right care
right place
right time
right outcome

NHS
Merton
Clinical Commissioning Group

MERTON CLINICAL COMMISSIONING GROUP
GOVERNING BODY

Date of Meeting: 26th January 2017

Agenda No: 8.1 **Attachment:** 09

Title of Document: Update on clinical thresholds and policy changes	**Purpose of Report:** Decision/ review
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:	
Recommendation(s): That the governing body should: 1. Note the progress in developing an engagement plan for the on-going review of IVF 2. Discuss and decide on safeguards for IVF during the period of the review 3. Decide to adopt guidance for clinicians to help patients be more ready for surgery 4. 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.	
Committees which have previously discussed/agreed the report: Governing body considered an initial paper in public meeting in December, 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) See each proposal for further detail.

1. IVF Process update

In December Merton Clinical Commissioning Group's (MCCG) governing body received and approved a paper *"Review of IVF"* (The December IVF Paper). The December Paper built on the content of MCCG's Financial Recovery Plan (FRP). Based on the recommendations in that paper, MCCG decided to commence a review of IVF services. We have commenced engagement and expect to return to the governing body in March for a decision on whether or not to proceed through further consultation processes to make a change to the access criteria for IVF.

The governing body should note the following developments in IVF access across SWL since the December IVF Paper:

- Croydon CCG commenced an 8-week public consultation on moving IVF to an exceptions only basis on 4 January, which will conclude on 1 March 2017.
- Richmond CCG launched engagement on tightening access to IVF under the heading 'Choosing Wisely'. On 17th January Richmond CCG decided to commence formal consultation on applying tighter access criteria for IVF.

Between now and March, Merton will undertake considerable public engagement and will discuss the prospect of the change with the OSC, and will seek to understand how to reach some stakeholder groups that will help us to draw together a full equalities assessment.

We are going to use the engagement process to ensure that the public are able to help us to develop the specific form of our proposal.

Equalities – preliminary assessment (to be further developed before anticipated March decision to progress the options)

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 initial engagement and working with other SW London CCGs, but there are a number of issues which we need to consider in more detail for Merton during coming weeks that 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 engagement period in February and March, data from local providers and Individual Funding Request (IFR) team to understand if there are any particular groups at higher risk of gynaecological/ obstetric conditions which could impact on fertility. Early findings indicate that the issue with the highest potential impact are age, disability, race/ethnicity and socio-economic.

The number of people in the Merton population affected by this proposal is low: the NICE fertility guidance CG156 costing template predicts 193 people aged 18-39 in Merton 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:
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.

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

Disability:
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 conditions that can cause long-term infertility.

A key topic for engagement would be whether some of these issues would be encompassed within the safeguards or 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, or living with conditions that could benefit from early intervention and treatment.

A key area for the engagement 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. Reaching this group will be a key aim of our engagement.

2. IVF Safeguards during the review period

In December Merton Clinical Commissioning Group's (MCCG) governing body received and approved the December IVF Paper that built on the content of MCCG's Financial Recovery Plan (FRP). We have commenced engagement on the IVF issue and expect to return to the governing body in March for a decision on whether or not to proceed through further consultation processes to make a change to the access criteria for IVF.

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 and it is that Richmond will commence public consultation in February, following their decision on 17th January 2017.

Merton CCG recognises a number of risks which exist for the period of the review including a potential for an increased number of patients trying to seek access before the review concludes which would relatively disadvantage patients who might become eligible in future periods and a movement of patients from Croydon and Richmond if it appears likely that access at those CCGs will change access criteria in the near future.

It may therefore be prudent to put controls in place during the period of the review, that would last until the governing body sees the outcomes of the engagement or any future consultation and makes a final decision about the access criteria for IVF and specialised fertility (which could of course result in the CCG confirming the existing policy).

The proposal is that during the period of the review in to force, that all referrals for IVF are directed through the CCGs prior approval system and subject to the safeguards noted, do not proceed for IVF treatment until the review period is complete. Any referrals received by the Providers for IVF should not to be accepted for treatment and must be returned to the CCG. This reflects a decision made by Richmond CCG on 17 January 2017, which included the key clarification that referrals for fertility investigations should continue as usual, and the prior approvals process would apply to the IVF component of the pathway.

