Midlands and Lancashire Commissioning Support Unit

Policy Development Project Working Group Meeting 12 Minutes
Date: Tuesday 14th November 2017
Meeting time: 13:30 to 15:30
Dial in Details: 0800 917 1950 and use passcode 69175070 followed by

Agenda Item		
1	**Attendance**	**Apologies**
	Helen Pressage (HP) – *Warrington CCG* Zoe Graham (ZG) – *Warrington CCG* Moira Harrison (MH) – *South Sefton & Southport & Formby CCGs* Martin Stanley (MS) – *Halton CCG* David Marteau (DM) – *Halton CCG* Neil Meadowcroft (NM) – *Knowsley CCG* Craig Porter (CP) - *Knowsley CCG* Debbie Lowe (DL) – *MLCSU IFR Senior Manager* Anna Donaldson (AD) - *MLCSU Comms lead* Jennifer Mulloy (JM) – *MLCSU EIRA Business Partner* David Partington (JM) – *MLCSU EIRA Business Partner* Jane Wright (JW) – *MLCSU GP Lead* Michael O'Brien (MOB) – *MLCSU Policy Development Project Manager (Minutes)*	Ruth Hunter (RH) – *St Helens CCG* John Hampson (JHa) – *Public Health Specialist* Anne Henshaw (AH) – *MLCSU Medicines Management Team* Pam Hughes (PH) – *MLCSU Service Director* Judith Nielson (JN) – *Liverpool CCG* Jo Navin (JNa) – *MLCSU Comms Senior Manager* Harinder Sanghera (HS) – *MLCSU Senior IFR Development Lead*
2	**Welcome and Introductions**	
	DL welcomed all to the meeting and introductions were given.	
3	**Minutes of last meeting – Accuracy & Matters Arising**	
	MOB explained that roughly half of the actions that came out of the 31st October meeting have been completed, with the rest currently in progress. **Actions from the last Working Group meeting held in October 2017:**	

Action ID	Action	Update
1	MOB to update references in TOR to Public Health consultant/specialist	MOB advised that this has been completed
2	MOB to make final amendments to the Working Group Terms of Reference then circulate.	MOB advised that this has been completed and will be circulated shortly.
3	MOB to bring the November working Group forward so final decisions can be made against the red rated policies coming out of the EIRA and Engagement work.	MOB advised that this has been completed.
4	MOB to draft a letter to providers to give them notice that revised policies will be issued in January 2018 and to share this with Commissioning Leads.	MOB advised that this is in hand and will be completed shortly.
5	MOB Collate list of December and January Governing Body meetings to support planning for Governing body papers and issuing of policies.	MOB advised that this is ongoing as he is still waiting for dates from Halton and Knowsley CCGs

	6	DP and MOB to liaise about ensuring copies of EIRAs for all Policies are made available to CCGs via the Governing Body papers that will be prepared in the coming weeks.	MOB advised that this has been completed.

4 Communications and Engagement update

AD gave an update for this item. She explained that the comms and engagement work for suite 1 and 2 has now been finalised and the report of findings has gone out. The next stage is to provide a summary for Governing Bodies so AD asked those in attendance what specific information they needed. It was noted that it would be useful to have a summary by area but CCGs will also need to see a Merseyside summary.

CP noted that Governing Bodies may wish to see a breakdown of local respondents to give their papers a local flavor. AD noted that this this has already been provided but that this needs to be in narrative form so this will be picked up and produced.

ACTION: JNa to begin production of local summary paragraphs.

ACTION FOR ALL: CCG Commissioning Leads to email JNa with an indication of what information they will need to submit to their Governing Bodies over the next 48 hours.

AD then explained that the comms and engagement plans for suite 3 have been circulated and that further comments and input would be welcome as there are differing levels of engagement for each CCG. It was noted that Knowsley CCG are not participating in phase 3. DL suggested that HK will liaise with CP to manage their transition out of the project in the coming weeks.

ACTION: HS to liaise with CP to manage the Knowsley CCG transition out of the project.

AD addressed the recent data breach with the CCGs. She noted we are working closely with our Information Governance Team and that there is a clear process to follow. Part of this process includes writing to those patients affected. The draft letter will be sent to CCGs later this week for sign off with the plan being to issue it to patients on Friday 17th November. AD explained that it has been made clear that this is an NHS to NHS data breach and that no patent details have been released into the public domain. AD explained that our Information Governance team is working closely with the ICO to ensure that the relevant assurances are put in place to mitigate against such issues in future and that we are embedding a more robust assurance process around use of patient data in the communications element of the project. It was noted that new staff need to receive full Information Governance Training and not just refresher training. The Comms team is taking proactive steps to address this issue and another call with the ICO is taking place later this week to agree next steps. AD explained that a logging system has been set up to capture any interactions with affected patients and these queries will be addressed by the MLCSU PALs team so patients will receive answers to any queries within 48 hours. AD advised CCGs to direct any patients that contact them, to the MLCSU PALs team.

