NHS Birmingham and Solihull and NHS Sandwell and West Birmingham Clinical Commissioning Groups

Clinical Treatment Policies

'YOU SAID, WE DID' SUMMARY REPORT

October 2018

Contents

Treatment Policies Clinical Development Group: YOU SAID – WE DID Report

Background

In July 2017 the three Birmingham and Solihull Clinical Commissioning Groups (now NHS Birmingham and Solihull CCG) established a Treatment Policies Clinical Development Group to oversee the review and development of a number of clinical policies. Membership of the TPCDG includes clinical and management stakeholders who have met monthly (2017-18) to discuss and assess Evidence Reviews and related draft policies. Membership has included representation from NHS Sandwell and West Birmingham Clinical Commissioning Group.

The Treatment Policies Clinical Development Group provides the required governance and oversight of the policy programme by:

- Providing direct clinical input and examination of nationally and, where appropriate, internationally available historic and more contemporary evidence research.
- Monitoring project planning, timelines and progress of all treatment policy areas.
- Initial engagement with a range of relevant stakeholders including local provider clinical subject matter experts, local politician members of the Birmingham and Solihull Councils' Joint Health and Oversight Committee and the Sandwell Council equivalent, and patient and public representatives.
- Ensuring the appropriate input, endorsement and sign off of the updated policies.

- Interconnecting with existing Birmingham and Solihull CCG Governance frameworks by submitting updated policies to the Clinical Policies Advisory Group (CPAG) and the Clinical Policies Quality Sub Committee.

Public and Clinical Engagement

A core element of the policy harmonisation programme has been the public and clinical consultation and engagement period. For a 6 week period (*May 14th – June 22nd 2018*) – Birmingham & Solihull and Sandwell Clinical Commissioning Groups undertook a clinical and public consultation exercise. The purpose of the engagement was both to share 22 DRAFT policies (and accompanying literature including DRAFT patient leaflet, Equality Impact Analyses and Evidence Review) and gather feedback on the proposals. Upon conclusion of the engagement period – a full summary report of the feedback was prepared and presented to the Treatment Policies Clinical Development Group (TPCDG) for their discussion and consideration. (The full summary report is available upon request)

Using the 7 commissioning principles to underpin their evaluation and consideration of the feedback – the TPCDG members assessed all the public and clinical feedback received and responded accordingly.

- CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment;
- CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment;
- The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor;
- CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment;
- CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community;
- CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance; and
- Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered.

The high level components of these discussions for each of the policies are set out below in the form of a 'You Said -We Did' report.

Policies with no clinical or public feedback

Seven of the 22 DRAFT policies received no clinical or public feedback engagement during the consultation.

The TPCDG members received presentations covering both the clinical and public engagement processes and expressed confidence in the engagement mechanisms and approach.

As a result the TPCDG members agreed that the following DRAFT policies would be endorsed in their current version and proceed to the next stage of CCG governance for sign off and implementation.

1. DRAFT Policy Treatment for Snoring
2. DRAFT Policy Painless Rectal Bleed
3. DRAFT Policy Lithotripsy/Renal Calculi
4. DRAFT Policy Breast Implant Revision
5. DRAFT Policy Reversal Male Sterilisation
6. DRAFT Policy Reversal Female Sterilisation
7. DRAFT Policy for the use of Upright / Open MRI Scanning

Policy: Carpal Tunnel Syndrome

You Said:

1. No public feedback received
2. Clinical Feedback - Clarification requested as to the appropriate location for undertaking Nerve Conduction Studies (NCS) (Primary or Secondary Care)
3. Clinical Feedback – queries and suggestions reference the appropriate management and process for reviewing revision/failed carpal tunnel procedures.

We Did:

1. Noted by TPCDG
2. Nerve conduction studies can be undertaken either by the GP or the secondary care provider. However, it was noted that if the GP is to request NCS, then this is a separate referral and so the patient will have to wait for this diagnostic test and then results and then be referred to the secondary care provider for assessment and management. If the patient is referred directly to the secondary care provider, then they can undertake the NCS at the assessment appointment in outpatients and reduce the wait time for the patient.
3. TPCDG agreed that revision surgery for failed carpal tunnel surgery needs due consideration. This will therefore be developed as a stand-alone policy (not an addendum to the current policy) and added to the Phase 3 of the Treatment Policy Harmonisation Programme which is due to commence in late 2018.

Policy Outcome

- **The draft policy is endorsed by the TPCDG and will proceed to the next stage of CCG governance for sign off and implementation.**

Policy: Arthroscopy Hip Surgery for Femoral Acetabular Impingement (FAI)

You Said:

1. These Policies seem to be in line with the current evidence and NICE guidelines. We are already following them.
2. Is it possible to involve and engage with the Local GPs so that the criteria and policies can be implemented at the GP referral level please.
3. Policy was discussed by the young adult hip MDT. Overall the group welcomed the draft proposals, are in agreement and supportive.
4. Of note the issue of an MDT was raised and that the requirements for an effective MDT needs to be specified. Recognise that the CCG may not be able to be too didactic around how the internal clinical business is run, it was felt that there is a need for a defined minimum requirement for MDT meeting (possible membership proposals were included)
5. In addition an important point to note is that the patients should be input onto the non-

arthroplasty hip registry. This ensures continued mid and long term monitoring of outcomes and is a driver for clinical effectiveness and quality. It is important to note that the study was not designed for cost effectiveness of FAI surgery.

