.
- Race - there is evidence to suggest that hirsutism is more prevalent in certain races. It is less common in Asian people.[10]
- Sex - Breast procedures and hirsutism will mostly affect women and Gynaecomastia will affect men.
- Deprived Communities – Although there is no direct discernible difference anticipated across communities. It should be noted that less deprived patients may not be able to self-fund these procedures

[6] http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/is-cosmetic-surgeryavailable-on-the-NHS.aspx
[7] https://aestheticsjournal.com/news/jeremy-hunt-says-cosmetic-surgery-should-not-beavailable-on-the-nhs
[8] https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhsconstitution-for-england
[9] https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/
[10] http://patient.info/doctor/hirsutism-and-virilism

4.6.6 **Dermatology.** The public consultation in Eastern Cheshire supported the proposals to amend treatment thresholds for the following procedures

Consultation Theme	Treatments in a year (*Note total activity is included not patients affected)*	What did the public say in response to the Consultation ? (number of responses shown)		What proportion of the public supported the proposal		Did the Eastern Cheshire respondents support the proposal
Dermatology Service		Maintain Current Thresholds	Add Further Thresholds	%		Support
Benign Skin Lesions	212	172	221	56%	45%^	✓
Desensitising Light Therapy	1386	135	208	61%	46%*	✓

4.6.7 Our proposals are:

- Introduce a threshold for surgery to remove benign skin lesions to only allow routine funding for any of the following:
  - Sebaceous cysts
  - Lesions causing functional impairment
  - Lesions of face which could be regarded as a significant disfigurement
  - Any lesion where there is a suspicion of cancer should be referred in line with national/locally defined pathways
- Introduce a threshold for desensitizing light therapy for PMLE (polymorphic light eruption) to only allow routine funding for the following (must meet all points below):
  - Diagnosis made by Dermatology Consultant (or equivalent)
  - Severe functional impairment
  - Symptoms remain severe despite preventative treatments
  - Light therapy deemed likely to make significant improvement

4.6.8 Rationale for change

- In summary the vast majority of skin lesions are benign e.g. Naevi and very rarely do they undergo malignant change. NHS Choices states that there is no cure for polymorphic light eruption, careful avoidance of the sun and using sunscreens is advised. Desensitisation may increase resistance of the skin to sun. [11,12,13,14]

4.6.9 Equality Impact Assessment

- Age - PMLE is more prevalent in patients aged 20-40.
- Disability - in rare circumstance, a patient may feel their disability is worsening due to lack of treatment as part of this policy. If a clinician deems their case to be clinically exceptional, they can apply for funding via an Individual Funding Request.

[11] http://www.bad.org.uk/shared/get-file.ashx?id=117&itemtype=document
[12] http://www.nhs.uk/conditions/polymorphic-light-eruption/Pages/Introduction.aspx
[13] http://patient.info/doctor/benign-skin-tumours
[14] https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhsconstitution-for-england

- Race - PMLE may be more prevalent in fair skinned people[15]
- Gender - the male/female ratio of PMLE varies between 1:2 and 1:4 and the disease occurs preferentially in young women.[16]
- Deprived Communities - although there is no direct discernible difference anticipated across communities. It should be noted that less deprived patients may not be able to self-fund these procedures.

4.6.10 **ENT (Ear Nose and Throat).** The public consultation in Eastern Cheshire supported the proposals to amend treatment thresholds for access to microsuction:

Consultation Theme	Treatments in a year (*Note total activity is included not patients affected)*	What did the public say in response to the Consultation ? (number of responses shown)		What proportion of the public supported the proposal		Did the Eastern Cheshire respondents support the proposal
Earn Nose and Throat		Maintain Current Thresholds	Add Further Thresholds	%		Support
Microsuction	1931	160	271	63%	66%	✓

4.6.11 Our proposals are:

- Maintain access to primary care treatment and to introduce threshold for ear wax removal treatment in secondary care – including microsuction to only allow routine funding for any of the following:
  - Perforated ear drum
  - Otitis Externa which has not responded to treatment in primary care or is caused by previous irrigation
  - Hearing loss and all other methods of ear wax removal have failed
  - Enable inspection of ear drum due to clinical concern of other pathologies
  - Clinical risk of other methods of removal

4.6.12 Rationale for change

- In summary evidence is limited for mechanical methods of removing ear wax by trained staff using instruments e.g. Microsuction.[17]
- Specific feedback was received from Action on Hearing Loss and consider as part of the clinical review of feedback and the recommendation above.

