# Update
# Commissioning Policy Harmonisation across Birmingham, Solihull & Black Country

Presentation to Birmingham and Solihull Health and Wellbeing Boards

May 2016

# What are Procedures of Lower Clinical Value (PLCV) ?

- PLCV as a term is nationally recognised in the NHS, but doesn't communicate well with clinicians or the public
- National evidence tells us that:
  - some procedures such as cosmetic surgery have low evidence of clinical necessity/effectiveness, but
  - other procedures such as hip replacements and cataract surgery that national evidence shows such procedures have a higher level of clinical necessity/effectiveness.
- National clinical evidence is continually changing and therefore NHS Commissioners must periodically review and update all their commissioning policies accordingly.
- And yes we need to find a better descriptor such as *'Clinical Treatment Policies' or 'Treatment Commissioning Policies'*

# Examples of Procedures of Lower Clinical Value (PLCV) ?

Procedures of lower clinical value (PLCV) cover a range of types of clinical treatments examples of which are:

- relatively ineffective (e.g. grommets and myringotomy, and certain spinal procedures for back pain)
- potentially cosmetic procedures
- effective, but where the balance between benefit and risk is close in mild cases (e.g. **cataract surgery and primary hip or knee replacement**)
- effective, but where other, cost-effective alternatives should be tried first (including hysterectomy for heavy menstrual bleeding)

# Why Are We Looking At Procedures of Lower Clinical Value (PLCV) ?

## Why are we looking at Procedures of Lower Clinical Value?

At the moment, the criteria for a core set of PLCV may vary between areas. This can cause differences in the availability of some procedures between areas. You may have heard this called "postcode lottery" in the media and it can cause frustrations for both patients and clinicians.

The CCGs across Birmingham and Solihull believe there should be a single, consistent core set of policies which is fairer to patients. General Practitioners (GPs) and CCG staff have been working with colleagues from the local councils and public health to review each of the policies to ensure they are in line with robust clinical evidence and national guidance.

# Background 1

- Variation in the content and implementation of clinical policies across CCGs can create a known and well-publicised risk to NHS Commissioners and frustration for patients and clinicians.
- The Clinical Chairs Network across Birmingham and Solihull CCGs agreed in Autumn 2013 to develop a single core set of around 20 commissioning policies. All 7 Bham, Solihull and Black Country CCGs engaged and participated in this process (although later in 2015 Dudley dis-engaged)
- These 'core policies' are also being adopted by 4 S Staffs CCGs
- Each CCG was requested to provide a commissioning lead and a clinician to participate in the working group. The backgrounds of members have included: GPs, Public Health, Medicines Management, Pathway Design, Contracting and Individual Funding Requests.

# Background 2

- Local provider economies such as HEFT or UHB or City and Sandwell have all operated more extensive PLCV policy suites over the last 3-5 years
- The core suite of proposed policies can be found operating across the whole of England by local CCGs and NHS England

