NHS
Richmond
Clinical Commissioning Group

Richmond Clinical Commissioning Group Report Summary

Meeting Title	Governing Body in public		**Date**	17 January 2017	
Report Title	Summary Paper – Thresholds and policy changes – introduction and communications update				
Agenda Item	2.2		**Attachment**	F	
Purpose *(please indicate with X)*	Approval/ Ratification	**X**	Discussion / Comment		Information	
Author: *(name & job title)*	Andrew Moore – Prog Dir Financial Recovery		**Executive Leads (Clinical and Officer)** *(name & job title)*	Graham Lewis (Chair) Kathryn Magson (AO)	
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Summary and purpose of report

The paper is a summary of 4 substantive papers coming to the governing body in January 2017 dealing with changes to thresholds for elective care.

Financial and / or resource implications

Each paper includes this information – overall the programme of change is critical to the CCG returning to financial balance

Quality and safety / patient engagement / impact on patient services

Each paper includes a summary of the specifics and this paper shows some of the process and outcomes of our engagement to date.

Equality and / or privacy impact analysis

Each paper includes this information and it has been a key feature of our work to date.

Committees that have previously discussed/agreed the report and outcomes

As a key component of the CCGs recovery plan, these concepts have been discussed and progressively agreed at many of the CCGs key committees. See the timeline in the body of this report.

Communication plan and stakeholder involvement

The CCG has been working with stakeholders across Richmond and has a formal communications and engagement plan – which is replicated below.

Report recommendation

That the governing body should:

Note that the four substantive papers presented to this meeting:

- IVF – move to consultation
- IVF – draft letter to providers
- Surgical Readiness – Proposal to adopt the change as a guidance document
- Effective Commissioning Initiative (ECI) Policy updates

Endorse the programme to review access to prescriptions for gluten free foods, Vitamin D for maintenance, baby milk and self-care medications as described in the 'Choosing Well for Richmond' material. In addition to these areas, the SWL medicines optimisation work

programme comprises the review of biologic and other specialist drug pathways, stopping or switching medicines or products which are considered to be a low priority, poor value for money or where safer alternatives exist, tackling pharmaceutical waste, new models of care and other transformation approaches to the supply and use of medicines.

Noting that subject to discussions with the Richmond Health Oversight and Scrutiny Committee (which could suggest formal consultation on one or more proposed change), and subject to safeguards identified during the of engagement exercise, that the CCGs Executive Management Team will finalise the form of these changes and implement them.

CORPORATE OBJECTIVES *(please indicate with X against relevant priority area / strategic objective)*	
1. Sustainability	
Deliver a financially sustainable health economy balancing the need for effective use of resources and the need for innovation.	**X**
2. Commissioning for quality	
Work in partnership with local health providers and commissioners to commission quality integrated services that achieve good health outcomes, are accessible and promote equality for local people.	**X**
3. Clinical leadership	
Support the development of the CCG as a continually improving and clinically led commissioning organisation.	**X**
4. Engagement	
Enable local people, patients and stakeholders to have a greater influence on services we commission and develop a responsive and learning organisation.	**X**
5. Statutory duties	
Deliver our statutory and organisational duties and ensure the CCG is a highly effective membership organisation.	**X**

Background

In September Richmond Clinical Commissioning Group's (RCCG) governing body received and approved a paper *"RCCG re-commissioning and clinical threshold options report"* (The September Paper). The September Paper built on the content of RCCG's Financial Recovery Plan (FRP), also presented to that governing body meeting, and set out a range of options for RCCG to consider which would have the effect of making savings.

In November RCCG's governing body received a more detailed paper, which outlined the case for a number of changes. That meeting agreed to a number of changes:

1. Decisions called type C:
    a. A decision to commence engagement on a review of IVF and specialised fertility access criteria– 2 papers are presented to this meeting – one recommending a move to a commence consultation on further tightening thresholds for access to IVF [Paper reference 2.2.1] and another suggesting some safeguards which should apply during the review/ consultation period [Paper reference 2.2.2]. If the governing body accept the decision to proceed to consultation, the CCG will advocate an 8 week formal consultation take place and the governing body be offered a final decision as soon as possible after that date.
    b. A decision to commence engagement on how best to encourage patients to be more ready for surgery (stopping smoking, addressing excess weight) – a paper is presented to this meeting, suggesting that following initial feedback, the CCG decide to clarity its intentions to make the new policy in the form of guidance, rather than a change in enforceable access criteria [Paper reference 2.2.3]. If the governing body accept this change, guidance will be prepared and enacted as soon as possible.
2. Decisions that were called type A & B – these changes to clinical thresholds have now been turned in to amendments to the current ECI document and are being presented for approval, with a cover paper [Paper reference 2.2.4]. The ECI policies themselves are either attached or available on the CCG's website. If the governing body approves this paper, providers will be given 1-month notice of the changes and all referrals will need to comply with those new criteria from that date.

The CCG has also moved forward to engage the public in relation to a range of changes to the access to medicines. This includes considerations around the criteria for access to:

- Prescriptions for Gluten Free Foods
- Prescriptions for Vitamin D
- Prescriptions for baby milk and specialist infant formula
- Prescriptions for self care medications

These changes have arisen as part of a South West London wide review of medicines, have received broad support. Subject to the view from the current engagement activities including Richmond OSC, it is recommended that the next steps around engagement

(locally and across SWL) are delegated to the CCGs Executive Management Team with the final decision on the outcomes referred back to Governing Body as soon as possible (ideally March 2017).

Medicines Optimisation Programme

The SWL medicines optimisation work-plan was discussed on the 13th December at the Richmond CCG Governing Body Seminar. This comprises of the review of biologic and other specialist drug pathways, stopping or switching medicines or products which are considered to be a low priority, poor value for money or where safer alternatives exist, tackling pharmaceutical waste, new models of care and other transformation approaches to the supply and use of medicines.

This includes the review of prescriptions for gluten free foods, Vitamin D for maintenance, baby milk and self-care medications as described in the 'Choosing Well for Richmond' material.

The financial aim of this work programme is to create a net saving of £10m across SWL from 2016/17 over 5 years. A contributing factor was the increasing cost pressures on the prescribing budget for primary and secondary care. It was believed that opportunities were available by working more collaboratively across a wider geography (that being SWL-wide) to achieve more system-wide change to optimise use of medicines.

The SWL Directors of Commissioning and Finance have approved the investment plan to enact the SWL work programme, as have the SWL Clinical Board and Medicines Optimisation Committee for the general principles and content, subject to the appropriate governance across SWL and/or locally as deemed appropriate and utilisation of existing resources.

The provider contracts from 2017/18 include the requirement to work collaboratively both in secondary care and across the interface with primary care. This work has been shared with secondary care, mental health and community and primary care colleagues and aims to progress collaboratively with these and other key stakeholders including patients and the public, GPs and community pharmacists.

Wider engagement process and update

Although the CCG have been discussing these proposals in many fora over the last 6 months, more recently proposals have been discussed at the Richmond Healthwatch committee and at the CCG's community involvement group. As part of Richmond Healthwatch's public event on 7 December attended by 120 local residents, CCG representatives discussed and answered questions on the changes being proposed to local healthcare and the reasons for the need to make changes.

The proposals have previously also been discussed with Health and Wellbeing Board in late 2016. A briefing on the FRP proposals has been shared with Richmond's overview and scrutiny committee and we will ensure that a summary of the changes is discussed with Richmond's Oversight and Scrutiny Committee in February.

In line with the recommendations agreed at November Governing Body, detailed public engagement ("Choosing Wisely") is currently taking place on proposed changes to local healthcare relating to IVF and specialised fertility treatments; supporting patients to be surgery ready and prescriptions for gluten free foods, Vitamin D, baby milk and self-care medications. This includes an online survey and discussion at local CCG and voluntary sector forums taking place during January e.g. community involvement group and PPG network and Richmond Council for Voluntary Services (CVS) health & wellbeing network. The Choosing Wisely document has been distributed to those on the CCG's database, corporate stakeholder list, clinicians, GPs, pharmacists and dieticians and members of staff as well as organisations with a specific interest such as Fertility Fairness and the Coeliac Society. A press release has been sent to the Richmond & Twickenham Times. The survey is being promoted via the CCG's website and social media – CCG Facebook and Twitter and also by the local authority and other local partners. Both RCVS and Richmond Healthwatch are promoting it via their membership and networks.

The online survey runs until 3 February. As at 11 January 111 responses have been received. A high level snapshot of the feedback received to date is provided below. A full report detailing the responses will be produced once the survey is closed.

86.4% of respondents agree with the statement "I understand why the local NHS is looking at the prioritisation of health services, procedures and funding". Feedback relating to all proposals is the potential impact of the proposals on vulnerable sections of the community e.g. low income households, older people and individuals with complex and enduring conditions such as mental health.