6. Concerns were voiced about the proposal to limit availability of hip arthroscopy to provider trusts able to fully support patients with a multidisciplinary team due to the ability of some patients to then access such services.
7. The preferred choice of arthroscopic surgery over open surgery is perceived as limiting patient choice. One of the eligibility criteria for hip arthroscopy is that patients are offered choice of modality of surgery. However, the consultation document states that 'where surgery is considered appropriate following an assessment, an arthroscopic surgery should be promoted as the treatment of choice over open surgery'. It is difficult to see whether patients will be offered real choice when one method is being promoted over another.
8. Some people aren't suitable to have hip arthroscopy, some patients should have physio instead of arthroscopies. Anything that aids the patient's movement and it would help with patient isolation issues.
9. For instance, the hip arthroscopy policy aims to limit availability to provider trusts able to fully support patients with a multidisciplinary team. If services are then limited to particular locations, what plans are in place to ensure that all Birmingham residents regardless of location are able to access these services. Especially taking into consideration transport, parking, age of users and other issues that might affect those with lesser economic means or those that would have to rely on public transport.
10. Hip waiting list for Dudley is 4 weeks whereas Sandwell is 20-30 week, this needs reviewing.

We Did:

1. The CCGs welcomed the clinician support and feedback.
2. Birmingham and Solihull CCG & Sandwell and West Bromwich CCG have created a video which provides information for GPs regarding the proposed 22 new Treatment Policies. During the engagement period the DRAFT policies were highlighted to GPs.
3. The CCGs welcomed the clinical support and feedback.
4. The CCGs noted the request for specification regarding the requirements for an effective MDT, however it was felt that this would be difficult to mandate as this was within the remit of the provider organisations to ensure correct governance. However, the policy states that this should be a verifiable MDT and the CCG would request evidence of this from any providers undertaking this procedure.
5. The CCG agreed that for patient safety and monitoring of efficacy then it would be added to the policy that inputting patients into the non-arthroplasty hip register would be a requirement of a provider trust.
6. Limiting the availability of hip arthroscopy to certain provider trusts who are fully equipped to undertake this procedure has been made on the basis of patient safety. With this surgical intervention, ensuring that providers are fully resourced to support a patient undergoing such an invasive operation in the safest most clinically effective environment.
7. As stated in the policy, it is a preferred choice, not a mandated choice, the CCG have enabled a suitably qualitied clinician with the support of the MDT to have an individual conversation with each patient to ensure that a shared-decision making process is undertaken and the most appropriate plan of care is jointly made for that individual.
8. This is a reason why the CCG have commissioned only trust with a supporting MDT (surgeons; physiotherapists; radiographers; allied health professionals) to undertake these procedures so that following a referral a patient may be holistically assessed and the most appropriate plan of care made for that individual by appropriately qualified clinicians, which may be a plan for conservative treatment (physiotherapy, pain management etc) as opposed to surgery.
9. All provider trusts have to have parking and disabled access facilities in place. For patients

who do not drive and have mobility issues, then there is the option for patient transport for those who meet the eligibility criteria for this service.

10. Waiting lists are a constant challenge for provider trusts, ensuring that operating theatre time is used in the most efficient and effective manner enables these waiting times to be alleviated and ensuring that specialist clinicians can assess complex patients and undertake a shared –decision with the individual patient can ensure that operating theatre time is maximised and that surgeons' time is used in the most efficient manner.

Policy Outcome

- **The draft policy is endorsed by the TPCDG and will proceed to the next stage of CCG governance for sign off and implementation.**

Policy: Knee Arthroscopy for degenerative Knee Disease

You Said:

1. Public Feedback:
2. Knee arthroscopy should still be considered if pain control was unsuccessful and that further alternative treatments for knee arthroscopy in degenerative knee disease be explored.
3. If pain killers cannot limit the pain then this procedure of washing out joints eg: knees should be considered.
4. What is the cost and if inexpensive, why not still consider the procedure? If it even gives short term benefit then it should be considered.
5. Clinical evidence shows that it is not best practice as it does not always relieve for long periods of time but group still thinks it should be considered for some cases
6. Need to know how long it would last once a washout is done could determine whether it should still be considered.
7. For the policies that will no longer be funded, are there alternative treatments that should be considered. For instance the 'Knee Arthroscopy for Degenerative Knee Disease', are there other arthroscopy techniques that might be useful and be of benefit than arthroscopic debridement?
8. Can you outline how many patients would be affected by the proposed changes to each policy? For example, you propose to limit the availability of knee arthroscopy for degenerative knee disease. How many people have received a knee arthroscopy in the last year and how many of these patients would no longer be eligible under your proposed policy change? Is this in line with NICE guidelines?
9. Clinical Feedback - These Policies relating to T&O seem to be in line with the current evidence and NICE guidelines. We are already following them.
10. Is it possible to involve and engage with the Local GPs so that the criteria and policies can be implemented at the GP referral level please?
11. I've circulated to all the hip and knee surgeons at XXX but haven't received a single response. I guess we must assume that they are entirely happy with commissioning proposals.