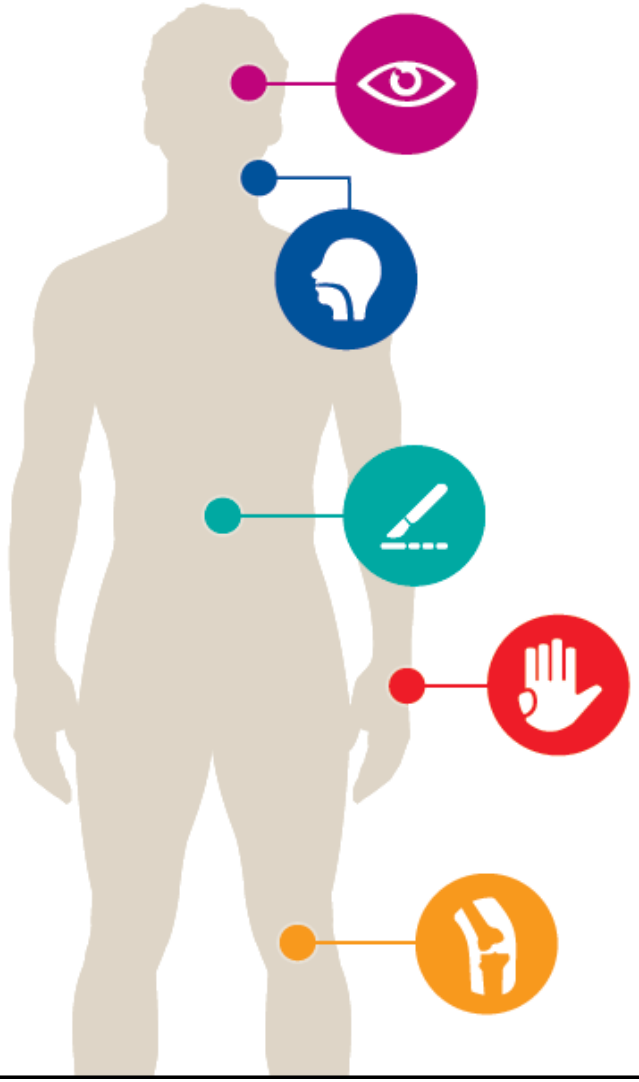
## Is this about **saving money?**

No. The quality of care given to patients is the most important factor for these policies, not money. The development of these policies will help to ensure the NHS offers treatments, which are in-line with the latest available evidence.

Whilst we believe that standardising policies across Birmingham and Solihull will help us to deliver a more efficient service, our main priority is for PLCV to be offered fairly and consistently across Birmingham and Solihull.

No procedures decommissioned, but some patients may not meet revised clinical eligibility for some treatments

# What Does This Mean For Patients ?



## What does this **mean for patients?**

By having one standardised core set of policies, all patients who may require a PLCV will have to meet the same criteria, wherever they live in Birmingham and Solihull. This ensures all patients are treated fairly.

There may be circumstances where a patient will no longer be able to receive a treatment, which they would previously been able to have. In these cases, the patient will be supported by their GP to consider the alternatives available to them, which may be of greater benefit.

The criteria for a core set of procedures will be the same, regardless of which GP the patient sees, or which hospital they attend across Birmingham or Solihull.

# Why Do We Have Commissioning Policies?

**Kings Fund – Delivering Better Value in the NHS (June 2015):**

- Unwarranted variations in provider clinical practice and health outcomes across the country
- This means some invasive treatments in the NHS are not needed.
- Tackling unwarranted variations could free up NHS resources to be used more clinically effectively locally.
- Unfortunately there is no national definition on which NHS services are of 'low(er) value'; as a result, various lists of potentially low(er)-value procedures have been drawn up NHS Commissioners across England (finding of Audit Commission in 2011).
- Despite this there is reasonable consensus of what procedures form part of a local set of Commissioning Policies across English NHS Commissioners.

# What Does Each Policy Detail?

- Policy will state whether procedure is:
  - **Not routinely commissioned**: would require an Individual Funding request to demonstrate clinical exceptionality
  - **Restricted:** only funded if particular clinical criteria / thresholds apply
- Which clinical procedure codes are covered by the policy
- Short summary explanation of what the procedure entails
- If 'Restricted' then what the clinical thresholds for treatment are.
- Summary of what clinical guidance commissioners have used to inform the detail of the commissioning policy, e.g. NICE, Royal Colleges or Other Clinical Associations
- Each policy is then subject to an Equality Impact Assessment review/report.

# Harmonisation Approach

- A joint working group established across Birmingham, Solihull and Black Country
- Representatives included GPs, Public Health, Medicines Management. Commissioning and clinical lead from each CCG
- List of 21 policies agreed for review (covering 45 procedures)
- Equality Impact Assessments for each policy
- Engagement with patients/public, interested clinicians and other bodies

# Aims of the Policy Review

- Fairness & equity for patients by removing the ‘postcode lottery’
- Clinically robust and national evidence based
- Efficiency – ensure we invest in treatments which are clinically proven and provide health benefit to patients