It is anticipated that the governing body would make a final decision on access criteria, after the formal consultation, and within a period of 6 months i.e. by the end of July 2017 (which would allow engagement to conclude, consultation material to be prepared, the maximum possible 90 day consultation period, 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.

The suggested text of a letter to providers is attached as Appendix 1 to this paper.

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 IVF 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. However patients who have been referred for infertility investigations, but have not yet commenced IVF would be subject to the pause.

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 and challenges to the proposed changes and any moves which pre-empt those changes.

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 15 patients per month – as the CCG currently funds less than 150 patients per year.

If the engagement, consultation and review concludes that no change should be made, there will be a backlog of patients waiting for IVF. 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 up to 6 months delay could further reduce the chances of success. If exceptional circumstances apply then the pause can be waived and this process will need to be governed by the CCG.

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 IVF 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 15 patients per month, but only to the same extent as all patients would be impacted by the eventual change.

3. Surgery Readiness Guidance

In December Merton Clinical Commissioning Group's (MCCG) governing body received and approved a paper *"Surgery Readiness Options"* (The December Surgery Readiness Paper). The paper suggested options for helping patients to be more ready for elective care and discussed whether the CCG should strictly enforce stop smoking and BMI pathways for the majority of elective care or make the policy for guidance only.

It is now our view, that following our work it is preferable not to pursue a threshold policy that 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 implication is that while the CCG will issue guidance to all clinicians which shows the benefits of helping patients to be more ready for surgery, encourages patients to understand the risks and take action, may require the CCG to increase access to relevant services and monitor the take-up rates and measure the change in patients fitness at the point of treatment, there will not be any new policy which directly prevents a patient gaining access to treatment. The CCGs position will be strong encouragement for patients to agree to improve their fitness and to consider, if necessary, choosing not to be referred until their fitness improves, or to undertake fitness improvement actions in the period between referral and treatment.

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
- a recognition that more data is required to justify a mandatory restriction and 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
- 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 and providing encouragement for appropriate patients undertake steps before being referred, or undertaking, elective procedures (subject to exceptions) and the CCG will monitor compliance with the guidance and actively address areas where there lower levels of take-up which could require:

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

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 engagement 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:

- Merton 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 Merton

  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 Merton.

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 public engagement 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 might 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 could be delayed from accessing elective surgery while they improve their Surgical Readiness and clinical judgement should be exercised in all cases. As noted in December, some procedures would 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. These limitations are less relevant while the policy is guidance only – the ultimate safeguard is clinical judgement and patient choice.

Patients who delay elective care 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.

4. 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)

Since the governing body meeting, the proposed policy changes have been drafted into the form of a marked up new version of the policies [Attached as a reference as Appendix 2]

The change 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

Of note are a number of changes that have been proposed by Croydon CCG, which were mentioned in December – in particular those additional changes relate to minor amendments to clarify policies in relation to:

1. Rhinoplasty
2. Pinnaplasty/Otoplasty
3. Dilatation & curettage (D&C) (within Obstetrics, Gynaecology & Reproduction)
4. Hysterectomy for heavy menstrual bleeding
5. Therapeutic facet joint injections/medial branch blocks

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 (see Appendix 2 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 % reduction 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 as a diagnostic and therapeutic treatment and that a stricter threshold should apply to the procedure	14.9	178	30-70%
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	475	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	154	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	170	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	187	25-50%

Topic	Ref in ECI v.1.7.2	2015-16 case volume	Range of impact (Low-High %)
Limit cataract surgery provision for second eye operations and update criteria.	10.3	1,165	10-20%
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	326	25-50%
Asymptomatic Gallstones	6	19	50-90%
Circumcision	7	87	10-25%
(Adeno) Tonsillectomy – Change to update to NICE guidance – changes to the evidence before referral for surgery	9.1	125	25-50%
Grommets – changes to adult criteria	9.2	60	25-50%
Varicose Veins	15.2	97	25-50%
Obstructive Sleep Apnoea in Adults (surgical)	12	3	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	 7 9	 25-50%

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
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.
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	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.

Topic	Proposed changes to existing policies	Rationale
	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 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.

Appendix 1 - DRAFT content of letter to IVF Providers

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.

MCCG'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 December , 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 IVF 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