Midlands and Lancashire Commissioning Support Unit

NHS Halton Clinical Commissioning Group
NHS Knowsley Clinical Commissioning Group
NHS Liverpool Clinical Commissioning Group
NHS St Helens Clinical Commissioning Group
NHS South Sefton Clinical Commissioning Group
NHS Southport and Formby Clinical Commissioning Group
NHS Warrington Clinical Commissioning Group

Collaborative Policy Development Project: Governing Body paper seeking sign off of all policies reviewed to date, ahead of implementation with Providers

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Executive Summary

The purpose of this paper is to support Clinical Commissioning Group (CCG) Governing Bodies with their processes to agree and sign off the policies in the current *Cheshire and Merseyside Procedures of Lower Clinical Priority (PLCP) and Fertility policy 2014/15* that have been through a process to review and update the procedures and treatments listed within the policy, which is being project managed by Midlands and Lancashire Commissioning Support Unit (MLCSU).

The project is being managed on behalf of 7 CCGs and following just over a year of work, CCGs are now in a position to implement 42 reviewed and updated policies with providers. This paper outlines the background to the project and the process that has been followed in order to review and engage on the proposed changes with both clinicians and the public. The paper also demonstrates the decisions that have been taken by the Project Working Group throughout the journey for each policy and the key decisions that were taken in November 2017 following extensive work from an equality and engagement perspective to understand how certain changes may impact on clinicians, patients and the public.

CCG Governing Bodies are asked to agree and sign off the policies that have been developed so that formal notification can be sent to providers, allowing all reviewed policies to be issued in February 2018.

Background to the Project

Since September 2016 MLCSU and seven Merseyside and Warrington Clinical Commissioning Groups have been working collaboratively to review the procedures and treatments listed in the current *Cheshire and Merseyside Procedures of Lower Clinical Priority (PLCP) and Fertility policy 2014/15* and develop new policies as directed by the CCGs. The review has been undertaken as part of policy harmonisation for the CCGs involved.

For clarity, the current suite of policies available requires updating. This project is part of a regular review of policies that was due to take place in 2015; however this was delayed due to organisational change within Commissioning Support Units. There are over 100 policies that require review and possible update.

MLCSU has implemented a Policy Development team to review and update clinical policies with the aim of minimising postcode variations to commissioning across CCGs involved by having a single local clinical policy. This service specification is more cost effective because it is delivered at scale for all 7 CCGs.

CCGs engaged in the Project

CCGs engaged in the Policy Development Project are:

- Halton CCG
- Knowsley CCG
- Liverpool CCG
- St Helens CCG
- South Sefton CCG
- Southport and Formby CCG
- Warrington CCG

The process

The process for reviewing each policy has been as follows:

1. At the start of each phase in the project the views of the Working Group were sought, to determine which policies they wish to see progressed within that stage. Decision making here has been supported by analysis of activity and costs via SUS and Aristotle to determine high cost and activity procedures to focus on in the early stages of the project.

2. Policies for review have been shared with the MLCSU IFR Panel for their initial clinical input and this has included input from Public Health and Medicines Management experts.

3. Any suggested amendments made by the IFR panel are then circulated to the Virtual Clinical Forum (VCF) which is made up of representative GPs from the participating CCGs. The Forum has provided comments and suggestions in light of the feedback received from the IFR panel. At this stage an initial draft for each policy has been created by the Project Team.

4. Initial drafts have been taken to the PDP Working Group for review. The Working Group has also identified where specialist input may be required and if this is the case it is sourced by the Project Team, for example, the cataracts policy and the suite of back pain policies.

5. Once the Working Group were content with the revised draft proposals they were then shared by CCG Commissioning Leads with their CCG GP leads and Secondary Care Providers. This was not a form of public communications and engagement, as it was carried out separately. Following GP and secondary care feedback, was discussed with the Working Group and any necessary further amendments were made.