# Procedure Policy Scope

| Cosmetic Surgery Procedures | Other Procedures |
|---|---|
| • Abdominoplasty / Apronectomy<br>• Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat<br>• Liposuction<br>• Breast Augmentation<br>• Breast Reduction<br>• Breast Lift (Mastopexy)<br>• Inverted Nipple Correction<br>• Gynaecomastia (Male Breast Reduction)<br>• Labiaplasty<br>• Vaginoplasty<br>• Pinnaplasty<br>• Repair of Ear Lobes<br>• Rhinoplasty<br>• Face Lift or Brow Lift (Rhytidectomy)<br>• Hair Depilation (Hirsutism)<br>• Alopecia / Hair Loss<br>• Removal of Tattoos / Surgical correction of body piercings and correction of respective problems<br>• Removal of Lipomata<br>• Medical and Surgical Treatment of Scars and Keloids<br>• Botox Injection for the Ageing Face<br>• Viral Warts<br>• Thread / Telangiectasis / Reticular Veins<br>• Rhinophyma<br>• Other Cosmetic Procedures<br>• Revision of Previous Aesthetic Surgery Procedures | • Adenoidectomy<br>• Non Specific, Specific and Chronic Back Pain<br>• Botulinum Toxin for Hyperhidrosis<br>• **CATARACTS**<br>• Cholecystectomy for Asymptomatic Gallstones<br>• Male Circumcision<br>• Dilation and Curettage (D&C) for Menorrhagia<br>• Eyelid Surgery (Upper and Lower) – Blepharoplasty<br>• Ganglion<br>• Grommets<br>• Haemorrhoidectomy<br>• **HIP REPLACEMENT SURGERY**<br>• Hysterectomy for Heavy Menstrual Bleeding<br>• Hysteroscopy for Menorrhagia<br>• Groin Hernia Repair<br>• **KNEE REPLACEMENT SURGERY**<br>• Penile Implants<br>• Tonsillectomy<br>• Trigger Finger<br>• Varicose Veins<br>• Dupretren’s Disease |

# What Is The Scale of Activity Covered By The Harmonised Policies?

| Policy | Category | All Activity No's 2015/16 to Month 10 | | | | All Activity No's 2015/16 to Month 10 - Tariff Cost | |
|---|---|---|---|---|---|---|---|
| | | Bham | Solihull | Bham (%) | Solihull (%) | Bham | Solihull |
| **All Cosmetic Procedures** | | **15,865** | **6,012** | **72.5%** | **27.5%** | **£ 5,242,123** | **£ 1,994,714** |
| Adenoidectomy | Restricted | 250 | 25 | 90.9% | 9.1% | £291,041 | £31,058 |
| Non Specific, Specific and Chronic Back Pain | Restricted | 1,359 | 447 | 75.2% | 24.8% | £884,787 | £245,004 |
| Botulinum Toxin for Hyperhidrosis | Not routinely commissioned | 174 | 48 | 78.4% | 21.6% | £121,144 | £35,964 |
| Cataracts | Restricted | 5,246 | 1,928 | 73.1% | 26.9% | £3,421,093 | £1,195,211 |
| Cholecystectomy for Asymptomatic Gallstones | Not routinely commissioned | 750 | 188 | 80.0% | 20.0% | £1,619,571 | £363,710 |
| Male Circumcision | Restricted | 373 | 90 | 80.6% | 19.4% | £331,447 | £78,224 |
| Dilation and Curettage (D&C) for Menorrhagia | Not routinely commissioned | 342 | 189 | 64.4% | 35.6% | £105,471 | £63,277 |
| Eyelid Surgery (Upper and Lower) - Blepharoplasty | Restricted | 71 | 23 | 75.5% | 24.5% | £68,024 | £18,203 |
| Ganglion | Restricted | 114 | 24 | 82.6% | 17.4% | £114,631 | £26,131 |
| Groin Hernia Repair | Restricted | 822 | 234 | 77.8% | 22.2% | £1,013,215 | £297,804 |
| Grommets | Restricted | 469 | 86 | 84.5% | 15.5% | £377,152 | £71,374 |
| Haemorrhoidectomy | Restricted | 73 | 20 | 78.5% | 21.5% | £67,731 | £19,072 |
| Hip Replacement Surgery | Restricted | 998 | 414 | 70.7% | 29.3% | £6,372,311 | £2,622,383 |
| Hysterectomy for Heavy Menstrual Bleeding | Restricted | 128 | 41 | 75.7% | 24.3% | £360,604 | £115,371 |
| Hysteroscopy for Menorrhagia | Not routinely commissioned | 1,928 | 528 | 78.5% | 21.5% | £1,017,580 | £257,214 |
| Knee Replacement Surgery | Restricted | 1,132 | 397 | 74.0% | 26.0% | £7,577,861 | £2,732,721 |
| Penile Implants | Not routinely commissioned | 5 | 1 | 83.3% | 16.7% | £26,386 | £4,206 |
| Tonsillectomy | Restricted | 786 | 131 | 85.7% | 14.3% | £892,176 | £140,564 |
| Trigger Finger | Restricted | 39 | 14 | 73.6% | 26.4% | £37,776 | £12,360 |
| Varicose Veins | Restricted | 717 | 249 | 74.2% | 25.8% | £753,048 | £271,103 |
| **All Other Procure Policies** | | **15,776** | **5,077** | **75.7%** | **24.3%** | **£ 25,453,049** | **£ 8,600,954** |
| | | **31,641** | **11,089** | **74.0%** | **26.0%** | **30,695,172** | **10,595,668** |