We Did:

1. Noted by TPCDG
2. Items 2-7. Confirmation the policy is in line with NICE Guidance. Rather than revising the policy based on the request to keep the procedure – the public should have full information about the procedure so that they can understand the impact of post-surgical infections, repeat surgery, poor surgical outcomes, and limited/short-lived impact on pain/mobility, as well as increasing the risk/likelihood of needing an arthroscopy sooner than otherwise would have been the case.

3. Items 8 – the CCG have responded to the Birmingham MP with the information requested.
4. Items 9-11. TPCDG noted the feedback and flagged the engagement work undertaken with GP's (also noted that the referral communication can be a 2-way process with providers also communicating referral requirements with GP's)

Policy Outcome

- **The draft policy is endorsed by the TPCDG and will proceed to the next stage of CCG governance for sign off and implementation.**

Policy: Dupuytren's Contracture

You Said:

1. Is it possible to involve and engage with the Local GPs so that the criteria and policies can be implemented at the GP referral level pls?
2. These Policies relating to T&O seem to be in line with the current evidence and NICE guidelines. We are already following them. Dupuytren Injections which are also in line. However, we will strongly recommend that Blueteq is unnecessary.
3. P4 is inconsistent with the DD leaflet (at least it suggests that disease more severe than moderate disease can be treated). This has functional AND MCP AND PIPj OR 1st web contracture. I think it should be functional AND MCP OR PIPj OR 1st web contracture….Isolated PIPj contracture which causes functional problems should not be restricted from treatment – it is these contracture that are more difficult to manage than the isolated MCPjs. (Though I notice that the NICE guidelines state the former, this is not what is stated in your DD leaflet).
4. The NICE guidelines go into a fair bit of detail about PNF, and how it was not sure how a cord could be suitable for CCH but not PNF. I cannot see in the guidance anywhere that it does not think that PNF is appropriate. The recommendations 1.2 "…, CCH is recommended as an option …only if all of the following apply:….Percutaneous needle fasciotomy (PNF) is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon….." ie you can only use CCH if PNF is not considered appropriate. It isn't removing the possibility of using PNF. I speaks as a surgeon who doesn't use PNF as I have no experience of it, so I have no vested interest, but I cannot see why PNF is now not commissioned.
5. In response to the guidelines I think it just needs to be made clear that severe disease can be treated – in the first section it says 'at least moderate disease' then only includes moderate disease not 'at least' moderate disease the final section.
6. DD leaflet: page 2 …."any contracture…..(inter-phalangeal joint…)" I think this should be proximal inter-phalangeal joint. Is this leaflet for patients or clinicians. It seems too simple for clinicians and too complex for patients. There is a muddle between "patients should.." and "you". There are a lot of "often"s when I think "usually", "commonly", "frequently" or "normally" might read better. Recurrence is quoted at 40%, but it depends on when your end point is. 50% at 5 years is commonly quoted (probably cos it's easy to remember), but I suspect that practically all patients will experience recurrence or extension of their disease if they life long enough after intervention. However this recurrence doesn't always cause functional problems. There is inconsistency in the criteria. Page 2 top part says contracture 30-60… shouldn't it be a contracture of at least 30 degrees. After all a contracture of over 60 degrees would be eligible. But then at the bottom any contracture of the PIPj is eligible. Therefore what I think you mean is any contracture over 30 degrees at MCPj or any contracture of PIPj or symptomatic contracture of the first web space so long as it is causing functional problems. It seems from the leaflet that severe disease is not eligible for

treatment, which I am sure is not the case, but if it's only discussing DD management where the use of CCH is an option against surgery, then I guess that this is reasonable. CCH isn't really the correct thing to use in most severe cases.

We Did:

1. Birmingham and Solihull CCG & Sandwell and West Bromwich CCG have created a video which provides information for GPs regarding the proposed 22 new Treatment Policies. During the engagement period the DRAFT policies were highlighted to GPs.
2. The CCGs welcomed the clinical support and feedback and will forward the Blueteq feedback to contract managers.
3. This has functional AND MCP AND PIPj OR 1st web contracture. Has now been amended to: functional AND MCP OR PIPj OR 1st web contracture
4. National Institute for Health and Care Excellence (NICE) 2017 - Collagenase clostridium histolyticum for treating Dupuytren's contracture. Technology appraisal guidance # 459. TPCDG reviewed and revised the draft policy as per NICE guidance and specialist clinical steer.
5. TPCDG welcomed the clinical review and the policy wording was amended.
6. TPCDG welcomed the clinical review of the patient leaflet and amendments were made to simplify the leaflet for patients and ensure clinical continuity.