In response to the statement how much do you agree that the local NHS should reduce the number of IVF cycles to on an exception only basis 50% agree, 38% disagree and 12% don't know. A significant amount of feedback has been received on this proposal which include that CCG should not deviate from NICE guidelines on IVF; the proposal perpetuates the postcode lottery for IVF; the negative impact on health and well-being of individuals with infertility unable to access IVF; the CCG should offer at least one cycle of IVF; the CCG should offer investigations and set financial criteria for treatment.

84.4% of respondents agree that the local NHS should help increase patient readiness or fitness for surgery by supporting patients to stop smoking and/or reduce their weight.

85% of respondents agree with the statement "I understand why the local NHS is proposing to stop prescribing some items which are now readily available or cheaper to buy directly?"

75.2% agree that local NHS should stop providing Vitamin D other than for the exempt groups listed.

88% of respondents agree that the local NHS should stop prescribing over the counter medicines for minor illnesses other than the exempt groups listed.

73% of respondents agree and 22% disagree that the local NHS should stop prescribing gluten free products. Feedback received to date on this proposal includes clarification that prescriptions are only available for individuals diagnosed with coeliac disease and not with a gluten intolerance; gluten free foods remain expensive and not as cheap as proposed therefore staples such as flour, bread and pasta should be included; impact of patients not adhering to gluten-free diet including increased risk of long term health complications, impact on patient's quality of life and financial implications for the NHS; superior quality between gluten free products on prescription and supermarket versions.

74% of respondents agree that the local NHS should stop providing all prescribed soya, thickened or lactose free baby milk and infant formula other than the exempt groups listed. Feedback on this proposal includes exempting children under 16 from these proposals.

After the survey closes on 3 February a report setting out the findings for this stage of engagement will be produced and published on the CCG's website and sent to all who have expressed an interest in understanding the outcomes.

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Richmond Clinical Commissioning Group Report Summary

Meeting Title	Governing Body in public	**Date**	17 January 2017
Report Title	IVF and Specialised Fertility		
Agenda Item	2.2.1	**Attachment**	F(1)

Purpose *(please indicate with X)*	Approval/ Ratification	**X**	Discussion / Comment		Information	

Author: *(name & job title)*	Andrew Moore – Prog Dir Financial Recovery	**Executive Leads (Clinical and Officer)** *(name & job title)*	Graham Lewis (Chair) Kathryn Magson (AO)
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Summary and purpose of report

The paper proposes to commence a consultation to change the access criteria for IVF and specialised fertility treatments.

Financial and / or resource implications

These changes are necessary to assist the CCG to meet its financial obligations and have the potential to release funds which the CCG can apply to other priorities

Quality and safety / patient engagement / impact on patient services

This proposal will impact patients who are potentially eligible for IVF, by moving the access to limited cases only. The ultimate safeguard is the IFR process that will allow exceptional cases to proceed. It is anticipated that this change will reduce the number of patients eligible for treatment. The principal driver of this change is financial. There is evidence that IVF and specialised fertility treatments are effective, but in the current situation, unaffordable.

Equality and / or privacy impact analysis

A draft EINA has been completed for the IVF changes proposed – outcomes are recorded below. A formal EINA completion process will take place in parallel with the consultation – using the information we gather to ensure that the governing body is fully informed about the impacts before a decision is made.

Committees that have previously discussed/agreed the report and outcomes

Draft 1: Part of a list of options presented to a governing body seminar

Draft 2: Part of a list of options presented to a GP members forum in September

Draft 3: Part of list presented and discussed to the governing body in September

Draft 4: Part of a discussion at November governing body meeting – which decided to commence a review of the provision of IVF and Specialised Fertility

Communication plan and stakeholder involvement

See below for details. This has been a key issue in Choose Wisely – our engagement plan with the people of Richmond.

Report recommendation

That the governing body should:

Decide to commence a formal 8-week consultation process to examine tightening the access criteria for IVF and Specialised Fertility services for Richmond patients.	
CORPORATE OBJECTIVES *(please indicate with X against relevant priority area / strategic objective)*	
1. Sustainability	
Deliver a financially sustainable health economy balancing the need for effective use of resources and the need for innovation.	**X**
2. Commissioning for quality	
Work in partnership with local health providers and commissioners to commission quality integrated services that achieve good health outcomes, are accessible and promote equality for local people.	
3. Clinical leadership	
Support the development of the CCG as a continually improving and clinically led commissioning organisation.	**X**
4. Engagement	
Enable local people, patients and stakeholders to have a greater influence on services we commission and develop a responsive and learning organisation.	**X**
5. Statutory duties	
Deliver our statutory and organisational duties and ensure the CCG is a highly effective membership organisation.	**X**

Report Summary Version Jan 2017

Context and Introduction

In September Richmond Clinical Commissioning Group (RCCG) governing body received and approved a paper *"RCCG re-commissioning and clinical threshold options report"* (The September Paper). The September Paper built on the content of RCCG's Financial Recovery Plan (FRP), also presented to that governing body meeting, and set out a range of options for RCCG to consider which would have the effect of making savings by making three types of changes.

In November RCCG's governing body received a more detailed paper, which outlined the case for a number of changes. That meeting agreed to commence development of options for examining the criteria for provision of IVF (the November decision). That same meeting agreed to make some minor amendments to the existing IVF policy to align it more closely with other CCGs in SWL.

Rationale for the recommended decision

As the governing body papers in both September and November noted, there is a process to follow to consider the impact of changes proposed by a CCG.

The CCG has been engaging with stakeholders and building up considerable information about the range of issues we are discussing.

It is now our view, that following our work since September and in particular since November, that it is preferable to move towards a formal consultation on an option to change the access criteria to IVF and specialised fertility treatments to limited set of circumstances only.

The key reasons for this recommendation are that only two viable options have emerged from our engagement exercise:

1. Leave the policy unchanged from the position adopted at the November meeting;
2. Move IVF and specialised fertility treatments to a limited access basis with appropriate IFR safeguards.

The change would be to move access to IVF only for people in very specific circumstances, for example, infertility incidental to cancer treatment, to prevent transmission of chronic viral infections, or other clinically exceptional circumstances covered by the existing IFR process. It is expected that further exceptional circumstances could be identified during the engagement and consultation process.

The CCG has recognised that consultation is the best way to ensure that all issues are aired at an early stage and that the genuine interest of the public in this option is best captured by initiating a more formal process.

We note that Croydon CCG have commenced formal consultation on an option to move IVF access to a similar basis and have commenced an 8-week consultation process which commenced on 4 January 2017 and is set to conclude on 1 March 2017. There is an opportunity to harmonise our policy with Croydon and to share the lessons learnt from our consultations, whilst recognising the different issues for these two CCGs' populations.

Preliminary Equalities Assessment

One of the key actions for the CCG to complete before we make a final decision is to consider the impact of the proposed change. We have gathered considerable information by engaging with stakeholders, but there are a number of issues which we need to consider in more detail during the consultation and will feed in to the final decision making process

An equality impact needs analysis is currently underway for this proposal. Further information is required to inform the draft analysis including the findings from the Choosing Wisely engagement ending on 3 February, data from local providers and Individual funding request (IFR) team and understanding if there are any particular groups at higher risk of gynaecological/ obstetric conditions which could impact on fertility. Early findings indicate that the groups with the highest potential impact are age, disability, race/ethnicity and socio-economic.

The number of people in the Richmond population affected by this proposal is low: the NICE fertility guidance CG156 costing template predicts 104 aged 18-39 in Richmond would seek IVF treatment annually (0.52%) of the population in that age group. No estimate is available for the other forms of treatment.

Age:

The age profile of mothers giving birth in the borough of Richmond in 2011 is older than the London and England averages – 33.6% of mothers in the borough were aged 35 or over, compared to 19.8% in London and 16.1% in England. Fertility is affected by age and NICE guidance shows that conception rates both natural conception and successful pregnancies associated with IVF start a decline from the age of 35. Stopping fertility treatment will have a negative impact on women closest to the menopause and therefore the older age profile of mothers in Richmond.

This is a factor that we should consider in Richmond. We will explore the most effective ways of reaching this key demographic.

Disability:

For people with a disability or long-term health condition who are unable to or would find it difficult to have vaginal intercourse or who require specific consideration for methods of

conception. There are some iatrogenic[1] conditions that can cause long-term infertility.

A key topic for consultation would be whether some of these issues would be encompassed within the exceptional criteria, or should be specifically acknowledged as criteria that would permit funding if other criteria (analogous to the existing criteria) were also met.

