22/06/2018

Harmonised Treatment Policies - Phase 2

Healthwatch Birmingham welcomes the opportunity to respond to Birmingham and Solihull's consultation on *'Harmonised Treatment Policies – Phase 2'*. Our key role is to make sure that patients, the public, service users, and carers (PPSuC) are at the heart of service improvement in health and social care. In line with our role, we have focused our comments on:

- whether the proposals will improve the quality of care and lead to services that are responsive to the needs of patients and service users
- Whether proposed changes may address or lead to health inequality

We welcome the CCGs plan to ensure that policies incorporate the most up-to-date published clinical evidence, stop variation in accessing NHS-funded services across Birmingham and ensure that access is equal and fair. The premise that underpins Harmonised treatment policies is good as it ensures that there is an evaluation of the effectiveness of treatments and assessment of what works or does not work for patients. However, the effectiveness of these policies in meeting the needs of Birmingham residents will depend on how they are implemented and the principles that govern their implementation. In particular, should financial considerations become the overriding principle, then there is the potential for patient's wellbeing being considered second best. As such it is important to consider the following issues:

- 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?[1]
- For restricted procedures – what processes will be put in place to ensure that assessments are timely, that it is easy to access services, and people have choice.
    - 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

[1] https://blogs.bmj.com/bjsm/2018/05/09/no-longer-arthroscopy-for-degenerative-knee-disease-potential-benefits-from-a-novel-technique-should-not-be-ignored/

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.

- 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.

- The CCG needs to consider the potential impact of these policies on health inequality. As stated by NHS England, CCGs must have regard to the need to reduce inequalities between patients with respect to their ability to access health services and outcomes achieved for them by the provision of health services[2]. We are concerned that changes to some policies might affect some groups more than others. For instance:
  - 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.

  - In addition to the above, 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.

[2]https://www.england.nhs.uk/wp-content/uploads/2017/12/challenging-health-inequalities-report.pdf

- 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.
- As regards 'Gamete retrieval and cryopreservation' policy, we note that whilst female same-sex couples or single women are eligible for IVF, male same-sex couples or single men who have surrogate arrangements are not eligible. It is not clear in the document the reasons for this and is contrary to the CCGs duty towards inequality as well as the CCGs need to ensure equal and fair access to services.
- We also note with concern that the individuals family circumstances, such as having adopted or biological children, precludes them from accessing Gamete retrieval and cryopreservation treatment. NICE Quality Standard on fertility states that previous children, sexual orientation and relationship status should not be a factor in determining eligibility for treatment[3]

We believe that these issues need to be considered as plans, to roll out these policies, take shape. The CCG needs to take the diversity of Birmingham and the deprivation prevalent in the city, into consideration. In particular the potential impact it will have on some communities who might not be able to access private services to be able to travel to locations further to them etc. It is important that medical needs of service users and the public in Birmingham remain central in commissioning decisions.

Yours Sincerely,

Chipiliro Kalebe-Nyamongo

Policy Officer

Andy Cave

Chief Executive Officer

[3] https://www.nice.org.uk/news/blog/the-importance-of-3-full-cycles-of-ivf; https://www.nice.org.uk/guidance/qs73

22/06/2018

Harmonised Treatment Policies - Phase 2

Healthwatch Birmingham welcomes the opportunity to respond to Sandwell and West Birmingham CCG '*Harmonised Treatment Policies Phase 2 Summary*'. Our key role is to make sure that patients, the public, service users, and carers (PPSuC) are at the heart of service improvement in health and social care. In line with our role, we have focused our comments on:

- whether the proposals will improve the quality of care and lead to services that are responsive to the needs of patients and service users
- Whether proposed changes may address or lead to health inequality

We welcome the CCGs plan to ensure that policies incorporate the most up-to-date published clinical evidence, stop variation in accessing NHS-funded services across Birmingham and ensure that access is equal and fair. The premise that underpins Harmonised treatment policies is good as it ensures that there is an evaluation of the effectiveness of treatments and assessment of what works or does not work for patients. However, the effectiveness of these policies in meeting the needs of West Birmingham residents will depend on how they are implemented and the principles that govern their implementation. In particular, should financial considerations become the overriding principle, then there is the potential for patient's wellbeing being (even short term relief) considered second best. As such it is important to consider the following issues:

- 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?[4]
- For restricted procedures – what processes will be put in place to ensure that assessments are timely, that it is easy to access services, and people have choice.
    - 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.

[4] https://blogs.bmj.com/bjsm/2018/05/09/no-longer-arthroscopy-for-degenerative-knee-disease-potential-benefits-from-a-novel-technique-should-not-be-ignored/

- 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.

- The CCG needs to consider the potential impact of these policies on health inequality. As stated by NHS England, CCGs must have regard to the need to reduce inequalities between patients with respect to their ability to access health services and outcomes achieved for them by the provision of health services[5]. We are concerned that changes to some policies might affect some groups more than others. For instance:

  - Regarding 'Gamete retrieval and cryopreservation' policy, we note that individuals family circumstances, such as having adopted or biological children, precludes them from accessing Gamete retrieval and cryopreservation treatment. NICE Quality Standard on fertility states that previous children, sexual orientation and relationship status should not be a factor in determining eligibility for treatment[6]
  - In addition to the above, we note that Gamete retrieval and cryopreservation policy only covers women under the age of 40 years. We would have hoped that the Trust would follow NICE's Guidance for IVF treatment which places the reproductive age for females at 42 years.

We believe that these issues need to be considered as plans, to roll out these policies, take shape. It is important that medical needs of service users and the public in Birmingham remain central in commissioning decisions.

Yours Sincerely,

Chipiliro Kalebe-Nyamongo — Policy Officer

Andy Cave — Chief Executive Officer

[5]https://www.england.nhs.uk/wp-content/uploads/2017/12/challenging-health-inequalities-report.pdf

[6] https://www.nice.org.uk/news/blog/the-importance-of-3-full-cycles-of-ivf; https://www.nice.org.uk/guidance/qs73

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