Policy Outcome

- **The draft policy is endorsed by the TPCDG and will proceed to the next stage of CCG governance for sign off and implementation.**

Policy: Management of Chronic Fatigue Syndrome/ME

You Said:

1. Public Feedback:
2. *Is it being put under the umbrella of a mental health condition?*
3. *Is it wasted money if someone is on a CBT programme when it's a mental health related condition?*
4. *Pathways need to be made more clear in the leaflet.*
5. Clinical Feedback
6. Queries raised about the referral pathway

We Did:

1. Noted by TPCDG
2. Items 2-5. TPCDG noted that the questions appeared to link to the location of where the current CFS/ME service is provided as the condition is not put under the umbrella of a mental health condition. All patient leaflets will undergo a final review for clarity before implementation.
3. Item 5-6. The Clinical Lead Nurse clarified the queries directly with the Neuropsychiatry department.

Policy Outcome

- **The draft policy is endorsed by the TPCDG and will proceed to the next stage of CCG governance for sign off and implementation.**

Policy: Port Wine Stain

You Said:

1. Public Feedback:
2. Some treatments such as port wine stain removal shouldn't be treated as cosmetic as it has a massive impact on the mental health and wellbeing of an individual, especially if they are young and in school therefore more likely to be teased or bullied for how they look.
3. What if a child that looks differently is bullied? The social stigma that comes with it and the long term effects of bulling might cost the NHS more than the actual treatment to reduce the birthmark.
4. This isn't a cosmetic treatment due to the potentially social stigma that comes with it.
5. Is the laser treatment not funded because it's generally linked to underlying treatments? It's not clear in the leaflet
6. What if it's a little boy? Men and boys don't like wearing make- up so the psychological effect could be huge. If laser can reduce how obvious the birth mark is then surely it should be used.
7. Comments received on the draft policy for port wine birthmark raised concerns on the psychological impact of not having laser treatment. It was felt that particularly for children, bullying could result and that offering only camouflage makeup when laser treatment could reduce the birthmark was inappropriate
8. Port Wine stains should be funded if in a visible place
9. It is cruel to refuse to treat all port wine stains - placement and severity should determine need.
10. Apart from port wine stain agree with all
11. Clinical Feedback
12. Main issue raised by the team discussing the document was if the policy applies to all ages and if the role of laser to treat Children with PWS had been scoped.

We Did:

1. Noted by TPCDG
2. Items 2-10. Members noted the mental health impact/concerns raised by the public – when a psychological condition is cited – then an IFR request can be made.
3. Item 11-12. Lead Clinical Nurse for the project responded to the query.

Policy Outcome

- **The draft policy is endorsed by the TPCDG and will proceed to the next stage of CCG governance for sign off and implementation.**

Policy: IVF/Assisted Conception

Policy: Provision of NHS funded Gamete Retrieval and Cryopreservation for the Preservation of Fertility

You Said:

1. No clinical feedback was received during the engagement period.
2. We note that assisted conception is now only limited to those under 40 years of age and that only one cycle of IVF will be funded. Although the age limit is in line with NICE guidelines, we note that the CCG has failed to adhere to NICE Guidance that recommends that up to three IVF cycles should be available on the NHS. According to NICE, the cumulative effect of three full cycles of IVF increases the chances of a successful pregnancy to 45-53%. Three IVF cycles are the most cost effective and clinically effective number for women under the age of 40. As a result of the CCGs plans, this will mean that only those who can afford to continue treatment privately will be able to do so. Thus the outcome for

those from poorer backgrounds will be worse off as they might not be able to afford private treatment.