6. Once the Working Group was content with the revised draft proposals they were then shared with the public for communications and engagement work to take place. This engagement was determined by the level of change to the criteria between the original and proposed new draft of each policy, where three levels of engagement were identified and the appropriate level applied to each policy. Each policy was RAG rated, with Red rated policies containing elements of change that will affect patient access to that treatment. Green rated policies have not required any form of engagement.

7. The Governing Bodies for each CCG have previously been sighted on all policies and the proposed change and RAG rating.

8. Equality Impact and Risk Assessments (EIRA) have been completed on every policy and these have been progressed alongside the policies as they were being developed by the Project Team.

9. Legal advice has not been required against any of the policies in suites 1 and 2 and this has been determined via discussion with the PDP Working Group and input from the CCGs Communications Leads who have also been involved in the project.

10. Please be aware, a slightly different process was followed for the back pain policies as described at points 2 and 3 above. These policies were developed by working jointly with colleagues at the Walton Centre to align our proposed policies with the National Back Pain pathway that is being implemented in the region. Once the proposals were drafted, they were shared with the IFR Panel, the VCF and the Working Group for feedback before re-entering the process described at point 5 above.

How has each policy in suites 1 and 2 been developed?

Each policy has developed via the process described at page 2 above. Appendix 1 demonstrates the decisions taken against each policy and where, by whom and on what date the decision was taken to propose the change. This also includes the rationale for the decision. Given the extensive discussions held for each policy and the robust nature of the process we have followed, we have summarised all outcomes in the appendices. The minutes of each meeting and agreements made have been recorded and can be made available.

Suites 1 and 2 followed two distinct timescales. All policies in suite 1 were developed between September 2016 and January 2017. Given the low number of red rated policies in this suite, and the anticipated period of purdah that was due to take place from 27th March, the Working Group took the decision to move forward with the review of the policies in suite 2. It was anticipated that there would be a larger number of red rated policies in this suite because the focus for this suite was on cosmetic procedures. What was not anticipated was the snap general election that was called and extended the purdah period. We worked on the suite 2 policies between late January and mid-April.

At this point, to maintain momentum whilst we awaited the end of the purdah period, the project team also began a rapid review of 16 further back pain policies (not originally included in suites 1 or 2) working collaboratively with the Walton Centre due to their involvement with the National Back Pain Pathway. This work was completed during May 2017, in time for the beginning of the engagement period on the suites 1 and 2 red policies which started on 26th June and closed on the 18th September 2017.

The report of findings was then produced throughout October 2017 and issues coming out of the Communications and Engagement work and EIRA work were brought to the Working Group in November for discussion and decision. This is explained in more detail on pages 11 to 13.

Which Policies require CCG GB sign off?

All policies from suites 1 and 2 of the project now require final CCG Governing Body sign off. The following table summarises which policies went to engagement (Red) and those where this was not required (green) and provides a brief summary of changes for each red policy. Further detail can be found in Appendix 2:

Policy name	Suite	What has changed?
Policy Introduction	n/a	The introduction to the policy has been shortened to make it more succinct and more straightforward. The key issue to note here is the removal of the line saying the children under 16 can be eligible for certain cosmetic treatments for psychological reasons. This is explored in detail at page 11.
1. Policy for Surgical Treatments for Minor Skin Lesions	1	Statement stating the exemption of children from these policies, meaning children under 16 has been removed and therefore, will no longer be able to have surgery for Minor Skin Lesions due to cosmetic or psychological reasons. Specific criteria for this procedure have been clarified.
2. Rhinoplasty	1	Sentence stating the exemption of children from these policies has been removed; meaning children under 16 will no longer be able to have surgery for Rhinoplasty due to cosmetic or psychological reasons. Specific criteria for this procedure have been clarified.
3. Surgical removal of Lipoma	1	Not routinely commissioned. Lipoma's will be removed in cases where function of patient is inhibited but not for cosmetic or psychological reasons Policy will now also apply to children under 16 - specifically, psychological distress being removed. Statement referring to policies not applying to children under 16 has been removed in line with other policies.
4. Haemorrhoidectomy - Rectal Surgery & Removal of Haemorrhoidal Skin Tags	1	Removal of Grade 1 and 2 from surgery. This is clinically justified due to simple non-surgical treatments being available for these grades.
5. Policy for Hair Removal Treatments including Depilation, Laser Treatment or Electrolysis – for Hirsutism	1	Treatment criteria has been limited to only include; • Has undergone reconstructive surgery leading to abnormally located hair-bearing skin OR • Is undergoing treatment for pilonidal sinuses to reduce recurrence • All other criteria have been removed for clarity.
6. Surgical Revision of Scars	1	The following more specific criteria has been outlined: • For severe post burn cases or severe traumatic scarring OR • Revision surgery for scars following complications of surgery, keloid formation or other hypertrophic scar formation will only be commissioned where they are significantly functionally disabling or to restore normal function • The statement at the start of each policy, referencing cosmetic or Psychological problems, will not be included as a reason for surgery to take place. This is inclusive of both adults and children.
7. Cataracts Policy	1	The referral criteria has been reviewed and made less ambiguous for clinicians to refer. Additionally, more specific examples of what constitutes as 'quality of life' has been included in the policy to support appropriate referrals.
8. Removal or Replacement of Silicone Implants	2	The criteria for this operation now reflects the public health guidance, which outlines that for implants which have been inserted outside of the NHS, but have defected, the patient must seek advice from the original provider and only in the case of the implants failing and the original provider not being available or refusing to help, will breast implants be removed by the NHS.

Policy name	Suite	What has changed?
9. Male Breast Reduction Surgery for Gynaecomastia	2	The position of this policy has not changed and remains 'not routinely commissioned' however, it was previously written in a way which implied that the procedure was available under certain criteria.
10.Laser Tattoo Removal	2	The position of this policy has not changed and remains 'not routinely commissioned' however, it was previously written in a way which implied that the procedure was available under certain criteria.
11.Apronectomy or Abdominoplasty	2	The position of this policy has not changed and remains 'not routinely commissioned' however, it was previously written in a way which implied that the procedure was available under certain criteria.
12.Other Skin Excisions, Body Contouring Surgery	2	The position of this policy has not changed and remains 'not routinely commissioned' however, it was previously written in a way which implied that the procedure was available under certain criteria.
13.Surgical Treatments for Hair Loss	2	The differences in this policy are as follows: • the title of the policy has been clarified as 'Surgical Treatments for hair loss' • the proposed position for treatments to correct alopecia is that these are no longer commissioned • the proposed position for hair transplantation is that these are no longer commissioned • under the current commissioning policy, there are separate entries for Treatments to Correct Hair Loss for Alopecia, Hair Transplantation and Treatments to Correct Male Pattern Baldness so these have all been merged into one policy statement • clarity around access to wigs via the NHS has been included
14.Rhytidectomy - Face or Brow Lift	2	The criteria has been laid out more clearly and the following criteria have been removed: • To correct the consequences of trauma OR • For significant deformity following corrective surgery. However funding will not be approved to improve previous cosmetic surgery. In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity.
15.Circumcision	2	For Liverpool CCG, this procedure will no longer be available cultural and religious reasons. There is also a change to the criteria regarding pain on arousal as being a clinical reason to require the surgery. The addition of these criteria improves access to this procedure.
16.Pinnaplasty	2	Changing from set criteria to not routinely commissioned. Patients may apply for this procedure via an IFR. Removal of statement making children exempt from policy which means children under 16 will no longer be able to have a Pinnaplasty procedure for cosmetic or psychological reasons.
17.Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias and Surgical correction of Diastasis of the Recti	1	No change
18.Surgery for Asymptomatic Gallstones	1	No change
19.Dilatation and Curettage	1	No change