ACTION: JNA to send the CCGs the logging system for their information.

CP stated that his colleague Jackie Johnson is communicating with MLCSU and that she has spoken to NHS England but wanted to know if there is a sole point of contact leading the process from MLCSU as that would be helpful for the CCG. CP also asked if there is a written process that can go to their Senior Team that assures them about the process we are following? AD explained that she is happy to answer any questions alongside Haley Gidman from the MLCSU IG team and we will write up the process and circulate it to CCGs by close of play on Thursday.

ACTION: AD/JNa to write up process for managing the data breach and circulate to CCGs by close of play

on Thursday 16th November.

MS explained that the SIRO for Halton CCG has recorded the incident on STEIS but because it does not need to be logged multiple times this will need to be addressed by CCGs.

5 Suite 1 and 2 Red policies: issues for Commissioning Leads to discuss and agree

MOB took the Working Group through this item. MOB explained that following a meeting of the Project team last week to identify the issues coming out of the EIRA and the engagement work, there are **two** issues that require Commissioning Lead discussion and decision to be reached today. The following minutes should be read in relation to the embedded document below:

Red Policy EIRA and Engagement issues fc

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

MOB explained that 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 have been unable to find any evidence to support the suggestion that a womans physiological and hormonal development is more advanced at 21. MOB explained that the Project Team have worked to outline what we believe are the most realistic options for CCGs under this issue and these are:

Option 1	Option 2	Option 3
Keep the age criteria as they are (18+) No clinical evidence can be sourced that supports this criteria: **IMPACT OF IMPLEMENTING OPTION 1:** No impact will be seen here RISK AVOIDED	Implement the age change in criteria without evidence (21+) No clinical evidence can be sourced that supports this line: **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 RISK ACCEPTED	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 actual activity, complaints, FOIs, PALs, SARs requests etc No clinical evidence can be sourced that supports this line **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 EXPLOITED

JM noted that because there is no evidence to support this change, this can be viewed as direct discrimination between comparator groups. DL asked how exceptionality would apply here. Would an 18 year old be exceptional to another 18 year old? From an equality point of view, JM believes not and went on to explain that even when comparing an 18 to a 21 year old they would still be being treated differently for no justifiable reason. Overall, this is about objective justification and whether patients in these age brackets have a comparator. In this instance, it is felt that there would be direct comparators therefore there is significant risk here. JM also noted that under the Public Sector Equality Duty (PSED) if there is a case for challenge it puts CCGs at risk and unfortunately, even though other CCGs may have made similar changes in the past and seen no impact, this is still a risk.

CP said that he felt the proposed change from 18 to 21 should not have been taken forward and that given there is no evidence to justify the change option 1 is the most appropriate option - Keep the age criteria as they are (18+).

HP at this point also added that given that the numbers of these procedures being carried out on patients between the ages of 18 and 21 are so low, the impact on the activity and costs here of making the change to 21 are not sufficient to warrant the associated risk. MS also noted that good surgeons themselves will make an informed decision with the patient, taking their age into account. MS, HP and MH all agreed that option 1 was their chosen option.

DECISION: Halton, Knowsley, South Sefton, Southport and Formby and Warrington CCG colleagues all agree with option 1 – keep the age criteria for the Breast procedures at 18.

ACTION: JM to update the stage 2 EIAs to reflect the decision on the Breast procedures and age criteria and note this journey of change.

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

MOB explained that for the second issue the suggestion had been 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.* MOB explained that the Project Team have worked to outline what we believe are the most realistic options for CCGs under this issue and these are:

Option 1	Option 2	Option 3
Keep the original line in the policy	Remove the line regardless of the potential impact	**There is a subsequent line in the policy that states:**
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. 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.	*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**

JM noted that the argument for equalising patients by age by removing this line is open to debate because children are not the same as adults; they are less resilient to deal with physical and associated psychological issues so the eqaulisation argument is not sound from an equality perspective. The Royal College of Surgeons have said for example in relation to pinnaplasty that this procedure should be carried out in children of school age due to bullying, and lower psychological resilience. However, the counter argument we have seen here is that NHS resources should not be used to address children bullying other children. However if a child is being severely bullied, these

treatments may be effective in stopping the escalation into more serious mental health issues as well.

JM noted that there could be a challenge if the justification focuses on treating people of all ages exactly the same because age groups are different so this argument would not stand up.

