The Review of Clinical Policies for Lancashire and South Cumbria Clinical Commissioning Groups (CCGs) – Frequently Asked Questions (FAQs)

Why review policies now?

It has always been a responsibility of CCGs and predecessor PCTs to review clinical policies on a regular basis. This is done to ensure that changes in best clinical/medical practice are taken into account, including National Guidance from NICE (National Institute for Health and Care Excellence) and other bodies. It also means updates as a result of new legislation or legal decisions can be made to existing policies. All policies have a review date, which is usually within two or three years of their adoption. Each CCG had policies due for review.

Harmonising the review of clinical policies across all the CCGs in Lancashire and South Cumbria provides an ideal opportunity to co-ordinate these policies and related services and make them consistent and fair. It reduces what is often referred to as the postcode lottery of healthcare across this area of the North West. In addition, as part of its guardianship of local NHS services, CCGs must take into account fully and responsibly, the management of the limited resources at its disposal. Reviewing the effectiveness and value of clinical policies is part of that responsible management.

A thorough review of clinical policies takes time and this is likely to be an ongoing process.

Which CCGs are involved?

All 8 CCGs in Lancashire are involved. These are:

Morecambe Bay Clinical Commissioning Group (which includes South Cumbria)

Chorley and South Ribble Clinical Commissioning Group

Greater Preston Clinical Commissioning Group

West Lancashire Clinical Commissioning Group

East Lancashire Clinical Commissioning Group

Blackburn with Darwen Clinical Commissioning Group

Blackpool Clinical Commissioning Group

What is the review process meant to achieve?

The main purpose of the review is to deliver the following outcomes for the CCGs, and through them, clinicians and patients.

- Review historical PCT policies to ensure a consistent and fair approach to reduce the 'postcode' lottery that can result from having different policies across a geographical area
- Develop a set of policies and principles against which to make these decisions
- Determine procedures that the CCG will not commission either routinely or at all – because the procedure does not satisfy principles under which the CCG commissions services or because particular criteria need to be met for the intervention to satisfy the principles. These need to be set out and demonstrated prior to approval of funding
- Update policies in accordance with National Guidelines and best clinical practice
- Ensure the limited and finite resources available for healthcare are prioritised according to the risks of mortality, disability, pain, poor health and damage to quality of life
- Develop collaborative policies across the 8 CCGs in Lancashire

What will this mean to patients?

The policies under review guide the decisions made by CCGs about the care and treatment that will be made available to patients. This is in both what the CCG will commission and in what Providers of services will be asked and paid to deliver. This has a direct impact upon the services patients and the public can expect from their local NHS services. For the majority of patients this will mean little or no change to the services they access now as they will continue to be routinely delivered as part of the commissioner/provider contract. However, for some services, especially those subject to clinical policies, there may well be a change in the service provided or that a service is no longer provided at all on the NHS due to its low clinical value, poor or unproven patient benefit and prioritisation of resources.

This will also have a direct impact upon decisions made for individual funding requests, both in terms of the referrals that GPs/other health professional will make for their patients and in the decisions that IFR panels will make about those referrals.

By having one harmonised set of policies, all patients who may require a procedure will have to meet the same criteria, wherever they live in Lancashire or South Cumbria. This ensures all patients are treated equally and that those who will benefit the most from the treatment will be able to receive it.

In cases where a patient will no longer be able to receive a treatment, the patient will be supported by their GP/other health professional to find alternative treatments which may be of greater benefit to them or in demonstrating they are an exception to the norm.

What impact will this have on individual funding requests?

An individual funding request can be made by your clinician (doctor or other health professional) if they believe that a particular treatment or service that is not routinely offered by the NHS is the best treatment for you, given your individual clinical circumstances.

Having the same or identical policies across CCGs will make the process for individual funding requests more streamlined, more efficient and reduce the likelihood of errors. There will be less confusion for both staff, patients and clinicians and the service will be more consistent, equitable and fair for the population across Lancashire and South Cumbria as a whole.

What are procedures of limited clinical value?

Some routine treatments are described as 'Procedures of Limited Clinical Value' (PLCV), alternatively called 'Procedures of Lower Clinical Priority' (PLCP). These are procedures which national experts have suggested have only limited or temporary benefit, and which are not felt to be necessary to maintain good health. However, it may also include procedures which are deemed to be effective but which will only be so when specific criteria, conditions and circumstances are met. This means they need to be considered on a case by case basis and meet strict criteria before they can be funded by the NHS.

The clinical policies developed by the CCG are often concerned with procedures of limited clinical value and identify the criteria that must be met, the effectiveness of those procedures in dealing with the health problem or concern and circumstances when the treatments will be funded.

A clinical policy identifies the treatment that is or is not available on the NHS in the area covered by the CCG and must be followed by all clinical staff within the area, including GPs. However, if the treatment is not routinely funded or the criteria is not met but your GP or other health professional feels there are exceptional circumstances in your case and you would benefit from this treatment, then your GP/Health Professional can support you by submitting an individual funding request (IFR) on the grounds of exceptionality to the policy.

Is this about saving money?

