Cheshire and Merseyside
Commissioning Support Unit

Cheshire & Merseyside - Equality Analysis Report

– Commissioning of Low Clinical Value - Review

(Part One)

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1. Executive Summary

- The majority of consultees accept NICE's recommendations.
- NICE guidelines on commissioning low clinical value services can be adopted.
- Consultation has been conducted, responses have been received across the demographic spectrum and no appreciable discrimination has been discerned although authentic worries and risks have been identified that would have equality/ Human Rights implication.
- Accepting the following achievable recommendations would mitigate any Equality and Human Rights risk ensuring that negative impacts are mitigated in order to satisfy the Public Sector Equality Duty.

2. Recommendations:

- CCGs move to 3 cycles and raise age limit for IVF as part of meeting the PSED under advancing equality of opportunity (Gender Equality Act 2010 and Human Rights Article 16 (1)[1]).
- Better guidance on IVF for same sex couples and transgender applicants.
- Glucose monitoring (the continuous glucose meters in the management of diabetes); public views countered clinical evidence; caution is advised when following NICE guidance. (Disability- Equality act 2010).
- Lycra suites further evidence needs to be developed, but the suits can improve life chances for disabled children, practitioners to consider 'exemptions and Individual funding' (Disability- Equality act 2010).
- Training for key staff in relation to 'exemptions and Individual funding requests' for treatment on identifying equality and Human Rights implication (PSED Eliminate discrimination).
- Monitoring of decision making in relation to 'exemptions and individual funding' (PSED eliminate discrimination).
- Develop Policy Guidance for making decisions around 'exemption and individual funding' (PSED eliminate discrimination).
- Recognise that the Transgender community have a number of concerns and CCGs need to continue to work with the community. (Transgender, eliminating discrimination and advancing equality of opportunity – equality act 2010).
- Clinical specific comments made by the general public must be considered by the relevant decision makers and clinicians (annex 1).
- Develop Action plan to ensure recommendations cohere.

[1] Article 16. (1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

3. Background

The CCG's within Cheshire & Merseyside have inherited legacy documents, policies and procedures from the previous and now defunct PCTs.

The CCG's use NICE (National Institute for Health and Care Excellence) guidelines when deciding on how and what services to deliver. Nice have issued new guidance on the best technical application and appropriateness of some procedures deemed as 'low clinical value'. The aim of the 'low clinical value' guidance is to both update CCGs on new recommendation but also to give guidance to CCGs on what would be appropriate or not in terms of CCGs providing certain provisions.

As such the CCGs felt it was appropriate to ask interested parties for their views on the NICE update for their guidance.

Equality Impact Assessment:

The Law requires that any new service, significant change in service, reduction or removal of service has an Equality Impact Assessment to see if there are negative impacts, i.e. direct or indirect discrimination on particular people because of their protected characteristic, relating to the action. If there are negative impacts, then the CCG has to be cognisant of its Public Sector Equality Duty when making decisions with a view to mitigating the impact or in extenuating circumstances explaining why it cannot.

An Equality Impact Assessment is the document that:

I. Sets out the detail of the change in relation to the Equality legislation.

II. Analyzes the input from interested parties.

III. Identifies any concerns and worries related to equality issues.

IV. Proposes recommendations for Committee to consider.

4. Details of Change in Relation to Equality Legislation.

In order to identify potential equality impacts the full NICE guideline was reviewed, in the first instance to identify particular procedures that effect particular protected characteristics (see pre-EIA for full list). Once this was identified then a specialist team with clinicians looked at the detail of the change, many changes were simply procedural or 'better medicine' meaning there would be 'no clinical difference from the patients perspective' however, there were a number of changes that seemed significant enough that may have an 'equality impact' and of which interested parties may need to comment.

Speciality / Clinical Area
7.1. Infertility Services
20.3 Interventional treatments for Varicose Veins
19.2 Penile (Penis) Implants
21.1 BotulinumToxin
11.3 Mental Health
14.1 Oral Surgery – extraction of wisdom teeth
16.5 Plastic and Cosmetic Surgery
17.1, 17.2 - Respiratory Services
18.2, 18.3, 18.18, 18.19 Trauma and Orthopaedics
1.1 Weight Management (Bariatric) Surgery
2.1 Complementary Therapies (including Homeopathy)
3.1, 3.2, 3.4 Dermatology
5.2, 5.3, 5.4, 5.5. 5.7 Ear, Nose and Throat
8.1 Gastroenterology
9.1, 9.2 General Surgery
10.1 Gynaecology
13.1,13.2, 13.3, 13.8 Ophthalmology
16.1, 16.2, 16.3, 16.4, 16.6, 16.7, 16.8, 16.9, 16.10, 16.11, 16.12, 16.13, 16.14, 16.16, 16.17, 16.18 Plastic and Cosmetic Surgery
18.15, 18.17, 18.20, 18.21, 18.22, 18.23 - Trauma and Orthopaedics
4.1 Diabetes - Continuous Glucose Monitoring
3.3 Dermatology
6.1 Equipment (Lycra suits)
12.1, 12.2, 12.3 Neurology
13.5 Ophthalmology