# What are the changes for Birmingham & Solihull?

| Number of Policies | Explanation of Policy Change (If Any) |
|---|---|
| **47/47** | Procedure Policies – clinical evidence reviewed (NICE, Royal Colleges/Other Clinical Bodies) |
| **18/47** | Procedure Policies – No/limited changes |
| **10/47** | Procedure Policies – procedures changed to 'not routinely commissioned' |
| **3/47** | NEW Procedure Policies |
| **16/47** | Further evidence updates to clinical access criteria, but no change in policy categorisation (either 'restricted' or 'not routinely commissioned' |

# Engagement

Online survey and dedicated CCG website pages


- https://solihullccg.nhs.uk/get-involved/procedures-of-lower-clinical-value-survey
- http://bhamcrosscityccg.nhs.uk/get-involved/consultations-and-surveys/procedures-of-lower-clinical-value-survey
- http://bhamsouthcentralccg.nhs.uk/get-involved/procedures-of-lower-clinical-value-survey

# Engagement

- voluntary organisations/patient support groups/stakeholders such as MPs, councillors
- Two face to face public events

NHS Clinical Commissioning Groups (CCGs) in Birmingham and Solihull are asking for local people to comment on proposed changes to criteria affecting some procedures such as liposuction, cataracts surgery, hip and knee surgery and removal of tonsils. These procedures are referred to as Procedures of Lower Clinical Value (PLCV).

We are keen to meet with you and have arranged two events to provide the opportunity to find out more and share your views as part of the discussion focusing on three procedures – Cataracts, Hip and Knee surgery.

- **Wednesday 9 March**, 6.30-8.30pm, The Bond Centre, 180-182 Fazeley Street, Digbeth, Birmingham, B5 5SE - Book here
- **Thursday 10 March**, 5-7pm, Renewal Centre, Lode Lane, Solihull, B91 2JR - Book here

- Targeted engagement e.g. RNIB, Age Concern

# Engagement

We welcome your views and thank you for taking the time to provide feedback.

If you have any questions, or if you would like to discuss accessing this information in a different format or language, please contact us at Involvement.mlcsu@nhs.net or call: 0300 404 2999 Ext 6852. Standard call charges apply.

Take the survey

You can read more about PLCVs through the links below.

- Full policy document
- What has changed for each procedure
- Patient leaflet
- Equality Impact Assessments

- Patient leaflet and posters
- Social media
- Press releases

# Feedback from March Engagement Events in Bham & Solihull

- Policy criteria should take into account broader life factors impact
- Procedures classed as low value 'seem' to affect the elderly more
- Term 'low value' is inappropriate: not low value if you need it!
- Support the principle of evidence-based harmonised policies but should be nationwide
- What are the next group of treatment policies CCGs will develop?
- What is meant by 'cosmetic' in particular for children?
- Need to present policies in plain English that public understand
- Clinician/patient relationship important in deciding if a procedure should go ahead
- Suspicion that commissioning decisions will be made on cost grounds only
- More explanation needed on why these were considered 'low value'
- People reassured that harmonisation wasn't based on lowest common denominator e.g. cataracts policy
- People acknowledged that clinical practice changes over time e.g. hysterectomy, tonsillectomy
- Fairness as a principle supported but must ensure all GPs and Hospital Providers are following policies