Race:

Those who face language barriers such as some BME groups could be negatively affected by changes to treatment availability i.e. understanding the changes; what the IFR process is and how to use it. This could cause confusion and anxiety for some people and result in individuals delaying access to treatment they may be eligible for on an exception basis or living with conditions that could benefit from early intervention and treatment.

A key area for the consultation to consider is how best to reach these groups and ensure their views are taken in to account.

Socio-economic:

Couples in low-income households would be expected to be less able to access treatment privately. As infertility has a number of negative psycho social effects reduced access to treatment is likely to impact on the mental health of individuals who are unable to afford to access treatment privately.

Quality and safety / patient engagement / impact on patient services

Initial patient and public engagement is currently taking place on proposed changes to local healthcare relating to IVF and specialised fertility treatments; supporting patients to be surgery ready and prescriptions for gluten free foods, Vitamin D, baby milk and self-care medications which is due to end on 3 February. This includes an online survey and discussion at local CCG and voluntary sector forums taking place during January e.g. community involvement group and PPG network and Richmond Council for Voluntary Services (CVS) health & wellbeing network. The Choosing Wisely document has been distributed to those on the CCG's database, corporate stakeholder list, clinicians, GPs, pharmacists and dieticians and members of staff as well as organisations with a specific interest such as Fertility Fairness and the Coeliac Society. A press release has been sent to the Richmond & Twickenham Times. The survey is being promoted via the CCG's website

[1] iatrogenic relating to an illness/condition caused by medical examination, treatment or diagnostic procedures. Some drugs may cause side effects, which can lead to iatrogenic condition, for example some cancer drugs.

and social media – CCG Facebook and Twitter and also by the local authority and other local partners. Both RCVS and Richmond Healthwatch are promoting it via their membership and networks.

Early discussion on the CCG's financial recovery plan (FRP) proposals led by the CCG's Chief Officer took place with members at a Richmond Healthwatch committee meeting and at the CCG's community involvement group during November. As part of Richmond Healthwatch's public event on 7 December attended by 120 local residents, CCG representatives discussed and answered questions on the changes being proposed to local healthcare and the reasons for the need to make changes. A briefing on the FRP proposals has been shared with Richmond's overview and scrutiny committee.

Eight one survey responses had been received as at 9 January and the responses reflect a range of opinion about the proposed change (with a majority in favour of the change). We note that so far no feedback has been received which has indicated that there is another viable option that the CCG should consider. Opinion seems divided between retaining the access criteria as is, or moving to an exceptions only approach. This has helped the CCG to come to the decision to move to full consultation before the engagement survey has closed.

A full report on the findings from this stage of engagement will be available at the end of February. This report will be submitted to governing body in March. The findings will inform any proposals going to public consultation and a full equality impact needs analysis.

What happens next?

The CCG has not pre-judged the acceptance of this recommendation, so the first action following this decision will be to move from the current engagement phase to planning the consultation in detail and formally approaching the Richmond Health Oversight and Scrutiny Committee to discuss the requirements and potential timeframes for consultation.

As noted in the section above which notes the preliminary equalities impact, the CCG will need to plan a consultation process which gains further information to support the finalisation of a new policy and the implementation of appropriate safeguards.

The CCG is aware that several other CCGs have undertaken consultation exercises in relation to IVF and Specialised Fertility Services and as noted in our papers to the November governing body, we are interested as far as possible to harmonise our access criteria with other CCGs in South West London, so will draw on the material Croydon CCG is using for their consultation while taking account of the specific circumstances in Richmond.

The CCG wants to ensure that members of the public, patients, carers and those who have an interest in the proposals we are developing have the opportunity to inform them at an early stage. We need to talk through these proposals with local people and discuss with them how we prioritise the CCG's spend on health services to inform our resilience plans.

The CCG will utilise a range of methods for involving people which could include working closely with Healthwatch Richmond, Richmond CVS and other local voluntary or community organisations to reach into local communities as well as ensure we act on the sound and insightful local intelligence supplied by them. Existing forums such as the CCG's community involvement group (CIG) and patient participation group (PPG) network will be also used as a sounding board to ensure that if the CCG makes a decision to proceed to consultation that our plans will ensure that the patient voice is sufficiently taken into account.

As part of our formal equalities impact assessment we work with those communities that our initial engagement has indicated should be approached. The group seen as requiring particular attention is women from non-English Speaking Backgrounds and people living with disabilities. Further specific groups may be identified and we will assess any potential impacts on specific communities and will work with local voluntary and community organisations to discuss our proposals with these communities.

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Updated proposal (update from the initial version presented to November governing body)

Threshold Change Proposal: Specialist Fertility Treatments

1. Proposal Brief:

To further restrict funding for **specialist fertility treatments** including in-vitro fertilisation (IVF). Two options are offered: one slightly tightening clinical criteria and one moving to funding only in very limited circumstances.

The CCG's existing policy on funding for specialist fertility treatments and assisted contraception is contained in the document 2014/15 South West London Effective Commissioning Initiative (ECI Policy) and was amended in July 2014 (version 1.6 of the ECI Policy) and exists in the current version 1.7.2.

The general thresholds are established in Section 13 of the document (see section 13.3 (pp.46-47) for the general statement on Fertility Preservation for all CCGs in SW London (except Kingston)), noting then that each CCG has is own variation of this policy as it applies to specialist fertility treatments in Appendix G (pp105-140).

Under the existing Richmond CCG policy (see pp.125-132 of the ECI), the CCG currently routinely commissions the following treatments as appropriate for couples who meet evidence-based criteria:

- Richmond CCG will only fund fertility investigations and related drugs for
  - Women 45 years and below
  - Who are childless or only have one living child
  - Who are in a current long term relationship (at least one year)
- Richmond funds 1 cycle of fresh IVF and 1 of frozen for women between the ages of 23 to 39, but only one cycle for women aged 40-42, which recognises the lower likelihood of success. **[In November RCCG decided to limit the age to 40 and provide only 1 frozen cycle.]**
- Up to 6 cycles of donor sperm insemination with intrauterine insemination (IUI) for people who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem who are using partner or donor sperm

Note that there is a paragraph (last paragraph on p.126) which indicates that Richmond would also permit treatments where there is a special consideration in relation to methods of contraception e.g. after sperm washing where the man is HIV positive). It is unclear to which paragraphs this allowance applies, although from context, it is likely to relate to IUI following sperm washing.

Further criteria are established in a decision tree diagram (pp.127-128) and in specific additional criteria for Sub-Fertility Investigations (Annex B p.128) and Assisted Contraception (Annex C pp.129-131).

Both Sub-Fertility Investigations and Assisted Contraception include BMI and non-smoking criteria, as does the overall section 13 criteria. The Assisted Contraception criteria require that the neither partner have any living child from this or previous relationships (see childlessness criteria on p130).

There is a criteria for accessing Fertility Preservation Techniques (Appendix D pp.131-132) – related to the fertility impacts of radiotherapy, chemotherapy or as a result of treatment which causes harmful effects on sperm or egg production, impotence or has possible teratogenic effects and where stopping treatment to enable conception is not an option.

The CCG's current spend is estimated to be £450k in the current year.

The governing body decided to alter the threshold policy to match Merton CCG's policy (see paragraph 5.1.2 on page 117 of the ECI v1.7.2) of only funding 1 fresh cycle of IVF and if unsuccessful followed by a single frozen cycle.

The governing body also approved a change as in the case of Croydon, (see table on page 105 of the ECI v1.7.2), that the patient must be 39 years or younger at the time of application and, if approved, treatment should start within 6 months.

In North West London CCGs, the age limit for IVF has been set at 40 years.

As the evidence in the existing SWL ECI Richmond IVF (see page 129 of the ECI) notes:

"The likelihood of a live birth following conception declines with age. Chances of live birth per IVF cycle are:

- >20% for women aged 23-35
- 15% for women aged 36-38
- 10% for women aged 39 years
- 6% for women aged 40 years and over."

In addition, (HFEA) notes that:
"In 2010 (the year for which the most recent data is available) women having in vitro fertilisation (IVF) using fresh embryos created with their own fresh eggs, the percentage of cycles started that resulted in a live birth (national averages) was:

- 32.2% for women aged under 35
- 27.7% for women aged between 35–37
- 20.8% for women aged between 38–39
- 13.6% for women aged between 40–42
- 5.0% for women aged between 43–44
- 0.9% for women aged 45 and over"

The governing body adopted 39 years as the new maximum age for IVF on the same basis as Croydon, "the patient must be 39 years or younger at the time of application and if approved treatment should start within 6 months" rather than the current 42. Recognising the low likelihood of success for women of this age.

