right care
right place
right time
right outcome

NHS
Merton
Clinical Commissioning Group

MERTON CLINICAL COMMISSIONING GROUP
GOVERNING BODY

Date of Meeting: 23rd February 2017

Agenda No: 3.1 **Attachment:** 02

Title of Document: Update on clinical thresholds and policy changes	**Purpose of Report:** Approval
Report Author: Andrew Moore	**Lead Director:** Andrew Moore
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Executive Summary: This paper provides the governing body with an update on the progress of the programme of work and seeks a number of decisions	
Key sections for particular note (paragraph/page), areas of concern etc: Whole Document	
Recommendation(s): That the governing body should: 1. Approve the proposed changes to the ECI policies and delegate to the Chair and Accountable Officer the ability to approve minor amendments and clarifications to the policies as they are finalised and readied for implementation with other CCGs in SWL. 2. Receive verbal update on the Choose Wisely campaign in Merton and the progress of the South West London shared ECI process improvements.	
Committees which have previously discussed/agreed the report: Governing body considered an initial paper in public meeting in December and January, these areas have been extensively discussed in EMT, CRG, and Finance Committee.	
Financial Implications: The changes have savings impacts are have been included as part of the Financial Recovery Plan and QIPP schemes for 2016-17 and 2017-18.	
Implications for CCG Governing Body: Support for financial recovery and demonstration of leadership in working across the health system to implement good commissioning practice.	
How has the Patient voice been considered in development of this paper: Much of the work underpinning these changes has been carried out in cooperation with other CCGs in South West London (SWL) and there has been substantial engagement with the public across SWL. In Merton, these changes have been	

discussed at several patient engagement events and further engagement events are planned particularly in relation to IVF and medicines changes in February and March
Other Implications: (including patient and public involvement/Legal/Governance/Risk/Diversity/ Staffing) As discussed in the paper, these changes have already been subject to considerable patient and public involvement and much more is planned in the period up to the March governing body and beyond.
Equality Assessment: See the detail of each area for specific discussion of the equality impacts assessed to date.
Information Privacy Issues: None noted
Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution) Inclusion in the Choose Wisely materials for Merton.

Changes to clinical thresholds

In December Merton Clinical Commissioning Group's (MCCG) governing body received and approved a paper *"Evidence Based Commissioning"* (The December ECI Paper). The December ECI Paper built on the content of MCCG's Financial Recovery Plan (FRP).

In January, the governing body was presented with proposed policy changes drafted in the form of a marked up new version of the policies.

At that meeting the governing body decided to seek the advice of the CCGs Clinical Reference Group (CRG) to review the evidence and process leading to the proposed policy changes.

This paper briefly recounts the detail from previous papers in order to assist the governing body to make a decision about how to proceed.

Extract from Paper presented in January:
The proposed changes reflect the areas discussed in previous papers and are based on the current version of the policies (known as ECI version 1.7.2) which has been in force since mid-2014

Richmond CCG adopted the new version of the policies without amendment on 17th January 2017 with the same qualification of a delegation of authority to the Chair and Accountable Officer ability approve minor amendments to the policies as they are finalised and readied for implementation with other CCGs in SWL

The recommended changes
Merton 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 December and the reference in the policy document.

Table 1 (with CRG comments)

Topic	Ref in ECI v.1.7.2	2015-16 case volume	Range of impact (Low-High %)	CRG comment
Arthroscopic Knee Surgery weak evidence supporting the procedure as a diagnostic and therapeutic treatment and that a stricter threshold should apply to the procedure	14.9	178	30-70%	Supported
Surgical Management - Dupuytren's Fasciotomy surgery evidence that there are alternative treatments available which offer better value	14.5	12	30-50%	Supported
Pain Management Reduction in lumbar epidurals through MSK referral management and replacement with other treatments	14.6	475	25-50%	Supported in principle: Requires pain management service review
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%	Supported
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	154	15-35%	Supported
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	170	25-50%	Supported

Topic	Ref in ECI v.1.7.2	2015-16 case volume	Range of impact (Low-High %)	CRG comment
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	187	25-50%	Supported
Limit cataract surgery provision for second eye operations and update criteria.	10.3	1,165	10-20%	Not approved by CRG – further discussion required
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	Confirm that Merton do not fund. CRG supported a new policy if evidence that this procedure was being carried out
Minor Skin Lesions (treatment of) - alternative treatments and settings should be considered	4	326	25-50%	Supported – note that procedures should not occur in any setting
Asymptomatic Gallstones	6	48	50-90%	Supported

Topic	Ref in ECI v.1.7.2	2015-16 case volume	Range of impact (Low-High %)	CRG comment
Circumcision	7	87	10-25%	Partial support – suggest change in wording to allow procedure in cases of interference with normal sexual activity
(Adeno) Tonsillectomy – Change to update to NICE guidance – changes to the evidence before referral for surgery	9.1	125	25-50%	Supported
Grommets – changes to adult criteria	9.2	60	25-50%	Supported
Varicose Veins	15.2	97	25-50%	Supported
Obstructive Sleep Apnoea in Adults (surgical)	12	3	10-25%	Supported
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	7 9	25-50%	Supported

Table 2 (below) includes the details of three additional changes, which have 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 and to reflect more up to date guidance. These three changes provide further detail to assist in the application of the policies.

Table 2

Topic	Proposed changes to existing policies	Rationale	CRG Comment
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 Merton and Richmond CCGs – to clarify the appropriate use of the technique based on new evidence.	Supported
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	Clarifying amendment proposed by Croydon CCG and reviewed by Merton and Richmond CCGs – to clarify the appropriate duration of conservative treatment before this treatment should be accessed.	Supported

Topic	Proposed changes to existing policies	Rationale	CRG Comment
	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.*		
Therapeutic facet joint injections/medial branch blocks	CCG will only commission a spinal facet joint injection (medial branch block) for lumbar pain where: • There is a reasonable clinical suspicion that the 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.	This addresses a gap – while Merton and Richmond CCGs had 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	Supported in principle: Requires pain management service review

Topic	Proposed changes to existing policies	Rationale	CRG Comment
		holistic approach to managing e.g. considering lifestyle measures.	

How we developed the proposals 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.

Merton, Richmond and Croydon CCGs have engaged with stakeholders across SW London over the last 6 months. Merton CCG has engaged with our stakeholders on these changes. As most are 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 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 and we thank our colleagues at Croydon and Richmond CCGs for facilitating this process. 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 December 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, Merton along with Croydon and 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 December 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. Merton 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.

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 Merton. For example the CCG commissions just over 1100 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.

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.

On-going engagement is a key way in which the CCG can demonstrate that it is talking to our stakeholders about the choices we need to make and the ways in which those choices can be fairly implemented.

Early discussion on the CCG's financial recovery plan (FRP) proposals led by the CCG's Chief Officer took place with members at a Healthwatch committee meeting and at the CCG's PPE group late last year.

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

What happens next?
Merton 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.

We anticipate a need to ensure that the communication of these changes will require the CCG to ensure that both the nature of the change and the suggested alternative treatment pathways are identified and that those services are accessible.