Policy name	Suite	What has changed?
20.Policy for Private Mental Health Care- Non-NHS Commissioned Services: including Psychotherapy, adult eating disorders, general in-patient care, post-traumatic stress, adolescent mental health	1	No change
21.Policy for Hyaluronic Acid and Derivatives Injections for Peripheral joint pain	1	No change
22.Hip Replacement Surgery	1	No change
23.Knee Replacement Surgery	1	No change
24.Surgical Removal of Ganglions	1	No change
25.Adenoidectomy	1	No change
26.Policy for Tonsillectomy for recurrent Tonsillitis (excluding peri-tonsillar abscess) Adults and Children	1	No change
27.Hysterectomy for Heavy Menstrual Bleeding	1	No change
28.Varicose Veins Treatments	1	No change
29.Reduction Mammoplasty	2	This procedure went out to engagement as a red rated policy because it was proposed that the age criteria for this treatment increased from 18 to 21. However, following feedback from the EIRA and communication and engagement work as well as a lack of clinical evidence that could be cited to justify this change, the proposed change in the age criteria has been withdrawn and will remain at 18.
30.Breast Enlargement	2	This procedure went out to engagement as a red rated policy because it was proposed that the age criteria for this treatment increased from 18 to 21. However, following feedback from the EIRA and communication and engagement work as well as a lack of clinical evidence that could be cited to justify this change, the proposed change in the age criteria has been withdrawn and will remain at 18. There has also been a clarification around congenital absence (the obvious lack of breast tissue that is evident from birth) criteria which states there must be congenital absence with a difference of three cup sizes.
31.Mastopexy - Breast Lift	2	No change
32.Surgical Correction of Nipple Inversion	2	No change
33.Surgical Treatment for Pigeon Chest	2	No change
34.Labiaplasty, Vaginoplasty and Hymenorrhaphy	2	No change
35.Liposuction	2	No change
36.Policy for non-invasive interventions for low Back pain and sciatica	2	Aligned with the National Back Pain Pathway and NG 59.
37.Imaging for patients presenting with back pain.	2	Aligned with the National Back Pain Pathway and NG 59.

Policy name	Suite	What has changed?
38.Injections for back pain	2	Aligned with the National Back Pain Pathway and NG 59. *(Incorporating the previous policies for Facet Joint - Non Specific Back Pain Over 12 Months including radio frequency ablation, Epidural Injection, Radiofrequency Facet Joint Denervation Intra Discal Electro Thermal Annuloplasty (IDET) Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT) Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS))*
39.Spinal Fusion	2	Aligned with the National Back Pain Pathway and NG 59. *(Incorporating the previous policies for fusion,Non-Rigid Stabilisation Techniques,Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine and Transaxial Interbody Lumbosacral Fusion)*
40.Disc and Decompression procedures	2	Aligned with the National Back Pain Pathway and NG 59. *(Incorporating the previous policies for Endoscopic Laser Foraminoplasty, Endoscopic Lumbar Decompression, Percutaneous Disc Decompression using Coblation for Lower Back Pain, Percutaneous Intradiscal Laser Ablation in the Lumbar Spine, Automated Percutaneous Mechanical Lumbar Discectomy and Prosthetic Intervertebral Disc Replacement in the Lumbar Spine)*
41.Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain	2	Aligned with the National Back Pain Pathway and NG 59.
42.Therapeutic Endoscopic Division of Epidural Adhesions	2	Aligned with the National Back Pain Pathway and NG 59.

Decisions taken by the Policy Development Working Group following communications and engagement and Equality Impact and Risk Assessment (EIRA) work

Following the production of the report of findings from the communications and engagement work, the Project team analysed all issues raised through both these elements of the project and called a meeting of the Working Group on 16th November 2017. There were **two** issues that required Commissioning Lead discussion and decision:

1. Increasing the age criteria on the Breast related policies from 18 to 21.

As noted previously, a proposed amendment to the policies for Breast Augmentation and Reduction was to change the age criteria from 18 to 21. The project team and Public Health and GP colleagues were unable to find any evidence to support the suggestion that a womans physiological and hormonal development is more advanced at 21 so the following options were outlined for CCGs:

Option 1	**Option 2**	**Option 3**
Keep the age criteria as they are (18+) No clinical evidence can be sourced that supports this criteria:	Implement the age change in criteria without evidence (21+) No clinical evidence can be sourced that supports this line:	Implement the age change in criteria without evidence but cite that this is the case, therefore suggesting the policies are reviewed for impact after 12 months, taking into account activity, complaints, FOIs, PALs, SARs requests etc. No clinical evidence can be sourced that supports this line
IMPACT OF IMPLEMENTING OPTION 1: No impact will be seen here	**IMPACT OF IMPLEMENTING OPTION 2:** Activity and costs are likely to reduce however, CCGs may be open to legal challenge given that there is no clinical evidence cited to support this change in criteria	**IMPACT OF IMPLEMENTING OPTION 3:** Activity and costs are likely to reduce however; CCGs may be open to legal challenge given that there is no clinical evidence cited to support this change in criteria. If the impact seen is detrimental to patients and CCGs reputation, these policies can be reviewed at an earlier stage and rectified if required
RISK AVOIDED	**RISK ACCEPTED**	**RISK EXPLOITED**

An in depth discussion was held by Working Group members, and an informed decision was taken by representatives from Halton, Knowsely, South Sefton, Southport and Formby and Warrington CCG colleagues to proceed with **option 1 – keep the age criteria for the Breast procedures at 18.**

2. Removal of the children and psychological impact line from the introduction

The second issue requiring a decision by Working Group members was around the suggestion to remove the following line from the introduction to the policy : *Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress.* The policies affected by this line are:

- Rhinoplasty
- Surgical removal of lipoma
- Policy for hair removal
- Surgical removal of scars
- Pinnaplasty
- Removal of Skin lesions

- Surgical treatments for Hair loss

The following options were outlined to the Working Group members:

Option 1	Option 2	Option 3
Keep the original line in the policy **IMPACT OF IMPLEMENTING OPTION 1:** No impact will be seen here	Remove the line regardless of the potential impact **IMPACT OF IMPLEMENTING OPTION 2:** Activity and costs are likely to reduce however; CCGs may be open to legal challenge given that there is no clinical evidence cited to support this change in criteria. Given that these changes affect children this is a particularly emotive issue and is likely to gain significant scrutiny. Mitigation here is around other options that would be available to support children from a psychological point of view.	**There is a subsequent line in the policy that states:** *Psychological distress alone will not be accepted as a reason to fund surgery except where this policy explicitly provides otherwise. Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as a route into aesthetic surgery.* Combining the lines will allow the overall policy to remain clear that psychological distress alone will not be accepted as a route to surgery, however it could also be made clear that children need to meet all the criteria, as well as being able to cite psychological distress as a factor in their application for treatments **IMPACT OF IMPLEMENTING OPTION 3:** No impact will be seen here, and this will bring treatments for children more closely in line with the spirit of the review – to tighten up and strengthen the current criteria, whilst supporting CCGs duty of care towards patients, especially those more vulnerable in society.
RISK AVOIDED	**RISK ACCEPTED**	**RISK TRANSFERED**

This was a more difficult issue to address, with a range of arguments put forward for both retaining and removing the line. The argument for keeping this line in the policy focused on the fact that by removing this line there may be a risk of challenge because children are not the same as adults; they are less resilient to deal with physical and associated psychological issues so this could be a risk from an equality perspective. The main counter point for removing this line from the introduction was that NHS resources should not be used to address wider societal issues such as bullying, especially in relation to cosmetic procedures such as those affected by this change.

The Working Group felt that none of the options outlined would effectively address this issue, so it was suggested that the correct approach would be for all patients regardless of age to have had psychological assessment and support, i.e. input from IAPT for adults and CAMHS for children before surgery is offered as an option. The decision was taken by representatives from Halton, Knowsley, South Sefton, Southport and Formby and Warrington CCG colleagues to proceed with an option similar to **option 3 – a line has been developed based on an existing line in the introduction which now states:**

Psychological distress alone will not be accepted as a reason to fund surgery. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient's psychological wellbeing, their duration and

impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention.

Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as a route into aesthetic surgery. Any application citing psychological distress will need to be considered as an IFR .