The governing body considered options to put the entire policy up for review in line with the process adopted by Croydon CCG, and started a process of pre-engagement with stakeholders to consider the option to significantly increase the thresholds such that RCCG might:

- Routinely commission specialist fertility treatment only for people with infertility incidental to cancer treatment or to prevent transmission of chronic viral infections; or
- Not to routinely commission any specialist fertility treatment.

In either case, couples with exceptional clinical circumstances may still be eligible for funding by application under the Individual Funding Policy and the exceptional criteria including the specific causes of infertility such as cancer treatment or to prevent the transmission of chronic viral infections which are already mentioned.

No change is proposed under any options for couples whose courses of treatment are already underway (ie referral has already been made)

Rationale
Specialist fertility treatments are clinically effective but are not considered a priority for funding with the CCG's current financial situation.

Financial impact
Moving to single frozen cycle policy is expected to reduce the cost treatment – negotiations have not

yet taken place with our Provider to confirm the price differential. It is expected that this price change would not be the majority of the cost – as much of the cost is in the preparation for a first cycle.

An estimate of the number of couples referred because of infertility due to cancer treatment or for prevention of viral transmission isn't available. It is assumed that the number is low and that either option would be expected to save a large majority of the annual spend.

Identify any significant risks, issues or constraints to successful implementation:

Contracting advice is awaited re lead time for implementation – provision is exclusively through the Assisted Contraception Unit at Kingston Hospital.

The number of people affected by the change in policy would be low but infertility is an important problem to some of the people who are affected by it. It is also an emotive subject and much media coverage has been generated by CCGs various funding stances over the last 2-3 years.

IMPORTANCE – ASSESSMENT CRITERIA

2. Patient Disbenefit

The only alternative pathway for couples who could not access specialist fertility treatment to conceive a child of their own would be to pay privately. This course of action is likely to be prohibitively expensive for people living on a low income.

The number of people in the Richmond population affected by this proposal is low: the NICE fertility guidance CG156 costing template predicts 104 women aged 18-39 in Richmond would seek IVF treatment annually (0.52% of the population in that age group). No estimate is available for the other forms of treatment.

The existing IVF policy excludes couples in which either partner already has a living child and as such it discriminates against people who are already parents. Parenthood beyond postnatal maternity is not a protected characteristic under the Equality Act 2010 hence this issue will not be addressed under the EqIA but it may be noteworthy nonetheless. If proposed option 1 was pursued, the criterion would continue to apply and the policy would remain discriminatory. If proposed option 2 was pursued, the criterion would be obsolete.

Other CCGs have applied a tighter criteria, with couples with any living children excluded from the service entirely, where RCCG's existing policy allows some sub-fertility investigations services for people with 1 living child.

Equality impact assessment

Gender and sexuality as protected characteristics
The existing policy applies only to couples that include a female partner capable of carrying a pregnancy to term. The material effect on male-only couples would not change by adopting either of the two proposed options. As the criteria for most services refers to a woman.

Disability as a protected characteristic
The existing policy includes provision for up to 6 cycles of IUI for couples where the female partner who, secondary to a physical or psychosexual disability, is unable to conceive naturally. The policy states that funding must be accessed by the IFR route.

Continuing to offer the possibility to apply for individual funding through the IFR policy provides some mitigation against any other risk of direct and indirect discrimination.

Impact on health inequalities

The timescale for preparation of this proposal has not allowed information on the relative prevalence of infertility by sociocultural characteristics to be sought. Couples in income-deprived households would be expected to be less able to access treatment privately.

3. Clinical Disbenefit

Specialist fertility treatments have been assessed as being clinically effective and cost-effective by NICE. The average live birth rate from IVF varies from 32.2% in women under 35 to 20.8% in women aged 38-39 (HFEA). Overall, the number needed to treat to achieve one live birth is about 4.

Adopting either option would prevent the CCG from providing evidence-based care as recommended by NICE in clinical guideline CG156 Fertility problems: assessment and treatment.

Infertility is a recognised cause of psychiatric morbidity in some people: the NICE evidence review suggests it can cause anxiety and depression and psychiatric effects are more common in women affected than in men. The review also notes the anxiety and stress associated with undergoing treatment for infertility, and the bidirectional relationship between anxiety and stress and infertility. The timescale for preparation of this proposal has not allowed investigation of the magnitude of the marginal difference in psychological impact that might be expected by adopting either of the two options.

4. National Priority

The proposed change would not affect the CCG's ability to meet any of the outcomes on the NHS Outcomes Framework, as per the 2015/16 indicators set, nor would it directly affect the CCG's contribution to any of the outcomes on the Public Health Outcomes Framework, as per the 2015/16 indicator set.

No relevant national policy or service framework has been identified.

5. Local Priority

The Richmond Joint Strategic Needs Assessment does not identify infertility as a priority health need.

The CCG's published commissioning intentions for 2017/18 do not address infertility, except to note the possibility of this decision.

6. Financial Benefit

The estimated annual cost of the current policy based on current spend is that the initial change (to one fresh and one frozen cycle) and reducing the eligible age to 40 years could save 20% of existing spend (approximately £80k).

Allowing time for the Threshold Change process to be completed, it is anticipated that the proposed change would take effect from 01 April 2017.Costs for courses of treatment initiated before the adoption of a revised policy are not considered.

If after due process the governing body determined to cease funding IVF in all by exceptional cases, the total spend could be reduced by 80% - an annual saving of up to £400k.

The financial savings would be recurrent.

DO-ABILTY – ASSESSMENT CRITERIA

7. Stakeholders:

Commissioned provider is Kingston Hospital (Assisted Conception Unit)

Fertility campaign groups such as Fertility Fairness are active in advocating against restrictive funding policies.

It is difficult to predict whether general public and stakeholder support would be forthcoming and a comprehensive communications and engagement plan has been implemented

8. Buildings and Equipment:

Providers have dedicated premises and special equipment in order to be able to deliver the service. Providers could continue to offer services privately.

9. Workforce

Providers have a specialist workforce in order to be able to deliver the service. It is not possible to say whether the removal of Richmond's volume of work from the provider would lead to redundancies – this is something that should be discussed with the Provider.

10. Service Delivery

Effect on existing services

No other local commissioned services would be destabilised by this proposal.

Croydon CCG launched their consultation on a similar proposal in the week commencing 4 January 2017. That consultation is expected to close by 1 March 2017.

North East Essex, Mid Essex, South Norfolk CCGs have all adopted policies not to fund unless for infertility secondary to cancer treatment or to prevent viral transmission (from September 2015, September 2014 and November 2015 respectively).

Bedfordshire CCG recently (governing body Meeting on 22 September 2016) decided not to pursue a change to the threshold for access to specialised fertility services. The reasons stated were a lack of support from one of two Borough Councils (Bedford) and the risk that privately funded patients may opt for a more successful dual embryo implantation that could result in off-setting increases in maternity and complexity related costs.

Effect on other services

As described in section 3 Clinical Dis-benefit, there may be a net increase in need for mental health services as a result of further funding restrictions. Primarily it would be expected to be for primary care mental health services and talking therapies.

11. Investment Required

Nil outside the deployment of existing staff to engagement and consultation activities as part of the Choose Wisely campaign.

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Richmond Clinical Commissioning Group Report Summary

Meeting Title	Governing Body in public		**Date**	17 January 2017	
Report Title	Draft letter – pausing IVF and specialised fertility referrals during review of the service				
Agenda Item	2.2.2		**Attachment**	F(2)	
Purpose *(please indicate with X)*	Approval/ Ratification	**X**	Discussion / Comment		Information	
Author: *(name & job title)*	Andrew Moore – Prog Dir Financial Recovery		**Executive Leads (Clinical and Officer)** *(name & job title)*	Graham Lewis (Chair) Kathryn Magson (AO)	
Presented by: *(name & job title)*	Kathryn Magson (AO) Andrew Moore – Prog Dir Financial Recovery		**Further Information contact** *(email address)*	Andrew.moore16@nhs.net	

Summary and purpose of report

The paper proposes a process to pause referrals for new patients while the IVF and Specialised Fertility service is under review.

Financial and / or resource implications

This proposal draw on existing resources and is at no additional cost to the CCG

Quality and safety / patient engagement / impact on patient services

This proposal will impact patients who are potentially eligible for IVF, by pausing referrals for care by up to 6 months while the review of IVF is underway.

This change may have an impact on patients who will face a longer than usual period for access to the relevant services.

Equality and / or privacy impact analysis

A draft EINA has been completed for the IVF changes proposed – as noted in the other IVF paper to this governing body, collecting the information to support a full EINA is one the principal reasons for moving forward to consultation. This change is an extension of the impact of that review.