Yes and no. We believe that harmonising policies across Lancashire will help us to deliver more efficient and effective services. These services will be offered fairly and consistently across the area and be clinically appropriate. However, this exercise is taking place during a well-documented period of constraint for the NHS, which

cannot meet the rising demands and expectations placed upon it without identifying priorities and making difficult choices.

A review of the procedures of limited clinical value or of lower clinical priority not only provides an opportunity to consider the latest evidence around effective and appropriate healthcare but also an opportunity to consider what can be afforded in the light of all the other services the NHS is expected to provide. There will be some cases therefore, when the decision may be partly or even mostly about the money.

What are complementary and alternative therapies?

Complementary and alternative therapies are a wide range of healthcare services that are usually regarded as being outside the scope of conventional medical practice. They are often used alongside or instead of standard treatments and often take an holistic approach to the patient.

The therapies referred to in the policy include homeopathy, acupuncture, aromatherapy, reflexology, osteopathy and hypnotherapy but its principles may be applied to other therapies with similar characteristics that are considered 'alternative' or 'complementary' to standard treatments. Practitioners involved in delivering these therapies are often concerned with the general equilibrium and overall wellbeing of the patient, which is laudable but not necessarily appropriate to NHS commissioning.

What changes have been made to the draft updated and revised policy on complementary and alternative therapies?

The existing policy allows, in certain circumstances, for a number of these therapies to be provided outside the conventional treatment pathway or for therapy practitioners, such as osteopaths, to be referred to by NHS providers. The updated policy no longer supports this approach and only allows the use of complementary and alternative therapies within the NHS care pathway by NHS contracted providers of care. This is because the clinical evidence to support the use of these therapies is extremely limited and cannot sustain broader commissioning by the CCGs, especially in the current environment.

I've been to a chiropractor-reflexologist-osteopath and it worked for me – why should they be restricted or excluded services?

A number of these alternative therapies and treatments may well make a patient feel better and aid their general wellbeing but there is little clinical evidence that these therapies are beneficial in tackling specific health problems or ailments. For example, there is good evidence that osteopathy is effective in treating persistent or recurrent lower back pain but little evidence it is effective for neck, shoulder or lower limb ailments. In addition, the manipulative techniques used by osteopaths are similar to those used by physiotherapists when treating lower back pain so the gain

in using the alternative osteopathy is limited compared to the more conventional physiotherapy. Where there is benefit, the complementary therapies will be undertaken by suitably qualified practitioners within the NHS provider process.

You funded some of these complementary and alternative therapies before – why can't this continue? What has changed?

Yes, some complementary and alternative therapies were funded previously, in certain circumstances. Some will continue to be funded, but in more limited circumstances and only through the NHS care pathway.

There was limited clinical evidence to support the commissioning of these complementary and alternative therapies previously. This situation has not changed and there continues to be limited clinical evidence. What has changed is that your local NHS can no longer afford to support procedures and therapies where there is little or no evidence of their effectiveness when demand for treatments and therapies which have been proven to work are so high and rising. A combination therefore, of current clinical evidence and cost means your local NHS is taking a different approach to the funding of these alternative and complementary therapies.

Why do we need a new policy for rehabilitation after damage to the facial nerve?

Rehabilitation treatments following damage to the facial nerve are not routinely funded by the NHS and have been subject to a number of individual funding requests. When applications for individual funding requests begin to escalate for any particular treatments and are no longer confined to a handful of cases a year, CCGs must decide whether to introduce a service development, which if agreed would mean that treatment will be routinely funded, or whether to introduce a clinical policy which will identify the criteria that must be met for the treatment to be provided.

Introducing a service development is not based simply on the number of treatments now taking place but takes into account other factors such as the nature of the treatment, its effectiveness, the health gain achieved, value for money and its priority in relation to other treatments, new or existing. It was determined that the rising level of treatments for rehabilitation after damage to the facial nerve would be met most appropriately by introducing a new clinical policy.

How many cases for rehabilitation after damage to the facial nerve do CCGs have?

Damage to the facial nerve has a number of causes but overall there are over 300 cases a year across the CCGs in Lancashire. However, of these cases less than a third requires treatment. For the remainder the damage is temporary or the damage is limited and does not affect functions damaged by more serious cases, such as taste, eating and swallowing, eye closure, tear production and paralysis of the face.

I've heard of facial nerve palsy – is this a different problem?

No, facial nerve palsy is a condition resulting from damage to the facial nerve and is therefore, covered by the new draft policy. Facial nerve palsy refers to the partial or complete weakness of the facial muscles and can result in paralysis. Bell's palsy is one of the main causes of facial nerve palsy. A large proportion of damage to the facial nerve cases relate to facial nerve palsy.

When will these policies be adopted by the CCGs?

A firm date for the adoption of these policies has not been determined as there are still a number of processes to go through before the CCGs can approve and adopt these policies. Public engagement will take place over an 8 week period following which there may be changes made to the policies. The policies will then need to be considered by the Commissioning Policy Development and Implementation Working Group, which is overseeing the policy review process, before final consideration by the CCGs. It is anticipated however, that the policies will be adopted and implemented by February 2018.