Representatives from Liverpool and St Helens CCGs were unable to attend the meeting; however they have since confirmed via email on 15th November and 21st November respectively, that they are in agreement with the decisions taken by their colleagues on the wider Working Group. The minutes of the Working Group meeting where these issues were discussed can be found in appendix 3.

The final version of the revised Policy Introduction can be found at Appendix 4.

Executive Summary

This summary outlines the methodology, summary of results and external factors in relation to suite 1 and suite 2 policies as part of the Procedures of Lower Clinical Priority review work, publically known as 'Reviewing local health policies'. Detailed results analysis and comments from the survey, meetings and focus group can be found amongst appendices 5, 6 and 7.

Introduction

The Health and Social Care Act 2012 says NHS organisations have a duty to promote involvement of each patient and have, in S.14Z2 a duty to involve the public and consult where commissioning arrangements will change and this means that the implementation of changes will have an impact on the manner in which these services are delivered or the range of health services delivered to them.

The following section outlines the methodology used to determine appropriate engagement levels per policy and a summary of the results from the survey, meetings and events in accordance with the Health and Social Care Act 2012.

Methodology

Equality Impact Assessments and their role in the engagement plan

An Equality Impact Assessment was carried out for each of the policies reviewed in suite 1 and 2, which set out the approach for the engagement plans, providing a clear understanding of the change to each policy and what would be proportionate and fit for purpose engagement, considering the level of change. The Gunning principles were applied as follows; Public groups, OSCs and other clinic stakeholders were consulted as part of policy development work. There was then an open public engagement period of 12 weeks where surveys, meetings and focus groups were held. This length of time was chosen to reflect the volume of policies out for engagement. After this engagement period, all responses have been analysed and fed back to each CCG to consider in their final decision making.

NHS England were consulted upon during the development of engagement plans, in relation to the approach to engagement, ensuring the activity carried out would be meaningful and patients and public would be considered proportionately and fairly. Feedback from NHS England confirmed the approach was fit for purpose.

A communications and engagement working group was established with representation from all seven CCGs involved, as well as a project lead, a media lead, 2 senior engagement team members and Cheshire and Merseyside Area Lead from MLCSU. This group met on a monthly basis to discuss and make decisions about engagement plans for each of the policies. Additionally, a working plan was set out on a weekly basis outlining key activity for the upcoming week and any tasks which need to be completed. This allowed for an open, comprehensive and agile approach to the project.

It was clear from both the levels of proposed change and the EIAs that varying levels of engagement would be required for the policies and so a 'levelling' structure was developed. This structure ensured that each policy was given the due regard required and specifically identified and targeted the associated members of the public for their views. Levels were assigned to policies by the communications and engagement working group and approved by commissioners and third sector stakeholders.

Please see below a description of these engagement levels.

Table 1 – Engagement level explanation

Engagement Level	Description
1	Survey posted online and offline with no specific target
2	Survey posted online and offline, targeted as specific cohorts of people through social media and support groups/charities. Additional specific FAQs.
3	Survey posted online and offline, targeted as specific cohorts of people through social media and support groups/charities with, additional specific FAQs and 1 event OR face to face meeting with relevant groups

Once an engagement level has been assigned to the policy, an individual plan was developed for each of the policies outlining the specific cohorts of the public who will be targeted for engagement, and how this will be carried out.

For members of the public, clinicians, staff and third sector, 12 week engagement was carried out from 26th June until 18th September 2017 in the following forms.

Survey
The survey was designed in accordance with the Office of National Statistics where protected characteristics were included and measured as part of the survey.

The survey was designed with a mixture of both quantitative and qualitative questions, allowing respondents to provide free text to support the reason why they may have chosen to agree or disagree with the proposed change. For each policy, a plain English document was provided which summarised the policy and provided the rationale for the proposed change to allow participants to make an informed decision.