Committees that have previously discussed/agreed the report and outcomes

None for this proposal alone – this is a response to issues identified as part of the overall review of specialised fertility

Communication plan and stakeholder involvement

None for this proposal alone – this is a response to issues identified as part of the overall review of specialised fertility

Report recommendation

That the governing body should:

Decide to request that referrals for IVF and specialised fertility be paused and treatment not be started for new patients from a date to be determined, while the review of IVF and specialised fertility is underway.

CORPORATE OBJECTIVES *(please indicate with X against relevant priority area / strategic objective)*	

1. Sustainability	
Deliver a financially sustainable health economy balancing the need for effective use of resources and the need for innovation.	**X**
2. Commissioning for quality	
Work in partnership with local health providers and commissioners to commission quality integrated services that achieve good health outcomes, are accessible and promote equality for local people.	
3. Clinical leadership	
Support the development of the CCG as a continually improving and clinically led commissioning organisation.	**X**
4. Engagement	
Enable local people, patients and stakeholders to have a greater influence on services we commission and develop a responsive and learning organisation.	
5. Statutory duties	
Deliver our statutory and organisational duties and ensure the CCG is a highly effective membership organisation.	**X**

Report Summary Version Jan 2017

Rationale for the pause on referrals

In September Richmond Clinical Commissioning Group's (RCCG) governing body received and approved a paper *"RCCG re-commissioning and clinical threshold options report"* (The September Paper). The September Paper built on the content of RCCG's Financial Recovery Plan (FRP), also presented to that governing body meeting, and set out a range of options for RCCG to consider which would have the effect of making savings.

In November RCCG's governing body received a more detailed paper, which outlined the case for a number of changes. That meeting agreed to commence development of options for examining the criteria for provision of IVF and specialised fertility treatments. That same meeting agreed to make some minor amendments to the existing IVF and specialised fertility treatment policy to align it more closely with other CCGs in SWL.

We are aware that a number of other local CCGs are also reviewing their policies in this area, Croydon CCG has commenced an eight week consultation from early January to 1 March 2017.

In recommending that the governing body advance the IVF review to a public consultation phase (a decision put to this governing body under separate cover), the CCG recognised a number of risks which exist for the period of the review including a potential for a rush of patients trying to seek access before the review concludes which would relatively disadvantage patients who might become eligible in future periods.

This paper suggests that it may be prudent to put controls in place during the period of the review and which would last until the governing body sees the outcomes of the consultation and makes a final decision about the access criteria for IVF and specialised fertility.

The proposed pause and safeguards

Richmond CCG has already written to all acute providers to advise them that prior approval must be granted before any procedures listed in the current Effective Commissioning Initiative (ECI) version 1.7.2, which has been in force since 2014 are undertaken. IVF and specialised fertility are listed in the ECI and therefore will be subject to the prior approval process.

The proposal is that during the period of the review – commencing from the day that prior approvals come in to force, that all referrals for IVF and specialised fertility are directed by GPs through the CCGs prior approval system and subject to the safeguards noted, are not referred for treatment until the review period is complete. Any referrals received by the Providers directly should not to be accepted for treatment and must be returned to GP with a copy to the CCG.

It is anticipated that the governing body will make a decision, after the formal consultation, and within a period of 6 months ie by the end of July 2017 (which would allow consultation material to be prepared, followed by documentation and development of a final proposal for discussion and approval). If the review lasts more than 6 months, referrals should be

released so that no patient is subject to more than a 6 month delay in gaining access to treatment.

The safeguards proposed include ensuring that any patients who would become ineligible for care due to the passage of time during the review are not subject to the pause. For example a patient who would be under an age limit when the referral is generated, but would not be six months later should not be subject to the pause – there will be the ability to set out any exceptional circumstances where the pause should not be applied.

Risks and issues with this approach

We are concerned to ensure that access to IVF continues to be fair during the review process, that patients who have already commenced treatment are assured that they will be able to complete their pathway in accordance with existing rules, and that there is not a rush of referrals, or a shift of activity between neighboring CCGs during the review period.

The potential change in IVF has already received considerable attention – including prominent reporting in the local press that could lead to an unplanned surge in requests for treatment.

Scenario 1: If the CCG does not proceed to change the access criteria

One possible outcome of the review is that the CCG does not alter the existing access criteria. Based on the best available information, the pause will have impacted less than 10 patients per month – as the CCG currently funds significantly less than 200 patients per year.

If the consultation and review concludes that no change should be made, there will be a backlog of patients waiting for IVF or specialised fertility treatments. There is a risk that this backlog will cause a delay that might take some time to clear. If this is the case, the CCG will need to consider seeking additional short-term capacity to address those referrals and will need to discuss options with local providers.

Patients will have been disadvantaged during the pause. As our research has indicated, there is a decrease in fertility with age. There is a chance that the addition of 6 months delay could further reduce the chances of success. If exceptional circumstances apply then the pause can be waived.

Scenario 2: If the CCG does proceed to alter the access criteria

In effect the pause will have moved forward the change in policy, as the patients whose referrals have been held, will not then be referred for treatment. This could be viewed as pre-judging the final outcome – but this is not the case, it is an attempt to ensure an orderly management of the uncertainty of the outcome.

This will disadvantage patients approximately 10 patients per month, but only to the same extent as all patients would be impacted by the eventual change.

Appendix 1 - DRAFT content of letter to IVF Provider

RE: Notice that IVF Service is under review and request to pause commencement of treatment for new patients during the review period

As you are aware, the Clinical Commissioning Group is in a financially challenged position and has agreed a deficit plan with our regulator NHSE. We are required by NHSE to submit a Financial Recovery Plan (FRP) to demonstrate a return to financial balance in 2017-18.

RCCG's FRP incorporates a complete review of all expenditure to identify where the CCG can urgently reduce expenditure.

At a governing body meeting on 15 November, our governing body agreed to commence a process of reviewing IVF and specialised fertility services, including the possibility of moving to an exceptions only access criteria. The CCG has commenced initial discussions with impacted stakeholders and is planning to take a formal change proposal back to the governing body in early 2017, at which point the governing body will decide whether to proceed to consult on the change – with changes to be applied as soon as possible in the new year.

As a stakeholder, we are interested to hear your views about the potential changes, required safeguards and the issues in implementing the possible changes in access.

We are aware that a number of other local CCGs are also reviewing their policies in this area.

We are concerned to ensure that access to IVF continues to be fair during the review process, that patients who have commenced treatment are assured that they will be able to complete their pathway in accordance with existing rules, and that there is not a rush of referrals, or a shift of activity between neighbouring CCGs during the review period.

As a result, we would like to discuss with you arrangements to manage new referrals during the period of the review. Subject to safeguards (particularly in relation to women who are near to the age limit currently in place), we are of the view that these arrangements should involve a pause in commencing treatment for new referrals until the review is complete and all new referral being subject to prior approval by the CCG before any treatment commences

We would welcome the opportunity to discuss this change with you and the particular arrangements and safeguards that need to be put in place during the period of the review.

Yours sincerely

Richmond Clinical Commissioning Group Report Summary

Meeting Title	Governing Body in public		**Date**	17 January 2017	
Report Title	Surgical Readiness Guidance - Update				
Agenda Item	2.2.3		**Attachment**	F(3)	
Purpose *(please indicate with X)*	Approval/ Ratification	**X**	Discussion / Comment		Information	
Author: *(name & job title)*	Andrew Moore – Prog Dir Financial Recovery		**Executive Leads (Clinical and Officer)** *(name & job title)*	Graham Lewis (Chair) Kathryn Magson (AO)	
Presented by: *(name & job title)*	Kathryn Magson (AO) Andrew Moore – Prog Dir Financial Recovery		**Further Information contact** *(email address)*	Andrew.moore16@nhs.net	

Summary and purpose of report

The paper proposes that the CCG should adopt a Surgical Readiness Guideline – which will encourage patients who smoke or have excess weight to be more ready for surgery before undertaking most elective procedures which require significant anaesthesia. While in earlier papers amongst the proposals for change was an enforceable threshold, it is now recommended that this change be adopted as guidance and encouragement.

Financial and / or resource implications

This proposal draws on existing resources and is at no additional incremental cost to the CCG. If there is a case for increasing the number of places offered in smoking cessation or weight management services, it may be necessary to fund these using the savings gained by healthier patients who will have less surgical complications, shorter stays in hospital and overall will be healthier.

Quality and safety / patient engagement / impact on patient services

An outline equalities impact has been completed. As this proposal is now in the form of guidance and is voluntary, there is little potential for negative impact on quality. There is good clinical evidence that taking up an offer for these services has a positive effect on both patients and the health system as a whole.

This change may have an impact on patients who choose to delay treatment in order to improve their readiness for surgery, which is why the guidance needs to be applied using clinical judgement and the safeguards noted.