4.6.13 Equality Impact Assessment

- Age – Older patients may be more likely to suffer from excess ear wax. It is assumed that a high percentage of the attendees at ear wax clinic will be older.

[15] http://patient.info/doctor/polymorphic-light-eruption-pro
[16] https://openaccess.leidenuniv.nl/bitstream/handle/1887/12576/01.pdf?sequence=6
[17] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2907972/

- Disability - a patient may feel their disability is worsening due to lack of treatment as part of this policy. If a clinician deems their case to be clinically exceptional, they can apply for funding via an Individual Funding Request. It is quite common for people with learning disabilities to have problems with earwax.[18]
- Deprived communities – although there is no direct discernible difference anticipated across communities. It should be noted that patients may choose to self-fund these procedures. This is less likely to be an option in deprived communities.

4.6.14 **Fertility.** The public consultation in Eastern Cheshire supported the proposals to reduce the number of cycles of IVF treatment from 3. Slightly more people supported moving to 2 than 1. There was support for introducing revised smoking and BMI (Body Mass Index) thresholds and extending the time trying to conceive naturally from 2 to 3 years. There was opposition to the plan to cease commissioning IUI.

	Treatments in a year (*Note total activity is included not patients affected)*	**What did the public say in response to the Consultation ? (number of responses shown)**		**What proportion of the public supported the proposal**		**Did the Eastern Cheshire respondents support the proposal**
Fertility/Sterilisation		Maintain Current Thresholds	Add Further Thresholds	%		Support
IVF Number of cycles	91 cycles	162	246	60%	48%	✓
Of those suggesting further thresholds 59% (62% across C&W) suggest reduce to 2 cycles and 41% (38% across CWW) suggest reduce to 1 cycle.						
68% (63% across C&W)suggest adding BMI and Smoking thresholds, 50% (46% across CWW - 11% unsure) suggest 3yr wait threshold						
		Continue Funding	Stop Funding	%		Support
TESA/PESA	1	141	198	58%	42%+	✓
Donor Ocyte Cycle	No data - very low numbers	151	200	57%	40%^	✓
Donor Sperm		118	240	67%	45%*	✓
IUI		174	143	45%	28%	×
Of those suggesting continue funding- 39% (32% across C&W) suggest introduce new thresholds for male patients having vasectomy i.e. not under general anaethsetic. *+ 38% supported with 20% unsure ^40% supported with 20% unsure *note 37% supported continuing funding with 18% unsure*						

4.6.15 Our proposals are:

- Reduce the number of IVF cycles funded from three to one cycle in line with all of our peer CCGs locally in Cheshire and nationally as well as the vast majority of other neighbouring CCGs
- Maintain commissioning of intrauterine insemination (IUI) unstimulated where assessed as an appropriate treatment before IVF using NICE criteria (up to 6 cycles)
- Incorporate additional restrictions for IVF – BMI and smoking status of both partners to be used in revised eligibility criteria

[18] http://mhf-ld.unified.co.uk/content/assets/pdf/publications/earwax-easy-read-guide.pdf

- Eligibility threshold for IVF for period of trying to conceive to be increased from two years to three years for unexplained infertility (age to be taken into account)
- Stop routine funding of surgical sperm recovery, individual funding request for patients with genetic conditions
- Stop routine funding of donor oocyte cycle
- Stop routine funding of donor sperm

4.6.16 Rationale for proposals

- The recommendations above recognise the public responses received. The IVF recommendation specifically asks Governing Body to consider the benchmarking data available which demonstrates that the majority of CCG's commission 1 cycle of IVF. There is also clinical evidence to show chance of successful reduces which each subsequent cycle. The recommendations relating to surgical sperm recovery, donor oocyte cycle and donor sperm insemination recognise that the responses are marginal between continuing funding and stopping funding. Therefore, the recommendation is based on policies from other areas and the understanding that the IFR process will remain in place for exceptional circumstance/ genetic conditions. An eligibility criteria for which it would be appropriate to seek IFR approval could be drawn up.
- In summary the outcome and likelihood of success are reduced by previous IVF treatment must be taken into account when assessing the likely effectiveness of further treatment.[19]
  http://www.infertilitynetworkuk.com/