3. We note that IVF treatment will not be offered to women over the age of 40 contrary to NICE guidance that recommends that women between 40 and 42 should have at least one IVF cycle.
4. It is not clear from the documents provided whether the change of eligibility age from 42 to 40 will be the same for patients under Birmingham South Central and Solihull CCG. As it seems from the document that the change only applies to patients under Cross City CCG. Unless this has been brought in line with the other two CCGs, having different eligibility ages under the same CCGs will lead to inequality in access to services and health outcomes.
5. We note that assisted conception is now only limited to those under 40 years of age and that only one cycle of IVF will be funded. Although the age limit is in line with NICE guidelines, we note that the CCG has failed to adhere to NICE Guidance that recommends that up to three IVF cycles should be available on the NHS. According to NICE, the cumulative effect of three full cycles of IVF increases the chances of a successful pregnancy to 45-53%. Three IVF cycles are the most cost effective and clinically effective number for women under the age of 40. As a result of the CCGs plans, this will mean that only those who can afford to continue treatment privately will be able to do so. Thus the outcome for those from poorer backgrounds will be worse off as they might not be able to afford private treatment.
6. The proposed restricted age limit for assisted conception was unfair to women who had suffered illnesses such as cancer, meaning they were unable to have children until they had recovered and subsequently received assisted conception treatment
7. I worked and became financially secure before I thought about having children. I wanted to buy a house by the time I was 40. I've done that. I'm 41 now, married and financially very secure so I'm ready to have a baby. I've done everything to prepare myself for the moment and now we're ready. However, we've been having problems trying to have a baby and we've now discovered that we are not covered on the NHS for IVF treatment. I'm 41 and will be 42 in a few weeks, so I'm already too old to be covered – although I might be if I was in the other area where it's currently up to 42 now.
8. If they're healthy then why not allow them to have IVF? Up to 45 would be ok but I supposed that would only be ok if you had some evidence that there was a chance of success at that age. But I suppose if you showed that you could prioritise to help younger people have a baby, if they had a better chance, then maybe that's a better thing.
9. We've had two rounds of IVF previously paid for by the NHS. We're now on our third and have to pay for it ourselves. I think that there should be no age at all. People want to get their homes and education first. They want to be fit and health, so they're leaving it later to have a child.
10. Even though the evidence is there about age it should be based on health rather that how old you are. Some people may be 40 but have a body age of 30.
11. Some of the statistics behind IVF treatment are misleading. The difference between a 30 year old conceiving through IVF and a 43 year old is very narrow.
12. The considered proposal for assisted conception was felt by some not to have considered modern lifestyles where women have children later in life.
13. I think that IVF should be fair across the whole country. I have a friend who has relocated in order to be offered three cycles of IVF. It doesn't seem fair that in some areas you are offered none at all.
14. Most people agreed that the assisted conception proposed policy in terms of age for treatment should be the same across the CCG geographical areas; some even felt it should be applied nationally to prevent a postcode lottery.
15. However, some people fed back their concern on access to treatment being based on age, it

was felt that the policy was unfair to same sex couples and feedback on future relationships when those bearing children had failed, other aspects of the proposed policy were discussed and comments made for consideration when final decisions were made.

16. Eligibility for assisted conception for same sex couples was raised as being unfair. Fairness and equality, particularly with regard to sexual orientation was raised several times.
17. Childlessness – Every relationship should be sacred. We should all have the choice as humans to have the chance to have a child. If you could still have a child naturally then why can't you have a child through IVF? I totally disagree with the idea that if you've already had a child in a previous relationship you can't try for a child in a new relationship. If you're in love and you have a bright future then why shouldn't you be offered the treatment?
18. Previous sterilisation – I think this is quite shocking and very unfair that you can't have IVF if you have been sterilised and it's then been reversed.
19. IVF isn't just about getting pregnant, it would also help ensure that you have a healthy baby and screen for any problems.
20. Contentious (regarding IVF) but where does it stop. Might be cruel and heartless but there needs to be rules behind it.

We Did:

1. TPCDG acknowledged the lack of clinical feedback, the policy was written with significant input from local clinical experts who had previously reviewed a number of drafts of the DRAFT policy document before it was release for engagement.

2.-12. TPCDG acknowledged the clarity which was required regarding the rationale for the age restrictions.

With regard to the current Birmingham and Solihull CCG, alignment was required as prior to the CCG merging in April 2018, the four CCGs (Birmingham Cross City CCG; Birmingham South central CCG; Solihull CCG & Sandwell & West Birmingham CCG) had differing age limits for IVF:

- Birmingham Cross City CCG : one cycle of IVF was funded for couples / single women who met all of the eligibility criteria up to the age of 42 years.
- Birmingham South Central CCG: one cycle of IVF was funded for couples / women who met all of the eligibility criteria up to the age of 40 years
- Solihull CCG: one cycle of IVF was funded for couples / women who met all of the eligibility criteria up to the age of 40 years
- Sandwell and West Birmingham CCG: one cycle of IVF was funded for couples / single women who met all of the eligibility criteria up to the age of 42 years.

Following the CCG merger, Birmingham and Solihull CCG drafted a policy following review of the clinical evidence:

- There is high quality evidence from the 2013 NICE Clinical Guideline, more recently published evidence and the HFEA, all of which confirm that increasing maternal age is a key predictor of failure to have a live birth following IVF treatment.

Maternal age	**Live birth rate per treatment cycle started using patients' fresh eggs in 2013 (%)**
All ages	26.5
18-34	32.8
35-37	29.5
38-39	21.8
40-42	13.7

Therefore, based on the clinical data, the CCGs wanted to align the age limit for access to funding for

one cycle of IVF treatment across the region of responsibility. This was based on enabling the largest number of women to have the greatest chance of a live birth within the financial resources available.

13. & 14. Birmingham and Solihull CCG and Sandwell & West Birmingham CCGs would welcome the introduction by NHS England of a national policy regarding IVF treatment in order to tackle the 'post code lottery' fudning issue currently evident with regard to this treatment. NHS England have recently released a consultation document for national treatment policies and as part of this feedback, the CCGs will recommend that NHS England develop a national policies regarding Assisted Conception and Gamete Retrieval and Cryopreservation.