The following survey was provided in three ways;

1. Online – via elesurvey, a system that is compliant with UK Information Governance laws.

2. Hard copy –provided with a freepost envelope for return

3. Telephone - The phone line was available for members of the public to find out more information or ask questions about the survey and engagement process as well as carrying out the survey over the phone.

Providing the survey in these formats ensured that it was made as accessible as possible for all. In addition, all information about the project was provided in an easy read format and options for those who required the information in an alternative language was also promoted on all CCG websites, on the survey and on promotional materials such as the leaflet.

Meetings and events
Meetings and events attended followed a consistent approach and structure to allow for meaningful analysis and responses to coincide with survey results.

The following structure was used at each of the events and meetings attended;

- Introduction to project
- Approach to engagement outlined
- Discussion with group around aims and objectives
- Overview of policies included in suite 1 and 2
- Any specific policies highlighted by the group for further discussion and evaluation
- Feedback collected
- close

At each event or meeting the following materials were provided;

- Hard copies of the survey, including freepost envelope
- Leaflet explaining the rationale for the project
- All attendees were encouraged to complete the surveys

Throughout the engagement process and analysis of survey and meeting results, it became clear that further clarity and information regarding the removal of the 'children's statement' was required and so a focus group was conducted with the support of Young Peoples Advisory Service to gain better insight to the concerns raised in the survey results about the statement being removed.

For full details of outcomes of meetings and events and list of meetings and events attended, please see appendix 5.

External factors to consider

Media misrepresentation of facts
Although most media coverage for this work was balanced (see Appendix 5 for full media outcome details), for some of the policies, media misrepresentation of proposed changes to the policy caused some respondents to disagree with the change when asked if they agree or disagree, however within their comments supporting their agreement choice, respondents fundamentally disagree with the 'cut' of a service, as opposed to the update of criteria. In these instances, it was found that the negative comments supported the proposed change, resulting in quantitative analysis suggesting a larger proportion of people disagree with proposed change than the real number of people.

The following policies were mostly affected by this coverage;

- Hemorrhoidectomy
- Cataract surgery

Demographic responses
The volume of protected characteristics responding to the survey was recorded throughout, particularly those which were identified in the phase 1 EIA as could be more affected by a proposed policy change. It has been evidenced throughout the process that these identified groups have been targeted through support from the third and voluntary sector, as well as targeted online campaigns where appropriate. In some areas, responses from particular groups have been low, due to low interest in the topic and/or low volumes in communities.

Local area response rates
This work was carried out across the footprint of the seven CCGs involved. This meant that the CCGs could benefit from a larger cross section of responses, rather than being limited to their own area for views, particularly where some demographics may be lacking in some areas.

For the areas where response rates for some policies were low, it was identified that in addition to being able to learn from the other areas results, more extensive face to face engagement was required. The low response rates were generally due to one of the following factors;

- A more elderly population
- A low literacy rate
- Low internet access
- Low volume of people from various characteristics living in the area
- Where there is no change to criteria, but there is updated wording – feedback indicated they did not feel compelled to respond as they did not see the change as concerning or a risk.

Where there was little or no response to some policies which have a higher impact on patients and public, such as the age change for breast surgery and the removal of the statement allowing children to have access to surgical treatments based on psychological distress alone, the group worked to target the survey online to these audiences and also increase engagement, with offer of face to face groups and meetings to these target audiences. This additional work is documented in the documents below (see appendices 5, 6 and 7.).

All feedback from meetings and events was then coded in the same way as survey responses to provide consistency of analysis.

Results Summary
In total 187 people responded to the survey and over 120 people were reached via meetings and events across the 7 areas. The total number of responses and detailed responses per policy can be found in appendix 6.

Survey results were monitored on a weekly basis and any areas for concern, such as low response rate, was addressed either by increasing face to face activity or using social media targeting.

There was additional focus in areas where patient's impact was higher, for example, age changes or psychological distress restriction.

On review of results analysis as a project as well as local results, there were two key areas for concern raised by respondents for commissioners to consider;

1. Disagreement with changing the age of breast surgery from 18 to 21 years.
2. Some disagreement with the removal of the statement, currently allowing children under the age of 16 to have access to treatments purely based on cosmetic of psychological distress.