	IVF	IUI
Under 35	32.2% for women under 35	15.8% for women under 35
35-37	27.7% for women aged 35-37	11.0% for women aged 35-39
38-39	20.8% for women aged 38-39	
40-42	13.6% for women aged 40-42	4.7% for women aged 40-42
43-44	5% for women aged 43-44	1.2% for women aged 43-44
Over 44	1.9% for women aged over 44	0% for women over 44

- Overall, more than half of the women who have IUI will become pregnant during the first six treatment cycles. (Source NHS Choices using HFEA data)

4.6.17 Equality Impact Assessment

- Disability - for people with a disability or long-term health condition. Some physical disabilities may impede sexual intercourse. Also some medical treatments can cause long-term infertility. An individual prior approval request

[19] https://www.nice.org.uk/guidance/cg156

can be submitted if the patients' case is deemed clinically exceptional. There may be some impact on fertility for patients with mental health conditions. [20]

- Race - research carried out in America which suggest that black women have a higher prevalence compared to white women (Culley Hudson and Van Rooij 2009), although there is no UK evidence readily available. There is little difference between races and fertility. [21]
- Sexual orientation - this may affect same sex couples as they are unable to conceive naturally and may be more likely to require some of the specialist fertility services.
- Deprived Communities - this may have a more negative impact on deprived communities as patients may not be able to fund private cycles of IVF.

4.6.18 **Trauma and Orthopaedics.** The public consultation in Eastern Cheshire did not support the proposals to amend treatment thresholds. Following a further clinical review of the evidence it is proposed that some refinement of existing criteria takes place in order to maximise the benefits patients will gain from treatment.

Consultation Theme	Treatments in a year (*Note total activity is included not patients affected)*	What did the public say in response to the Consultation ? (number of responses shown)		What proportion of the public supported the proposal		Did the Eastern Cheshire respondents support the proposal
Trauma/Ortho/MSK		Maintain Current Thresholds	Add Further Thresholds	%		Support
Shoulder Arthroscopy		291	126	30%	31%	×
Knee Replacement	316	312	108	26%	24%	×
		Maintain Current Thresholds	Add Further Thresholds	%		Support
Duputren's Contracture	48	387	34	8%	8%	×
Of those suggesting continue funding- 42% (34% across C&W) suggest introducing thresholds and 58% (44% across CWW) suggest continue with no new thresholds						
Hip Injections	407 (total joint injections)	384	18	4%	5%	×
Of those suggesting continue funding- 37% (30% across C&W) suggest introducing thresholds and 63% (56% across CWW) suggest continue with no new threhsolds						

4.6.19 Our Proposals are:

- Refine the threshold for shoulder arthroscopy to stop routine funding unless all of the following have been tried and failed:
  - Activity modification
  - Physiotherapy and exercise programme
  - Oral analgesia
  - Intra-articular joint injections
  - Manipulation
  - And, frozen shoulder for at least 12 months
- Refine the threshold for surgery for Dupuytren's Contracture to only allow routine funding if:

[20] https://womensmentalhealth.org/specialty-clinics/infertility-and-mentalhealth/?doing_wp_cron=1474280591.3196799755096435546875
[21] http://www.unomaha.edu/news/2015/01/fertility.php

  - Metacarpophalangeal joint and/or proximal IP joint contracture of 30+
  - Severely impacting daily living and functional limitation
  - Young person with early onset disease without family history, clinical assessment demonstrates they will benefit from surgery
- Stop routine funding of conservative treatments for dupuytren's contraction – note, the term conservative refers to interventions such as certain injections. Primary care management such as stretching exercises are not included
- Retain existing criteria within existing policy for knee replacement surgery noting that other projects will support improved pathway (pre-optimisation of health before surgery and reprocurement of Musculoskeletal Physiotherapy service)
- Refine the threshold for hip injections to allow routine funding for hip injections for only any of the following:
  - Diagnostic aid
  - Introduce contract medium to the joint as part of hip arthrogram
  - Inflammatory arthropathy
  - Bursitis

4.6.20 Rationale for proposals

- The recommendation for shoulder arthroscopy recognises the public response but also considers benchmarking from other CCG policies as well as consideration that knee and hip arthroscopy are already in the current PLCP. It draws on evidence that suggests limited effectiveness for improving symptoms. The recommendation is for a specific threshold – this threshold was developed based on best practice from another CCG and sign off from clinicians in Wirral.
- The recommendation for Dupuytren's Contracture recognises the public responses but suggests a robust threshold is introduced for surgery. The threshold presented within the consultation was based on best practice and clinical input from hospital specialists in Wirral. A further recommendation is to stop routine commissioning of conservative treatments, this is based on current evidence of efficacy which is inadequate and therefore does not support routine use. It also takes into account local guidance from clinical specialists.
- The recommendation for knee replacement takes on board the public concerns around increasing pain thresholds and as such no change will be made to the current policy.
- The recommendation for hip injections considers the public response however suggests a threshold may be appropriate. This threshold will incorporate feedback from lead clinicians at Wirral University Teaching Hospital and clinical evidence to ensure the most appropriate patients receive this treatment. This will be relevant to adults only.
- In summary previous randomised controlled trials have shown little benefit for shoulder arthroscopy compared to exercise based treatment.