15. & 16. The (CCG) will not provide routine funding for the medical treatment required to give effect to a surrogacy arrangement because: (a) this treatment is not considered by the CCG to be a priority for NHS investment, (b) the CCG is unlikely to be in a position to be able to reach an assessment as to whether the parties have concluded a lawful surrogacy arrangement, and (c) the CCG is concerned that the funding of such treatment raises substantial risks that NHS bodies and clinicians providing care connected to surrogacy arrangements would be exposed to unknown medico-legal risks. IVF treatment will not be provided as part of surrogacy arrangements.
For heterosexual couples, single women or women in same sex relationships, IVF is only available to those who are defined as clinically infertile. If clinical investigations so not show that a woman in a same-sex relationship is infertile, then she will have to demonstrate as a heterosexual couple would have to through the failure to conceive after regular unprotected sexual intercourse for a period of 2 years. Single women or women in a same sex relationship are asked to demonstrate infertility in the absence of known infertility through undertaking 6 rounds of self-funded donor insemination via IUI as this is the most clinically effective method of achieving a donor pregnancy.
17. The eligibility requirement for both partners to be childless, has been reviewed by the CCGs, with limited resources, the CCG hopes to enable through this policy that the greatest number of people will have the opportunity to become parents.
18. Sterilisation: before undergoing a sterilisation procedure, a patient will be advised that this is a permanent procedure and has a very low success rate of reversal and the patient will the outcome of the procedure will be that the patient will have no further chance of parenting a biological child. Therefore, a patient who has undergone sterilisation has made an informed decision to not have any further children. The NHS does not fund reversal of sterilisation and therefore will not fund IVF when a patient has been sterilised.
19. This policy reviews the eligibility criteria for funding for patients who have been demonstrated to be clinically infertile. With a successful pregnancy following IVF, screening for any foetal anomalies would then proceed in the same way as it would for any pregnancy along the NHS ante-natal care pathway. For patients who require **Pre-Implantation Genetic Diagnosis** (PiGD), this is not covered by this commissioning policy as it is the commissioning responsibility of NHS England. Patients should be referred to the Genetic Centre at Birmingham Women's & Children's Hospital.
20. TPCDG noted the feedback.

Policy Outcome

- **The draft policy is endorsed by the TPCDG and will proceed to the next stage of CCG governance for sign off and implementation.**

Policy: Acupuncture for Indications other than Back Pain

You Said:

1. Public Feedback:
2. **Question 4- Have you or a loved one had any experience of the procedures currently being**

proposed in the new draft harmonised treatment policies with RESTRICTED CRITERIA?

3. Acupuncture for Indications other than Back Pain 15.09% 8
4. No clinical feedback received

We Did:

1. Noted by TPCDG
2. No further clinical feedback received following the Headache Team at Royal Stoke Hospital (UHNM) having previously submitted information for the draft policy. Public feedback was non-specific for this policy. The policy is consistent with NICE.

Policy Outcome

- **The draft policy is endorsed by the TPCDG and will proceed to the next stage of CCG governance for sign off and implementation.**

Policy: Management of Ear Wax

You Said:

7. Just to say that the ear wax referral policy was discussed in ENT Quality Improvement Half Day Meeting last week and it was thought to be ok.
8. Thank you for sending me these documents to work with and address our secondary care service, they are most useful.
9. Error regarding contraindications in the patient leaflet highlighted.
10. Group discussion:
    - *The group listed variation between their practices on the removal of ear wax. Some patients had been offered this and other hadn't.*
    - *There are some GPs that did not know of a policy and sends them to a specialist therefore more money is spent – this needs to stop*
    - How do you make sure that GPs offer these services to patients in a consistent manner?
11. Questionnaire:
    - Question 4- Have you or a loved one had any experience of the procedures currently being proposed in the new draft harmonised treatment policies with RESTRICTED CRITERIA?
    - *The majority of those that answered (43.40%) had experienced procedures relating to Treatment for ear wax*
    - Question 5- Do you agree with the list of procedures that are proposed to be not normally funded?
      Ear Wax as this may lead to more problems
    - Question 6 - Do you think any of the proposed changes would have a negative impact on your care/ the care of your family/ any particular group of patients within the community?
      Yes. Nobody knows how or when they might develop such conditions or may need to reapply for treatment e.g. in my case, ear wax treatment.

We Did:

1.& 2. Clinical feedback was welcomed by the TPCDG.

3. Amendments will be made to the patient leaflet

4. 5. & 6. Birmingham and Solihull CCG and Sandwell and West Birmingham CCG are currently reviewing the commissioning arrangements regarding the management of ear wax in line with the newly drafted policy which reflects NICE Guidance 2018.

Policy Outcome

- **The draft policy is endorsed by the TPCDG and will proceed to the next stage of CCG governance for sign off and implementation.**

Policy: Management of Umbilical, Para-Umbilical and Incisional Hernias.