# Feedback from March BSOL J-HOSC

| Recommendation | CCG Response to Date |
|---|---|
| Commissioners need to strengthen engagement and communication with the public around PLCV so that there is a clearer understanding of what this means in practice and demonstrates more clearly what the implications are likely to be. | Local CCGs see the February/March 2016 as the start of a wider process of Public Engagement as we start work on the second phase of harmonising local commissioning policies. This is therefore only a beginning, not the end. |
| GP/Primary Care need to be engaged as part development of new polices to enable the development of referral pathways | Local CCGs ensured that GPs were actively part of the policy process but are planning more regular engagement with each CCGs' Primary Care membership meetings in 2016 |
| Health and Wellbeing Board need to be involved in leading and having overview of these proposals. | Local CCGs through meeting with Bham & Solihull Health & Wellbeing Boards will seek views on the level of scrutiny and oversight HWBs believe is necessary and appropriate |
| That case study information and information in Plain English is more widely disseminated to the public about PLCV | Once we have the final draft of each policy with the help of patient panel reps we will start to work on 'Plain English' leaflets of each policy |
| That the Scrutiny Committee receives a final copy of the Consultation report. | A final draft is being prepared and will be share asap along with a 'You Said, We Did' document |
| That the Scrutiny Committee consider proposals for implementing PLCV at a future meeting (suggested date June 2016) with a focus on implications for service users. | We are awaiting confirmation from the J HOSC of a June or July date to update them. |

# Summary of Proposed Changes to Policies Being Considered Post-Engagement Period

| Policy | Proposed Changes |
|---|---|
| **Adenoidectomy**<br><br>**Grommets** | • New eligibility criteria for:<br>  • Children or adults with sleep disordered breathing/apnoea confirmed with sleep studies undergo procedure in line with recognised management of these conditions.<br>• Linkage between adenoidectomy and tonsillectomy removed.<br><br>• Clarification that this is 3-under 12 policy in line with NICE guidance and does not impact on clinically necessary grommet treatment for under 3s or over 12s.<br>• NICE CG60 does not include a requirement for '5 or more episodes of glue ear in a child before referral.' This requirement was included in the earlier SIGN CG66 therefore this particular criteria is removed from the draft policy. |
| **Breast augmentation/Breast reduction/Mastopexy/Inverted nipple** | For cancer patients potential psychological distress (lack of a clinically objective measure ) noted but concern about the risk of surgery on the non-cancer affected breast, plus consistency with the position of non-cancer patients. The term 'reconstructive surgery' which could include surgery on non-cancerous breast should be replaced with 'surgery on the affected breast'.<br><br>Public Health……*Feedback on link to public health issue of supporting successful breast feeding and obstacle of an inverted nipple.* |
| **Cataract Surgery** | Some recommend textual changes accepted. CCGs have retained the quantitative visual acuity threshold and the link to relatively subjective lifestyle factors until NICE publish their guideline for the diagnosis and management of cataracts in Summer 2017. |
| **Miscellaneous Cosmetic Surgery procedures** | Where these impacted on children (0-17) option remains to make an IFR application in 'exceptional' cases (including psychological issues). Estimate volumes of potential cases low. |
| **Back Pain** | Policy re-written to ensure clinical flow from primary/community to intermediate to secondary care stages ranging from conservative therapy management to actual invasive procedures. Clarifications re: impact of new ***draft*** NICE guidance and links to BSOL Spinal Surgery/Back Pain national pathfinder project. |