- There is limited effectiveness of surgical repair via arthroscopy for improving symptoms.
- Current evidence for efficacy of radiation therapy for Dupuytren's Contracture is inadequate and therefore does not support routine use. [22] [23] [24] [25]

4.6.21 Equality Impact Assessment

- Age - More likely to affect older people. Positive effect – elderly people may prefer alternative treatments that do not require repeated hospital visits. Negative effect – elderly people may take longer to adjust to self-care treatments and may require additional support.
- Disability - in rare circumstance, a patient may feel their disability is worsening due to lack of treatment as part of this policy. If a clinician deems their case to be clinically exceptional, they can apply for funding via an Individual Funding Request. Older people are more likely to have mobility issues and therefore may be more adversely affected.
- Carers - positive effect – elderly people and their carers may prefer alternative treatments that do not require repeated hospital visits. Negative effect – elderly people and their carers may take longer to adjust to self-care treatments and may require additional support.
- Deprived community - Although there is no direct discernible difference anticipated across communities. It should be noted that less deprived patients may be unable to self-fund these procedures.

4.6.22 **Sterilisation.** The public consultation in Eastern Cheshire did not support the proposals to stop funding sterilisation.

Consultation Theme	Treatments in a year (*Note total activity is included not patients affected)*	What did the public say in response to the Consultation ? (number of responses shown)		What proportion of the public supported the proposal		Did the Eastern Cheshire respondents support the proposal
Sterilisation	No data	375	36	9%	11%	×
Of those suggesting continue funding- 39% (32% across C&W) suggest introduce new thresholds for male patients having vasectomy i.e. not under general anaethsetic. *+ 38% supported with 20% unsure ^40% supported with 20% unsure *note 37% supported continuing funding with 18% unsure*						

4.6.23 Our proposals are:

- Maintain access to vasectomy procedures under local anaesthetic in Primary Care settings but stop funding male sterilisation (vasectomy) under general anaesthetic
- Female sterilisation criteria is unchanged

[22] http://www.dbc.fi/new-evidence-questioning-the-effectiveness-of-shoulder-arthroscopyfor-degenerative-shoulder-disorders/
[23] https://www.nice.org.uk/guidance/IPG573/chapter/1-Recommendations
[24] http://www.nhs.uk/Conditions/orthopaedics/Pages/Introduction.aspx
[25] https://www.evidence.nhs.uk/Search?q=orthopaedic+guidelines

4.6.24 Rationale for proposals:

- In assessing the clinical and patient feedback it was clear there was little support for the proposal and concern for unintended consequences of restricting NHS provision of sterilisation .
- The number of people affected by the recommended proposal is minimal and where there is a compelling exceptional reason for need access to vasectomy under general anaesthetic and IFR would be required.

4.6.25 Equality Impact Assessment:

- Disability – it was highlighted of the need to ensure correct consent protocols are observed for people with a learning disability.
- Deprived communities were identified as being most likely to be affected by the original proposals as they would not be able to self-fund treatment
- Gender - treatments affect relevant gender.

4.6.26 **Urology/Uro-gynaecology.** The public consultation in Eastern Cheshire did not support the proposals to stop funding drugs for the treatment of erectile dysfunction or posterior tibial nerve stimulation (PTNS).