DL asked the group, why would we not consider the circumstances from a clinical exceptionality point of view? JM asked that if you have a child who is distressed because of the shape of their ears, If they do not fit the criteria for the policy, what would make them fit under exceptionality? JW explained that usually, under IFR we would acknowledge bullying but the panel would be unlikely to make a decision based on this because it is not exceptional. JW also explained that for treatments such as minor skin lesions, these are purely cosmetic and are very often pushed for by parents, so the question for the panel becomes, is the risk of doing something worse than not doing something? Finally, JW noted that as we have discussed previously, psychological distress cannot be measured.

JM explained that she spoke to Andy Woods this morning and this issue was raised and that because psychological distress is difficult to measure, an alternative approach may be to have a statement in these policies that acknowledges lower psychological resilience in children, and states that if a patient has been undergoing treatment for psychological distress first, and this has not addressed the issue, then surgical options can be considered.

DL 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. We therefore need a clear statement that says we expect an appropriate mental health service has been used, and that this would have to have been attempted before surgical options are considered.

To summarise, DL noted that Working Group members are in agreement to remove the above line from the introduction but that we need to have a clearer statement under the Psychological Distress section of the introduction stating what mental health services patients should have used before moving towards surgery. NM, CP and HP all agreed with this agree with this.

JW suggested that the statement needs to say surgical interventions will only be considered after ‘appropriate psychological interventions have been tried but found not to be appropriate’.

DECISION: Halton, Knowsley, South Sefton, Southport and Formby and Warrington CCG leads in attendance agreed that the removal of this statement is the correct approach and that the psychological distress section needs to be strengthened as per the above.

ACTION: MOB to circulate these minutes to Judith Nielson and Ruth Hunter for their decisions on these policies.

ACTION: MOB to update policies affected by these discussions for inclusion in CCG Governing Body papers

The final issue that has been raised applies to patients undergoing Gender Reassignment. This is not an issue that has affected our policy work to date, so no decision was required here, however it is important that this is shared with the group as it is an issue in the Lancashire project. The issue is around cosmetic treatments for patients going through the gender reassignment pathway and core and non-core treatments. Core treatments are funded by NHS England and non-core treatments are funded at the discretion of CCGs. An example was cited of a male patient transitioning to female and therefore requiring breast development. At present if the patients’ core treatment to develop breast tissue fails the GIC refer the patient to the CCG for further treatment. Lobby groups suggest that this is not appropriate because they suggest that these treatments are not cosmetic which is how they would be viewed under IFR – you are treating someone with Gender Dysphoria, not a cosmetic issue. JM noted that this has been recorded in the EIRA work as an area for CCGs to be aware of.

MS suggested that if a patient has hormone treatment and they end up with asymmetric breasts, the commissioning policy would apply if they have completed their transition, however if they are still within the pathway and not achieved what they wanted then it would not be appropriate to refer them to their CCG. All in attendance agree with this approach. JW noted that from an IFR perspective, we treat patients in the gender they identify with and apply the relevant criteria and that this is reflected by NHS England guidance. DL noted that in mitigation we

	need to look at this from an IFR perspective and reviewing these patients as a cohort. JM explained that their direct comparator would be other women under the GIC pathway who have had the same treatment. It was suggested that JM prepare some written guidance for the IFR Panel on how to manage cases where transgender patients are seeking non-core treatments. ***ACTION: JM to prepare written guidance for the IFR Panel on how to manage cases where transgender patients are seeking non-core treatments.***
6	**Any Other Business**
	No other business was raised.
8	**Date of next meeting**
	Date of next meeting: MOB noted that the date for the next meeting will be changed shortly and a new date circulated.

Actions:

Action ID	Action	Owner	By When
1	JNa to begin production of local summary paragraphs.	Jo Navin	
2	CCG Commissioning Leads to email JNa with an indication of what information they will need to submit to their Governing Bodies over the next 48 hours.	All CCG Leads	
3	HS to liaise with CP to manage the Knowsley CCG transition out of the project.	Harinder Sanghera	
4	JNa to send the CCGs the logging system for their information.	Jo Navin	
5	AD/JNa to write up process for managing the data breach and circulate to CCGs by close of play on Thursday 16th November.	Anna Donaldson/Jo Navin	
6	JM to update the stage 2 EIAs to reflect the decision on the Breast procedures and age criteria and note this journey of change.	Jenny Mulloy	
7	MOB to circulate these minutes to Judith Nielson and Ruth Hunter for their decisions on these policies.	Michael O'Brien	
8	MOB to update policies affected by these discussions for inclusion in CCG Governing Body papers	Michael O'Brien	
9	JM to prepare written guidance for the IFR Panel on how to manage cases where transgender patients are seeking non-core treatments.	Jenny Mulloy	