Equality and / or privacy impact analysis

An outline equalities impact has been completed. As this proposal is now in the form of guidance and is voluntary, there is little potential for negative impact on health inequalities.

Committees that have previously discussed/agreed the report and outcomes

Draft 1: Part of a list of options presented to a governing body seminar

Draft 2: Part of a list of options presented to a GP members forum in September

Draft 3: Part of list presented and discussed to the governing body in September

Draft 4: Part of a discussion at November governing body meeting – which decided to commence a review

Communication plan and stakeholder involvement

RCCG has been discussing options in a number of forums since the Financial Recovery Plan was first published in mid-2016. In particular, since the governing body decision on 15th November 2016, the CCG has engaged with patients and the public via a range of media – including producing the 'Choose Wisely' campaign, and a supporting survey.

Report recommendation

That the governing body should:

Decide to adopt Surgical Readiness as guidance only and not incorporate smoking cessation or weight/ BMI threshold to a wide range of elective procedures.

Approve the development of guidance and other materials to support the implementation of the guidance with immediate effect and note the process proposed.

CORPORATE OBJECTIVES *(please indicate with X against relevant priority area / strategic objective)*	
1. Sustainability	
Deliver a financially sustainable health economy balancing the need for effective use of resources and the need for innovation.	**X**
2. Commissioning for quality	
Work in partnership with local health providers and commissioners to commission quality integrated services that achieve good health outcomes, are accessible and promote equality for local people.	**X**
3. Clinical leadership	
Support the development of the CCG as a continually improving and clinically led commissioning organisation.	**X**
4. Engagement	
Enable local people, patients and stakeholders to have a greater influence on services we commission and develop a responsive and learning organisation.	**X**
5. Statutory duties	
Deliver our statutory and organisational duties and ensure the CCG is a highly effective membership organisation.	**X**

Context and Introduction

In September Richmond Clinical Commissioning Group (RCCG) governing body received and approved a paper *"RCCG re-commissioning and clinical threshold options report"* (The September Paper). The September Paper built on the content of RCCG's Financial Recovery Plan (FRP), also presented to that governing body meeting, and set out a range of options for RCCG to consider which would have the effect of making savings by making three types of changes.

In November RCCG's governing body received a more detailed paper, which outlined the case for a number of changes. That meeting agreed to commence development of options for examining a smoking cessation and Body Mass Index (BMI)[1] access criteria / threshold for elective care.

Rationale for the recommended decision

As the governing body papers in both September and November noted, there is a process to follow to consider the impact of changes proposed by a CCG on patients.

It is now our view, that following our work since September and in particular since November, including discussion with our GP members and the public that it is preferable not to pursue a threshold policy which would require patients to undertake, or successfully complete stop smoking or weight loss before being referred to elective care in all but the most urgent cases.

The key reasons for this change in recommendation is:

- feedback from public health colleagues that mandatory programmes are less likely than voluntary schemes to result in long term behaviour change, and that this change fits in well with good public health practice which NHS clinicians should be implementing via a Making Every Contact Count (MECC) approach;
- a recognition that more data would required to justify a tighter policy including the potential costs of commissioning the potential number of places required in effective services – data which could be gathered over a period of time of implementing a guidance only policy and monitoring impacts, while building up capacity in the required services;
- to align ourselves with changes at other CCGs in South West London
- the cost and length of a potential consultation process which would have delayed bringing forward this important health improvement initiative for arguably little greater impact
- there is faster impact of the benefits of the scheme as guidance can be implemented as soon as it has been prepared, communicated and appropriate capacity is in place

In moving to this option, the CCG does not limit the ability to consider formal threshold changes at a later date, should this become necessary. It may be that after 6 or 12 months of guidance being in place, evidence may emerge that a mandatory threshold would be more effective.

Adopting this option will place more obligations on the CCG to work collaboratively with GPs and secondary care providers to examine referral pathways and ensure that the guidance is adopted.

The guidance will be firm in recommending patients undertake steps before being referred for elective care (subject to exceptions) and the CCG will monitor compliance with the guidance actively – and actively address areas where there lower levels of take-up which could require:

- increasing access by building a business case where there is unmet demand
- further support for referrers including embedding surgical readiness guidance in referral management software and processes
- promoting the use of patient decision making aids to help patients understand the risks of not taking

[1] BMI is the body mass divided by the square of the body height, and is expressed in units of kg/m2

action.

How will we develop our guidance and the related implementation plan

The CCG wants to ensure that members of the public, patients, carers and those who have an interest in the proposals we are developing have the opportunity to inform them at an early stage.

We have included this option as part of our Choose Wisely campaign and this is a key vehicle for making sure we have engaged with the public.

We anticipate that the following products will be developed as a next step:

- Richmond Guidance on Surgical Readiness – including the policy statement and a summary of the evidence of the benefits of following the guidance – a document suitable for clinicians and including the method to gain access to services to promote surgery readiness
- An easy to use document for patients being referred for elective care which assists patients to understand:
    - the risks of undergoing surgery, impacts on recovery and long-term health outcomes
    - the short and long term benefits of improving surgical readiness
    - how and where to access help in Richmond

  It is likely that this document will need to be translated in to a number of languages and made available widely to ensure that hard to reach groups are given equal access to the information.

Surgery ready – quality and equality impacts

The NHS Five Year Forward View challenges CCGs to increase activity that focuses on preventing ill health, such as obesity, smoking, alcohol and other major health risks. In order to achieve this many CCGs are considering initiatives to promote smoking cessation and weight loss for patients identified as needing elective surgery which what we are doing in Richmond.

Both obesity and smoking disproportionately affect those from more deprived backgrounds. There is a risk that by stopping or delaying surgery on the grounds of obesity or smoking these proposals if they became policy would further increase the gap of health outcomes between the most and least deprived areas. This was part of the reason that the policy will only be expressed as guidance and relies on patients agreeing to accept a recommendation to access services to be more ready for their treatment.

Public Health will be undertaking an evaluation of the CCG's proposal to support patients to be surgery ready. This evaluation together with the Choosing Wisely engagement that ends on 3 February will inform an equality impact needs analysis that will be developed along with the guidance documents.

What are the risks of this approach?

There are risks with this approach:

While opting for guidance rather than a significant change to thresholds accelerates the impact the change, and there is evidence that this option would be more effective in long-term change, a formal threshold may in the short-term drive greater levels of referral in to services.

There is a risk that the greater levels of referral could overwhelm the capacity of the current services to absorb the increased demand. This is mitigated by the adoption of this proposal as guidance only, the

understanding that new on-line options will offer a greater access to an effective service. By keeping this area under active review, there is the potential to make out a business case of an expansion of service based on real, rather than anticipated demand.

Patients will be delayed from accessing elective surgery while they improve their Surgical Readiness and clinical judgement should be exercised. As noted in November, some procedures should typically not be delayed:

- cardiology,
- cardiothoracic,
- neurosurgery and
- fracture related procedures

It has been subsequently noted that surgery for specific weight loss (such as bariatric surgery) should also not be delayed

Patients who have elective care delayed while undertaking surgical readiness treatment might deteriorate. There is also the possibility that with access to appropriate alterative treatments to a procedure which itself has risks, a recovery period could be delayed or avoided entirely.

Summary of the proposal discussed by the governing body in November – which will form the basis of the guidance

The CCG proposes to examine introducing guidance on the management of obese patients requiring routine elective surgery who may require a general or spinal/epidural anaesthetic.

The new policy builds upon BMI and smoking elements of the existing hip and knee arthroplasty[2] and IVF policies already adopted by the CCG (see existing SWL ECI Policies at 14.8. 14.10 and Appendix 1). Note also that a number of 'cosmetic' procedures already include a BMI threshold.

In summary, the proposed guidance is:

Patients with a BMI over 40 (or with a BMI between 30 and 40 with metabolic syndrome) are expected to lose weight and should not receive surgery until

- They reduce their weight by at least 10% over 9 months
- Or to a BMI less than 30

Obesity is a major contributory factor to premature death and ill health in England and this policy aims to ensure the use of medical triggers to inform patients of the benefits of losing weight and support them in doing so. Patients who successfully lose weight will benefit from fewer complications and will achieve wider health benefits.

The new policy could apply to routine referrals to ALL surgical specialities (excluding cardiology, cardiothoracic, neurosurgery, fracture related procedures and weight loss procedures) that may require a general or spinal/epidural anaesthetic.

The CCG also proposes to examine a policy on the management of smokers requiring surgical referrals.

All smokers requiring a surgical referral to ALL surgical specialities should be referred to an appropriate smoking cessation services in order that they are aware of the risks associated with smoking and surgery and have the opportunity, and are supported by use of patient decision aids, to quit in advance of their surgery.