Consultation Theme	**Treatments in a year (*Note total activity is included not patients affected)***	**What did the public say in response to the Consultation ? (number of responses shown)**		**What proportion of the public supported the proposal**		**Did the Eastern Cheshire respondents support the proposal**
Urology/Uro-Gynaecology		Continue Funding	Stop Funding	%		Support
ED Drugs	1429	255	133	34%	36%	×
PPTN Stimulation	No data	314	41	12%	7%	×

4.6.27 Our proposals are:

- To continue to fund pharmaceutical intervention for erectile dysfunction however the existing prescribing policy will be reviewed against best practice and updated to ensure cost effectiveness
- Secondary care interventions for erectile dysfunction will be restricted to patients with certain medical conditions e.g. post cancer
- Continue funding percutaneous posterior tibial nerve stimulation (PTNS) for urinary and faecal incontinence

4.6.28 As with the existing policy patients whose circumstances are identified as being exceptional would be able to have their situation considered through an Individual Funding Request (IFR) in order to assess whether the CCG would agree to fund their treatment. The full details of the proposals consulted on can be found on the CCG website.[26]

26 https://www.easterncheshireccg.nhs.uk/Downloads/Your-Views/Commissioning%20Policy%20Review/Service%20Review%20Consultation%20Procedure%20and%20Definition%20supporting%20matrix.pdf

4.6.29 Rationale for proposals:

- A further evidence review and local specialist support identified PTNS as a valid treatment compared to alternatives
- Recommendation to stop funding for erectile dysfunction recognises the public response but also considers clinical evidence that suggests pharmacological interventions are only successful in two thirds of patients.
- Local clinical review identified opportunities to target prescribing more effectively e.g. choice of medication based on value for money

4.6.30 Equality Impact Assessment:

- Age - Older people may be more adversely affected by erectile dysfunction and percutaneous posterior tibial nerve stimulation (PTNS).
- Disability - in rare circumstance, a patient may feel their disability is worsening due to lack of treatment as part of this policy. If a clinician deems their case to be clinically exceptional, they can apply for funding via an Individual Funding Request. Psychological factors are responsible for some erectile dysfunction issues[27]
- Sex - Men are affected for all, women may be affected for percutaneous posterior tibial nerve stimulation (PTNS) only Deprived communities - although there is no direct discernible difference anticipated across communities. It should be noted that patients may choose to self-fund these procedures. This is less likely to be an option in deprived communities.

5. Finance

5.1. Implementation of this policy has been assessed and if the proposals being recommended are implemented a full year saving on Payment by Results (PbR) activity of £0.4m has been identified.

5.2. The decision on reducing IVF cycles commissioned from three down to one cycle is a key component of these savings (almost half of IVF expenditure relates to further cycles beyond first).

6. Quality and Patient Experience

6.1. Depending on the decisions made by Governing Body, it will be essential to ensure any thresholds are adhered to in order that we consistently apply the revised thresholds.

6.2. Inevitably any “tightening” of clinical treatment thresholds will have some impact on an individual perception of quality care and patient experience. The CCG will therefore ensure that the changes are effectively communicated to both clinicians and members of the public.

6.3. There is potential that the proposed changes to the PLCP Policy may lead to an increase in referrals for Individual Funding Requests (IFRs) however, this will be closely

[27] http://www.webmd.com/erectile-dysfunction/guide/ed-psychological-causes

monitored and clinicians will be reminded that this route is intended for patients deemed clinically exceptional.

7. Consultation and Engagement (Public/Patient/Carer/Clinical/Staff)

7.1. Plans for engagement with the public and key stakeholders regarding the proposed changes were coordinated by NHS Wirral Clinical Commissioning Group. Much consideration was given to the timeframe applied to the consultation; due to the potential impact of change the decision was taken to conduct a full 90 day consultation. Timeframes for consultation should be proportionate and realistic to allow stakeholders sufficient time to provide a considered response. The discussion around the commencement of the consultation and the timeframe applied was also agreed with the five partnering CCGs and formal advice was sought from NHS England. There was a general consensus that the consultation should take place over a 90 days period.

7.2. A thorough stakeholder mapping exercise was performed to ensure a robust communications and engagement framework was developed, which targeted a wide cross section of the general public, key stakeholders and specialist groups who may be affected by the changes proposed. NHS England were consulted and involved in the development of the proposals for the consultation.

7.3. A summary of the consultation undertaken can be found in Appendix 1. In total Eastern Cheshire CCG received 460 responses to the consultation. This includes responses received in writing have been added onto the online survey tool for the purpose of aggregating results.

7.4. Across all CCGs undertaking the consultation a total of 1821 responses were received, broken down as follows:

- 724 Wirral
- 460 Eastern Cheshire
- 347 South Cheshire and Vale Royal
- 290 Western Cheshire

8. Health Inequalities

8.1. In developing the proposals to consult on consideration has been given to an assessment as to where national Right Care comparator benchmarking would indicate the CCG is already undertaking levels of procedures which are significantly different to our peers. For example we have “relatively low” levels of knee replacements and therefore this would not support a clinical basis to raise treatment thresholds.