You Said:

1. The issue of wound infection after open hernia repair is complex and there is no clear guidance.
    - I have investigated this in my own clinical practice and have successfully reduced SSI (surgical site infection) in open hernia repair by over 80% ($p<0.05$) using a care bundle design as part of a Safety and Quality improvement project and integrated it integrated into the WHO checklist.
    - This was a pilot study and does not represent Level 1 (RCT) evidence but the results were so large that I feel I should share the case study because it suggests that open repairs can be done with acceptably low infection rates using a care bundle approach.
2. Comments on draft hernia policy and leaflet
    - Post-operative advice would be helpful. Needs to be on the flyer, for example; will symptoms come back, what to do if it does and how do they avoid return illness?
    - Doctors' communication is quite vague in surgeries and they have scored low. This needs to be addressed immediately to regain confidence with the patients.
3. Question 4- Have you or a loved one had any experience of the procedures currently being proposed in the new draft harmonised treatment policies with RESTRICTED CRITERIA?
   Management of Hernias 24.53% 13
4. Question 5- Do you agree with the list of procedures that are proposed to be not normally funded?
    - More detail required before I would say yes or no especially around management of hernia and hip arthroscopy.
    - In some cases the appearance of a hernia can affect daily life, it's not just about pain, walking, sleeping.
5. Question 7 - Do you agree with the list of procedures that are proposed to have restricted criteria?
   Not sure about changing hernia as husband needed it

We Did:

4. The TPCDG welcomed the clinical feedback, the proposed policy does not rule out open hernia repair, the proposed policy encourages clinicians to have am open shared decision making review of the individual patient's circumstances in order to ensure that the surgical method which is best suited to the patient is undertaken to enable the best possible outcome for that patient. The information received is extremely useful in supporting the clinician in offering a choice of surgical repair to the patient which best suits the patient and the surgical expertise of the clinician.
5. Post-operative advice will be given to the patient by the surgical team on discharge from hospital following the procedure being undertaken.
6. 4. & 5. The policy has been created to ensure that patients are able to access surgical repair of hernias in the safest circumstances. There will always be a very low clinical risk in undertaking a surgical procedure and so the need for surgery must out weigh this risk.

Policy Outcome

- **The draft policy is endorsed by the TPCDG and will proceed to the next stage of CCG governance for sign off and implementation.**

Policy: Complementary and Alternative Therapies

You Said:

1. Attached anecdotal and paper evidence from patients with regard to cupping and some research papers to support.
2. Indicated further anecdotal evidence for aromatherapy (which is extremely patient focused and is generating excellent outcomes) would be supplied but was not received during engagement period.
3. *I'm emailing you my testimony of the benefits of cupping as requested. After having ACDF and fusion surgery of C3/4 on my spine in October 2016 I was referred to XXXX for physiotherapy. After several sessions XXXX suggested trying cupping on my neck as i have suffered severe pain and stiffness to my neck area since the surgery. Following the cupping sessions I have experienced some relief in the stiffness of the neck and a reduction of the intensity of the headaches. During the sessions I experience relaxation of the muscles in my neck and shoulders. The cupping used alongside my medication has made a marked difference in the intensity of my symptoms and gives me some relief from the pain and stiffness.*
4. *I am currently undergoing a course of cupping at XXXX Trust. When it was first suggested as a treatment option, I said no as I didn't realise that cupping was under the acupuncture umbrella. As I am needle phobic, I know that I wouldn't be able to tolerate needles and it was not an option I could consider. Luckily my physiotherapist has been trained in cupping and as I know it's non-invasive I said yes. On my second session I had woken with a cricked neck and after having my cupping session I had immediate relief and the tight muscles had reduced significantly afterwards. I am now half way through my treatment plan and would highly recommend cupping to anyone as it's not painful, non-invasive, cost effective and very effective. I have worked in the NHS for 17 years and I know that costing is a major factor in developing and implementing packages of care, this ancient art of cupping stands alone as once you have the cupping equipment you don't need extra supplies, such as single use only equipment, thus reducing storage requirements, by not ordering equipment and using cupping more within the physiotherapy department you are reducing your carbon foot print, thus making it cost effective. However as a patient myself I much prefer a holistic approach to patient care which is very important to me. Overall I feel extremely luckily that I was paired with the right physiotherapist who was trained in cupping enabling me to gain more movement in my neck and reduce pins and needles in my hands after being told I could have surgery but there was not a guarantee it would work, so for me cupping has been very beneficial.*
5. *just wanted to write a testimony about the cupping therapy XXXX is having with you. As you know X has pots syndrome & suffers with chronic pain in the back , shoulders & neck. X is definitely feeling the benefits of the cupping therapy, her shoulders, back & neck feel lighter & less knotted up & tight after a session. I really hope X can carry on with these cupping therapy sessions.*
6. *Any relieve from pain for a period, is helpful as there is nothing worse than being in chronic pain as well as all X symptoms especially for a child it's heart-breaking to see X suffering so*

much.