Patients are not required to have quit smoking to have surgery but must be in a position to make an informed choice about the risks.

This proposed change closely mirrors the guidance adopted in East and North Herts CCG – which has been successfully applied since 2012.

[2] *Busato A, Roder C, Herren S et al. Influence of high BMI on functional outcome after total hip arthroplasty. Obesity Surgery, May 2008: 18/5 (595-600); 0949-2658*

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Richmond Clinical Commissioning Group Report Summary

Meeting Title	Governing Body in public		**Date**	17 January 2017	
Report Title	Approval of new version of the Effective Commissioning Initiative (ECI) elective care thresholds document				
Agenda Item	2.2.4		**Attachment**	F(4)	
Purpose *(please indicate with X)*	Approval/ Ratification	**X**	Discussion / Comment		Information	
Author: *(name & job title)*	Andrew Moore – Prog Dir Financial Recovery		**Executive Leads (Clinical and Officer)** *(name & job title)*	Graham Lewis (Chair) Kathryn Magson (AO)	
Presented by: *(name & job title)*	Kathryn Magson (AO) Andrew Moore – Prog Dir Financial Recovery		**Further Information contact** *(email address)*	Andrew.moore16@nhs.net	

Summary and purpose of report

The paper provides the governing body with the detail of the changes in clinical threshold policies that have been discussed at previous meetings. Although the review was initially financially driven, these changes also reflect the CCGs responsibilities in reviewing services that are commissioned and how effective existing policies are. A small number of additional policy changes have been added since November and these are also recommended for approval.

Financial and / or resource implications

These changes are necessary to assist the CCG to meet its financial obligations and have the potential to release funds that the CCG can apply to other priorities. The treatments being subject of thresholds have been identified as offering lower value for the population as a whole. There may be costs in the provision of some of the conservative treatments that will replace the typically high cost and higher risk treatments being altered.

Quality and safety / patient engagement / impact on patient services

This proposal will impact patients who were potentially eligible for treatments under the current version of the policies, who now might no longer be eligible for treatment. In most cases, the impact and clinical review work from previous reports has shown that the amended policies are supported by evidence that the treatments are of lower clinical value and that more suitable alternatives exist to care for patients. The process of reviewing policies and amending them is business-as-usual practice for CCGs and the changes proposed in many cases are updates to policies to reflect more recent guidance, or to make the policy clearer.

Equality and / or privacy impact analysis

A key aim of documenting these policies and improving compliance with them is to ensure that access is by clinical priority rather than any other criteria. While some policies may impact particular patient groups more than others (e.g. hysterectomies are only carried out on women), a clinically led process of using evidence to set clinical criteria is a sound way in which alternative treatments can be suggested and equal access on clinical processes promoted.

No additional privacy impacts are expected from adding to and amending the existing policies.

Committees that have previously discussed/agreed the report and outcomes

Draft 1: Initial list of options presented to a governing body seminar

Draft 2: Initial list of options presented to a GP members forum in September Draft 3: List presented and discussed to the governing body in September Draft 4: Significant of a discussion at November governing body meeting of an extensive paper setting out the case for most the proposed changes. The meeting endorsed the change, subject to a final review of the wording and further involvement of public health in reviewing the changes.
Communication plan and stakeholder involvement
RCCG has been discussing options in a number of forums since the Financial Recovery Plan was first published in mid-2016. In particular, since the governing body decision on 15th November, the CCG has continued to talk to stakeholders and the public about these changes
Report recommendation
That the governing body should: Approve the proposed changes to the ECI policies and communicate the revised policies to providers as soon as possible. Delegate to the Chair and Accountable Officer the ability to approve minor amendments to the policies as they are finalised and readied for implementation with other CCGs in SWL – this will include version control information, introductions, updates to reflect recent process changes which support compliance with the policies.

CORPORATE OBJECTIVES *(please indicate with X against relevant priority area / strategic objective)*	
1. Sustainability	
Deliver a financially sustainable health economy balancing the need for effective use of resources and the need for innovation.	**X**
2. Commissioning for quality	
Work in partnership with local health providers and commissioners to commission quality integrated services that achieve good health outcomes, are accessible and promote equality for local people.	**X**
3. Clinical leadership	
Support the development of the CCG as a continually improving and clinically led commissioning organisation.	**X**
4. Engagement	
Enable local people, patients and stakeholders to have a greater influence on services we commission and develop a responsive and learning organisation.	**X**
5. Statutory duties	
Deliver our statutory and organisational duties and ensure the CCG is a highly effective membership organisation.	**X**

Context and Introduction

In September Richmond Clinical Commissioning Group (RCCG) governing body received and approved a paper *"RCCG re-commissioning and clinical threshold options report"* (The September Paper). The September Paper built on the content of RCCG's Financial Recovery Plan (FRP), also presented to that governing body meeting, and set out a range of options for RCCG to consider which would have the effect of making savings by making three types of changes.

In November RCCG's governing body received a more detailed paper, which outlined the case for a number of changes. That meeting agreed to proceed with the recommendations to change a number of policies and this paper is the result of the work since then.

These changes represent the first wave of work to update our policy, we recognise that the CCG and others in SW London will continue to review the entire document to progressively update policies and where appropriate to make additional changes and clarifications, subject to a similar process to this round.

The recommended changes

Richmond CCG has taken an important role in developing the revised wording of the policies that are currently shared in the majority of cases with all six CCGs in South West London.

The table below sets out the threshold changes which the governing body approved in November and the reference in the policy document (see Appendix 1 for a marked up version of the policy document).

A question from the governing body at the last meeting was the number of procedures that the CCG currently pays for under each policy – an estimate based on the 2015-16 year is included in the table, along with a range of possible % impacts from the proposed change in policy, but also and arguably more importantly increasing compliance with the policies and the better use of patient decision making aids to help patients decide to pursue more conservative treatments.

Table 1

Topic	Ref in ECI v.1.7.2	2015-16 case volume	Range of impact (Low-High %)
Arthroscopic Knee Surgery weak evidence supporting the procedure and that a stricter threshold should apply to the procedure	14.9	204	30-70%

Topic	Ref in ECI v.1.7.2	2015-16 case volume	Range of impact (Low-High %)
Surgical Management - Dupuytren's Fasciotomy surgery evidence that there are alternative treatments available which offer better value	14.5	12	30-50%
Pain Management Reduction in lumbar epidurals through MSK referral management and replacement with other treatments	14.6	241	25-50%
Hallux Valgus Osteotomy (Bunion Surgery) Increased thresholds to be applied to this treatment option, based on NICE guidance suggests, due to variance in surgical technique, outcome and efficacy is limited. Referral for surgery should be on a case basis and only if functional mobility impairment results	14.15 – new policy	90	40-70%
Carpal Tunnel Surgery Review and update MSK pathway for CTS management, patient journey should include hand therapy and advice on managing ADLs; static volar splinting, appropriate analgesic management for a minimum of six months. Should symptoms not subside or Thenar atrophy becomes apparent, only then should surgery be considered.	14.3	91	15-35%
Hip replacement deterrence and tightening of thresholds Implement Patient Decision Making Aids to reduce Hip replacement by limiting those patients receiving primary hip replacement surgery by the use of PDAs Strictly limit provision of total hip replacement arthroplasty, hip arthroplasty revision surgery and hip arthroscopy, unless associated to trauma and potentially life limiting	14.8	182	25-50%
Knee replacement deterrence and tightening of thresholds Role out use of PDAs for patients considering total hip replacement surgery, establish criteria of functional deficit impairment, EQ5D score, Oxford score and VAS. By implementing patient decision aids, and encouraging informed choice, we anticipate that a cohort of patient will decide not to pursue surgical treatment, therefore reducing the volume . In addition, new threshold to limit provision of total knee replacement arthroplasty, knee revision surgery and partial knee arthroplasty unless associated to trauma and potentially life limiting	14.10	172	25-50%
Limit cataract surgery provision for second eye operations	10.3	1045	10-20%

Topic	Ref in ECI v.1.7.2	2015-16 case volume	Range of impact (Low-High %)
Reversal of Female and male sterilisation. Governing body did not favour limiting access to male or female sterilisation, but asked for review of whether a policy should be adopted to address sterilisation reversal.	Not pursued – no existing criteria and very little evidence of activity	n/a	n/a
Minor Skin Lesions (treatment of) - alternative treatments and settings should be considered	4	365	25-50%
Asymptomatic Gallstones	6	27	50-90%
Circumcision	7	81	10-25%
(Adeno) Tonsillectomy – Change to update to NICE guidance – changes to the evidence before referral for surgery	9.1	118	25-50%
Grommets – changes to adult criteria	9.2	71	25-50%
Varicose Veins	15.2	73	25-50%
Obstructive Sleep Apnoea in Adults (surgical)	12	Block	10-25%
Cosmetic procedures A range of thresholds for cosmetic surgery could be adjusted and further compliance work carried out to reduce cost - list where current policies could be reviewed and thresholds and IFR process tightened. Specifically the two areas targeted for change are: 1. Rhinoplasty (nose) – tightening the threshold and making the criteria for accessing the procedure more specific 2. Pinnaplasty/Otoplasty (ears) - amendments to the policies tighten the criteria to require the demonstration of the impact of the condition before treatment is able to be accessed	 2.2 & 2.3	 11 3	 25-50%

Table 2 (below) includes the details of three additional changes that were not considered by the governing body in November 2016, but have subsequently been worked up with other CCGs in SW London and are put forward as additional changes.