9. Equality

9.1. For all clinical proposals Equality Impact Assessments (EIA) were undertaken and published on the CCG website in advance of the consultation. Copies of the assessments are available at the link below.

9.2. Following the consultation NHS Wirral CCG reviewed the EIA to assess if any changes were required based on the feedback from clinicians, members of the public or other representative groups who had responded.

10. Legal

10.1. In order to comply with our duty to consult on these proposals Eastern Cheshire CCG, along with the four other Cheshire and Wirral CCGs undertook a 90 day consultation process to gather the views of our stakeholders.

11. Communication

11.1. As part of the consultation and pre consultation period, a wide range of stakeholders were contacted to highlight awareness of the plans and seek the views of stakeholders.

11.2. Following the Governing Body decision a communications plan will be developed and implemented to ensure a consistent understanding of our policy exists across both clinicians and members of the public.

11.3. The final content of the policy has been drafted by Wirral CCG; working with local clinicians, including specialists to ensure the information is accurate.

12. Background and Options

12.1. The CCGs of Cheshire and Wirral have historically operated the Cheshire and Merseyside Commissioning Policy for 'Procedures of Lower Clinical Priority'. This policy sets out a number of procedures that are either not routinely commissioned or require a set threshold to be met prior to referral or procedure being undertaken.

12.2. NHS Wirral CCG has coordinated the Cheshire and Wirral CCGs in undertaking a process to review the current policy against evidence of best practice, clinical effectiveness and cost effectiveness. Following this a "long-list" of procedures to be potentially added or amended within the policy were identified by benchmarking our policy with those of peer CCGs, this was refined to a "short-list" by an expanded NHS Wirral CCG Clinical Operations Group review of evidence and an activity based review. This group included both clinical and lay representation.

12.3. Following the PLCP review described above, a list of potential procedures were discussed with CCG clinical leads for initial consideration and review. Wirral CCG went to clinicians with specialism in the proposed areas to refine the proposals.

12.4. NHS England were then sent a comprehensive list of proposals for external review and comment by their clinical leads prior to commencing consultation.

12.5. The proposed changes were summarised into a public document and published on the CCG website, with paper copies distributed to a number of locations.

12.6. Following the consultation the findings have been reviewed considering the views of clinicians, the public alongside the strength of clinical evidence. A consistent set of

proposals have then been taken to all five CCG Governing Body meetings across Cheshire and Wirral.

13. Access to further information

13.1 For further information relating to this report contact:

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14. Glossary of Terms

EIA	**Equality Impact Assessment**
IVF	**In Vitro Fertilisation**
IFR	**Individual Funding Request**
IUI	**Intra Uterine Insemination**
QIA	**Quality Impact Assessment**
PLCP	**Procedures of Lower Clinical Priority**
PTSN	**posterior tibial nerve stimulation**
TESA	**Testicular sperm extraction**

Governance

Prior Committee Approval / Link to other Committees
The paper has been reviewed and approved by the CCG Executive Committee including Clinical Leadership Meeting.

CCG 5 Year Strategic Plan programme of work this report links to ☑			
Caring Together		Quality Improvement	
Mental Health & Alcohol		Other	x

CCG 5 Year Strategic Plan ambitions addressed by this report ☑			
Increase the number of our citizens having a positive experience of care		Increase the proportion of older people living independently at home and who feel supported to manage their condition	
Reduce the inequalities in health and social care across Eastern Cheshire		Improve the health-related quality of life of our citizens with one or more long term conditions, including mental health conditions	
Ensure our citizens access care to the highest standard and are protected from avoidable harm	x	Secure additional years of life for the citizens of Eastern Cheshire with treatable mental and physical health conditions	
Ensure that all those living in Eastern Cheshire should be supported by new, better integrated community services			

CCG Operational Plan 2016/17 programme of work this report links to ☑			
Quality, Innovation, Prevention & Productivity	X	Transformation across a wider geographic footprint	
Transformation of Primary Care		Continuous Service Improvement	
Commissioning an integrated care system		Systems resilience	

CCG Values supported by this report – please indicate ☑			
Valuing People		Innovation	
Working Together		Quality	x
Investing Responsibly	x		

NHS Constitution Values supported by this report – please indicate ☑			
Working together for patients	X	Compassion	
Respect and dignity	X	Improving lives	
Commitment to quality of care	x	Everyone counts	