7. *I have been seeing XXXX since March 2018 to help manage my pain in my neck & shoulders. X has been using a acupuncture technique named cupping to help manage and reduce the pain. After my physiotherapy sessions with X my neck pain is lighter and the pain is reduced by 30/40%. I am a holistic been who believes in traditional natural remedies. I am person centred and believe this cupping technique is really aiding me.*
8. *Members of the public asked for the benefits of such therapies to be further considered, for example in cases of mental health illness, children's diseases such as Potts syndrome, neck and back pain and Parkinson's diseases If alternative pain relief has been tried and hasn't worked then if the patient prefers they should be allowed to go with Acupuncture. Electrical impulse is also used, if in-effective then patient should be offered alternatives such as acupuncture. There should be evidence that shows this procedure is clinically proven to work. The leaflet should explain why these therapies are not offered as some of them definitely have benefits to patients*
9. *Hypnotherapy/Yoga; at least one person felt that it was positive so they should still be considered. If you are a practitioner can you offer this; can there be clarity? Also, is there evidence that Yoga/Hypnotherapy works for mental health patients – will this still be offered in special cases?*
10. *The CCG is funding for dance therapy to help elderly eg: Parkinson. What evidence was done to stop this funding?*
11. *Tai Chi is very good and is not on the list; is this still being supported. It's great for balance for older people. More clarity required as to why these have been stopped.*
12. *Art therapy being stopped is contentious due to the positive outcomes that there has been seen in social prescribing, particularly with mental health patients and maybe palliative care.*
13. *Acupuncture worked extremely well for one patient. Her operation scar hasn't hurt since she had the acupuncture treatment.*
14. *What is the clinical effectiveness of these treatments? Might not be great but from a holistic and wellbeing point of view, might not be the right way to look at these policies. Don't just look at policies through a hard clinical point of view.*
15. *Interventions are just as important as policies. Is there evidence that shows that some of these therapies prevent others?*

We Did:

7. The TPCDG welcomes the feedback and supporting clinical papers which were reviewed by Public health colleagues. The submitted clinical papers were of an evidential grade which did not support the use of NHS resources.
8. – 15.Anecdotal information was supplied regarding cupping; acupuncture; electrical impulse; hypnotherapy; yoga; Tai Chi. Acupuncture is not part of the complementary and alternative therapies policy, a separate policy has been developed in relation to the use of acupuncture, which enables a course of acupuncture to be funded in certain clinical circumstances. With regard to the other interventions mentioned above, there was insufficient evidence found by the initial evidence review or submitted in the engagement phase to warrant the use of NHS resources to fund these interventions.

Policy Outcome

- **The draft policy is endorsed by the TPCDG and will proceed to the next stage of CCG governance for sign off and implementation.**

Policy: Vasectomy

You Said:

1. Draft policy for vasectomy. We have read through – it looks comprehensive and accurate. Nothing to edit or add here.
2. EIA and patient leaflet – edits and suggestions made for the content.
3. *I think that counselling should be in place before somebody has a vasectomy because things and people change in the future.*

We Did:

9. TPCDG welcomed the clinical feedback regarding the assessment of the draft policy and thanked the clinicians for taking the time to review the draft.
10. The comments and suggestions regarding the patient leaflet and EIA were also welcomed and will be reviewed and amendments made as required.
11. As outlined in the policy and the service specification for the vasectomy services across Birmingham and Solihull CCG and Sandwell & West Birmingham CCG, counselling is a mandatory requirement prior to a vasectomy procedure being undertaken.

Policy Outcome

- **The draft policy is endorsed by the TPCDG and will proceed to the next stage of CCG governance for sign off and implementation.**

Policy: Asymptomatic & Symptomatic Bunions

You Said:

1. These Policies relating to T&O seem to be in line with the current evidence and NICE guidelines. We are already following them. New ones are about Bunion surgery & Dupuytren Injections, which are also in line
2. Is it possible to involve and engage with the Local GPs so that the criteria and policies can be implemented at the GP referral level pls?
3. Patient experience of having problems with bunions. He went for an x-ray and then then had to wait for next steps. Told to self-care first before going through with any type of operation but was in pain in the meantime.

We Did:

12. The TPCDG welcomed the clinical review and feedback regarding the policy and thanked the clinicians for their time. Birmingham and Solihull CCG and Sandwell and west Birmingham CCG are currently redesigning the Musculoskeletal Triage Services and all referrals from primary and secondary care will in the future be reviewed through this service to ensure that patients meet the policy criteria before being referred to secondary care services.
13. The TPCDG will forward the Blueteq feedback to contract managers.
14. The pathway which the patient outlined is in line with National Guidance regarding the management of bunions. If a patient is in pain, then he/she should visit their GP for a review regarding their pain relief requirements.

Policy Outcome

- **The draft policy is endorsed by the TPCDG and will proceed to the next stage of CCG**

governance for sign off and implementation.