These changes are largely to address areas where CCGs have experienced difficulty in applying the current policies due to ambiguity in interpretation. These three changes provider further detail to assist in the application of the policies.

Table 2

Topic	Proposed changes to existing policies	Rationale
Dilatation & curettage (D&C) (within Obstetrics, Gynaecology & Reproduction)	Minor amendments to clarify that D&C is no longer recommended as a diagnostic tool in heavy menstrual bleeding (HMB). To detect histological abnormalities in HMB endometrial sampling or hysteroscopy with directed biopsy have superseded D&C for obtaining endometrial tissue. Evacuation of retained products of conception after incomplete miscarriage or delivery has been recommended in order to reduce potential complications such as haemorrhage or infection. Surgical evacuation has been considered the most effective method by D&C or vacuum aspiration/suction curettage. Evidence suggests that vacuum aspiration/suction curettage was safe, quick and easy to perform, and less painful than D&C and is therefore recommended as the first treatment option, with D&C only recommended where this is contra-indicated.	Clarifying amendment proposed by Croydon CCG and reviewed by Richmond CCG – to clarify the appropriate use of the technique based on new evidence.
Hysterectomy for heavy menstrual bleeding	Hysterectomy for HMB will only be funded if all the following criteria are met: 1. A levonorgestrel intrauterine system or LNG-IUS (e.g. Mirena) has been trialed for at least 6 months (unless contraindicated* or declined by patient) and has not successfully relieved symptoms. 2. A trial of at least 3 months each of two other pharmaceutical treatment options has not effectively relieved symptoms (or is contraindicated, or not tolerated). These treatment options include: • Non-steroidal anti-inflammatory drugs (NSAIDs) (2nd line pharmaceutical treatment) e.g. mefenamic acid • Tranexamic acid • Combined oral contraceptive pill • Oral and injected progestogens 3. Surgical treatments such as endometrial ablation, thermal balloon ablation, microwave endometrial ablation or uterine artery embolisation (UAE)** have either been ineffective or are not appropriate, contraindicated **Contraindications to LNG-IUS use include suspected or confirmed untreated sexually transmitted infections (STIs), pregnancy, pelvic inflammatory disease (PID), distorted or small uterine cavity, active trophoblastic disease, genital malignancy and Immunosuppression3* ***UAE may be appropriate for some women with HMB associated with uterine fibroids.*	Clarifying amendment proposed by Croydon CCG and reviewed by Richmond CCG – to clarify the appropriate duration of conservative treatment before this treatment should be accessed.
Therapeutic facet joint injections/media	CCG will only commission a spinal facet joint injection (medial branch block) for lumbar pain where: • There is a reasonable clinical suspicion that the	This addresses a gap – while Richmond had

Topic	Proposed changes to existing policies	Rationale
l branch blocks	pain experienced is generated by the spinal facet joints. • Patients have actively participated in the decisions in respect of their treatment; • Patients show commitment to taking responsibility for managing their condition by demonstrating relevant lifestyle changes which include weight loss, increased fitness through exercise and physiotherapy; diet control, avoidance of illicit drugs and alcohol, improvement in sleep patterns, managing mood and mental health; and improved engagement in activities of daily living and purposeful occupation where appropriate; • Back or neck pain is rated at a level of 7/10 on the standard pain scale; Back or neck pain causes significant impact on daily functioning which has been assessed using the HAD tool; AND • Patients have given their informed consent. **Clinical practice** Prior to the administration of the medial branch blocks facet joint pain should be confirmed by controlled diagnostic local anaesthetic block. In the diagnostic phase the patient may receive up to 3 injections 1-2 weeks apart, in the therapeutic phase, up to six injections 2-3 months apart provided there has been >50% reduction in symptoms for six weeks. Medial branch blocks beyond the first three injections should be provided as part of a comprehensive pain management programme.	considered and approved change to the use of epidural injections for lumbar back pain, Croydon also reviewed the evidence relating to Therapeutic facet joint injections/medial branch blocks. Key clarifications include: • Clear, specific and objective criterion e.g. back or neck pain now rated. • Includes a holistic approach to managing e.g. considering lifestyle measures.

How we developed our guidance and the related implementation plan

The CCG wants to ensure that members of the public, patients, carers and those who have an interest in the proposals we are developing have the opportunity to inform them at an early stage.

Richmond CCG has invested substantial time in considering these policy changes, and discussing with stakeholders on these changes. At most a technical and impact only a small number of patients who are likely to access these services only once, we have used our usual forums to engage with the public. We have included references these changes as part of our Choose Wisely campaign and this is a key vehicle for making on-going engagement with the public on these changes and to identify further opportunities.

GPs from across SW London have been key to reviewing the changes. Several rounds of comments were received and have been built in to the document. We have shared versions of our lists and the evidence base with all six SW London CCGs. We are actively working with all six to ensure the greatest level of consistency in policy is maintained. As Croydon,

Richmond and Merton CCGs have in particular worked on the early versions of these policies, there is possibility that minor amendments may be made to the policies as other CCGs work through their internal and external engagement processes. As noted in the November governing body paper, consistency is valuable and there are a number of advantages in working with our colleagues in all six CCGs in SWL and keeping the threshold policies in the SWL ECI common to all CCGs as far as possible:

- all SWL patients have common access to treatments and we don't expose patients to a 'post-code lottery', where changing GP could lead to a having different access to particular elective treatments;
- providers are not exposed to having to apply different sets of rules to patients from within SWL, depending on that patient's CCG – which could add complexity and compliance costs, albeit that many providers already face this challenge when treating patients from other geographies (e.g. North West or Central London have different thresholds);
- the 6 SWL CCGs are increasingly working together within the Sustainability and Transformation Plan (STP) footprint and can share the work of maintaining the thresholds and ensuring the whole system acts fairly to ensure consistent access;
- that referrers (e.g. GPs) have a widely shared understanding of what the latest evidence says and apply the same thresholds; and
- risk sharing across the patch in case of challenge relating to a clinical policy decision.

While there are clear advantages in working together across SWL, Richmond may need to take the lead in changing policies and implement new versions before all other CCGs in SWL can follow through their own governance. This should not be seen as a barrier to change, but should act as an encouragement to all parts of the system to share evidence and open shared decision making to capture as many of the benefits of collaboration as possible.

Richmond and Merton CCG hosted a GP and Provider workshop, where we outlined the evidence and rationale for each change. The workshop was constructive and useful suggestions were made which helped to clarify the changes proposed. As a result, we shared the material which went in to the November paper with providers as part of the contracting round which has just concluded and in many cases providers have acknowledged that there will be impact on the level of activity for treatments covered by these thresholds. Richmond CCG has also been active in implementing processes and systems that will support increased compliance with new and existing policies.

Summary of the Equalities Assessment

One of the key actions for the CCG to complete before we make a final decision is to consider the impact of the proposed change. We have gathered considerable information by engaging with stakeholders.

Early findings indicate that the groups with the highest potential impact are age, disability, race/ethnicity and socio-economic.

The number of people potentially impacted by each change is a reasonably small percentage of the overall population of Richmond. For example the CCG commissions just over 1000 cataracts per annum and the change for that policy is estimated to impact as many as 100 people per annum. On the lower end, some of the procedures are only carried out 10 times each year and the tightening of the policy may mean that 2 or 3 people will need to wait longer before becoming eligible for treatment.

The diverse range of changes means that many different characteristics could be in play. The key to note is that having a rules based approach to commissioning, setting clear clinical standards for access and governing those standards appropriately is a very effective way of improving equality of access. Even in cases where access to treatments is being restricted in favour of other more conservative options, having clear clinical criteria to decide who gets access should mean that inequalities are reduced.

What happens next?

Richmond CCG will rapidly finalise and communicate our changes in policy to our Providers. Threshold changes can take effect as soon as one month after notice is sent to Providers. The CCG will need to ensure that key systems are updated and that there are very effective communications to ensure that new policies are understood and enforced.