Based on these results and some additional face to face engagement with YPAS, MLCSU provided the CCGs with three options for addressing these issues, each relating the risk each option presents. These were then discussed as a working group and an option chosen, which takes into consideration the engagement work. This has been explored in detail at pages 11 to 13.

Once all Governing Bodies have reviewed and agreed on proposed updates to policies, a public facing summary document will be produced to share with the third and voluntary sector and to those who took part in the survey in order to demonstrate how their views made an impact on decision making.

Approach to Equality Impact and Risk Assessments (EIRA)

The Equality and Inclusion Team have equality impact and risk assessed all policies in suites 1 and 2 of the Policy Development project. Appendix 8 summarises the potential impact of changes proposed against all red rated policies and includes recommendations and actions that were considered by the policy group to ensure the CCGs meet their equality duty of "due regard" in relation to the Equality Acts Public Sector Equality Duty and to minimise any potential risk of challenge.

Back pain policies were noted as green policies and did not undergo engagement work under the Policy Review Group but instead went through a period of 'communication' during summer 2017. These policies were reviewed in alignment with the Walton Centre Vanguard work and the recently published NICE Guidance *Low back pain and sciatica in over 16s: assessment and management (NG59), November 2016*.

Draft Stage 1 EIAs from suite 2 that have previously been discussed at the policy group have been shared with the Merseyside Equality Lead – Andy Woods.

Considerations from meetings with the Working Group:

- All draft policies ragged as red have had a draft pre-engagement EIA completed – this is the stage 1 reports.
- The policies to undergo engagement were then updated with engagement feedback. All the EIAs have been revised to account for the proposed introduction change regarding children and young people under the age of 16 not receiving treatment based on psychological distress. Suite 2 Stage 2 EIAs have now noted the decision made at the Policy Development Group meeting on 14th November 2017 to retain the introduction line with a caveat that a medical intervention can be considered for children on the grounds of psychological distress on the grounds of possible challenge under the protected group of 'Disability'.
- The Suite 2 Stage 2 EIAs in relation to Breast treatment policies have been updated to reflect the decision made at the Policy Development Group meeting on 14th November 2017 to retain the minimum age eligibility criteria at 18 to avoid any possible challenge on indirect discrimination under the protected group of age.
- All updated EIA's have been converted into PDF and are included at appendix 9. These completed documents contain the stage 1 and stage 2 reports in one PDF.
- Discussion regarding future monitoring of IFR requests to include protected characteristics in order to identify areas of potential discrimination. Current monitoring of requests is limited and it is difficult to demonstrate that all groups are being treated fairly as data is not collected at protected group level. This issue sits within the IFR Process
- Consideration of wider governance and ensuring that decision makers / Governance Boards / committees within the CCG's know their legal duties – Public Sector Equality Duty.– CCG's to be aware of this. Previous paper was distributed to policy group members.
- It is recommended that EIAs are reviewed at least every 3 years.

Summary of CCG GB Dates and actions required from CCG Governing Bodies

ACTION: All CCG Governing Bodies are asked to confirm their acceptance of the proposals within this paper so that policies can go live with providers from week commencing Monday 15th January 2018

South Sefton CCG	Southport & Formby CCG	Liverpool CCG	St Helens CCG	Halton CCG	Knowsley CCG	Warrington CCG
19th December 2017	19th December 2017	9th January 2018	10th January 2018	4th January 2018	tbc	10th January 2018

Tuesday	Tuesday	Tuesday	Wednesday	Thursday	tbc	Wednesday

Policy Go Live

All CCGs should go live with their revised commissioning policies on the same date to ensure minimum disruption to providers, patients and the general public.

Policy go-live was originally identified as Wednesday 17th January 2018, however following discussion with the Working Group it has been agreed that once notification from all CCGs has been received that they have ratified the proposed policies, a formal letter will be issued to all providers, including a copy of the final revised policy, giving them the required 4 weeks' notice of the impending policy changes.