# Summary of Proposed Changes to Policies Being Considered Post-Engagement Period

| Policy | Proposed Changes |
|---|---|
| **Medical Circumcision** | CCGs believe current Medical Circumcision policy contains appropriate clinical criteria. However it agreed that individual CCGs were free to operate a supplementary local policy on Religious Circumcision if there Governing Body elected to. |
| **Eyelid Surgery (Upper and Lower) - Blepharoplasty** | RCS Paediatric guidance to be reviewed for children's threshold criteria. Seeking to engage BCH to support with the policy wording for this. |
| **Ganglion** | Having reviewed Orthopaedic Provider feedback access criteria for nerve conduction study removed while criteria added for:<br>1. painful lump causing disabling pain on activities of daily living and/or work;<br>2. Surgery for mucous cysts will be funded when causing distortion of nail growth and discharge predisposing to septic arthritis. |
| **Hip Replacement Surgery**<br>**Knee Replacement Surgery** | The BMI criteria was extensively reviewed. Conclusion was not sufficient or unequivocal evidence either to support/include or to not include a particular BMI for Hip replacement. Therefore criteria to have no set BMI while more strongly emphasising the need for surgeons/anaesthetists to carefully assess the clinical risk of surgery for higher BMI patients where the ASA score exceeds 2. Also insert new text into main policy suite introduction to emphasise the importance of engaging with local Lifestyle Management services. |
| **Groin Hernia Repair** | New eligibility criteria for:<br>• all patients with an overt or suspected inguinal hernia to a surgical provider except for patients with minimally symptomatic inguinal hernias who have significant comorbidity (ASA grade 3 or 4) AND do not want to have surgical repair (after appropriate information provided) |
| **Haemorrhoidectomy** | CCGs satisfied that the draft policy consistent with national guidance on treatment of rectal bleeding, but felt that it was necessary in the policy to make clearer the eligibility as follows:<br>• Minor text changes to confirm that pre-Haemorrhoidectomy recommended treatments such as Rubber Band Ligation and Injection of a Grade 1 or Grade 2 Haemorrhoid can still be undertaken in a clinic setting.<br>• For Grade 3 or 4 cases replace the term 'surgical treatment ' with 'Haemorrhoidectomy' |

# Summary of Proposed Changes to Policies Being Considered Post-Engagement Period

| Policy | Proposed Changes |
|---|---|
| **Penile Implants** | NICE has not published clinical guidance on Erectile Dysfunction (ED) in terms of clinical effectiveness, safety and tolerability and cost effectiveness of surgical treatments for ED, specifically penile prosthesis surgery. Commissioners will review and update this policy at that point but in the meantime will add the NHS England draft evidence review document web link to the Evidence section of the policy draft. |
| **Tonsillectomy** | A note will be added to the policy confirming that Walk in Centre or Out of Hours documented episodes that had been communicated in writing to GP Practices are included in the episode count. |
| **Varicose Veins** | The WG has re-reviewed NICE CG168 and agreed to:<br><br>• Remove reference to compression hosiery pre-surgical treatment as this is not part of NICE CG 168.<br>• Make more explicit the NICE recommended pre-surgical options.<br>• Emphasise that for patients who have 'varicose veins that have bled and are at risk of bleeding again' then they should be referred to secondary care immediately. |

# Next steps

| Date | Activity |
|---|---|
| **1 Feb – 14 March** | Engagement period (six weeks) including Public Meetings |
| **Late March - mid May** | Evaluation of survey results and report |
| **21st March to end of April** | Working Group reconvenes and considers engagement feedback. Where appropriate some policies may be revised |
| **24 March** | Discussion with Birmingham & Solihull Joint OSC |
| **Late May/early June** | Develop Governing Body paper and recommendations |
| **May - June** | Walsall and Sandwell and West Birmingham CCGs: additional consultation and briefing of their H&OSCs and Health and Wellbeing Boards |
| **May – June** | BSOL/Walsall/SWB/Wolves - Task and finish short life implementation group to undertake:<br>• Remaining Comms (RW BSC to summarise)<br>• Blueteq<br>• Final 'You Said…' response<br>• Joint response to RCS letter<br>• Actions from March J HOSC<br>• Updating/final proof reading of the Policy document |
| **June - July** | Present update to Solihull and Birmingham Health and Wellbeing Boards |
| **July TBC** | Present update to Birmingham and Solihull J HOSC |
| **June - August** | Birmingham, Black Country and Solihull CCGs Governing Bodies discuss/adopt new policies<br>• Birmingham CrossCity – July<br>• Birmingham South Central – July<br>• Solihull – start of August<br>• Sandwell and West Birmingham – TBC<br>• Walsall – TBC<br>• Wolverhampton - TBC |
| **July - August** | Public, Primary care, and provider next stage communications |
| **August - September** | Contract variations to include new harmonised policy suite in each local NHS and Independent Sector Acute contract across BBCSOL patch |

# In summary: key messages

- Services are not being decommissioned, but the criteria for accessing the services has been reviewed against latest clinical evidence
- Fairness through equitable access to consistent services across the patch, with fair decisions made based on a shared rationale and clinical evidence. Remove the ‘postcode lottery’
- Treatment policy development is not new for Birmingham and Solihull and is always continuous

# Thank You

Q&A