14.3 Oral Surgery 16.8 Plastic and Cosmetic Surgery 18.1, 18.4, 18.5, 18.6, 18.7, 18.8, 18.9, 18.10, 18.11, 18.12, 18.13, 18.14, 18.16, 18.22 Trauma and Orthopaedics 19.1, 19.4, 19.5, 19.6 Urology 20.1, 20.2 Vascular Services
5.1, 5.6, 5.8 Ear, Nose and Throat 9.3 General Surgery 11.1,11.2, 11.4, 11.5 Mental Health 13.4, 13.6, 13.7 Ophthalmology 14.2 Oral Surgery 15.1 Paediatrics 18.23, 18.24, 18.25, 18.26 Trauma and Orthopaedics 19.3 Urology

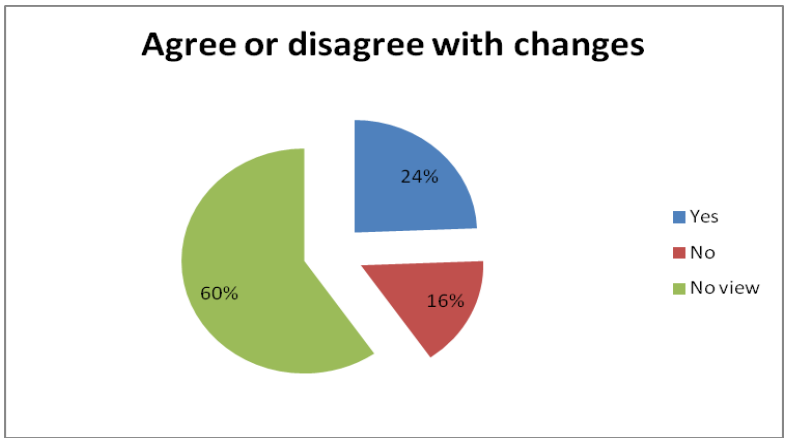
5. Analysis of Feedback from Interested Parties

The consultation reports show that extensive work was done in term of making interested parties aware of NICE's proposed changes and giving them opportunities to respond. Full methodology of the consultation are available in the individual CCG consultation report 'Commissioning Policy Review'.

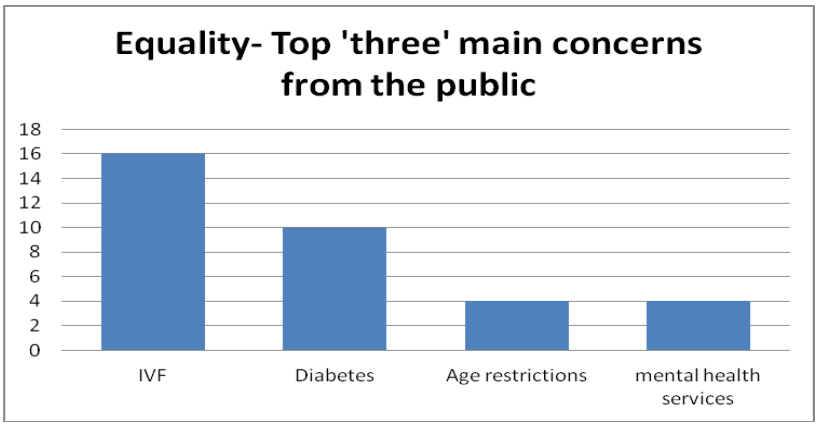
Online survey over view[2]

- 590 people entered online survey.
- Broad demographic mix of responders.
- Responders where in the majority female.
- Views aired by responders cut across the demographic.
- Of those that answered there was overwhelming support for NICE guidelines on commissioning low clinical value.

[2] Full online survey report is Part 2



- Clear concerns were raised, of which the top 'three' concerns linked to:



- IVF – overwhelming consensus that CCGs should offer 3 cycles and raise the age limit.
- Diabetes- In spite of clinical guidance suggesting that the continuous glucose monitoring was only beneficial to a narrow cohort of patients, public comments provided counter argument and evidence to this.
- Age Restrictions – concern was raised that to either not start a procedure or to curtail a procedure on the grounds of age was worrying – many provided contra evidence where the procedure as worked outside the age threshold.
- Mental health service – grave concern was raised over the diminishing mental health provision.

Focus Groups

Due to the difficulty in capturing opinions from the transgender community (due to its small size and dispersment) and because of the new specialist commission guidelines around 'gender dysphasia[3]' a focus group took place. A full report of this meeting and Transgender concern is in the annex 2 below, but the highlights are:

[3] Transgender dysphoria is the term used within the medical documents – its a term not necessarily supported by the transgender community. The Gender Dysphoria Protocol & Service Guidelines 2013/14

http://www.england.nhs.uk/wp-content/uploads/2013/10/int-gend-proto.pdf

- 6 representative from various Transgender groups attended.
- They will continually disperse information and feed information back to CCGs.
- Commented on 29 Policy areas.
- Comments were rated into high, medium and low importance.
- The high importance areas where areas that could disadvantage transgender community in relation to local CCG commissioning include:
    - Rhino Plasty
    - Augmentation Mammoplasty
    - Hair removal treatments
    - Removal of surgical scars
    - Treatment for hair loss

Other Interested parties

- Businesses connected to health care were also encouraged to give feedback – none of the feedback received highlighted any equality implication.

6. Risks.

Where the NICE guidelines provide for additional provision (e.g. .IVF 3 cycles and a higher age range) it would be incumbent on CCGs to ensure that all CCGs within the group follow the same actions. Failure to do so may potentially leave the CCG that offers less open to appeal and litigation.

In addition, CCGs need to keep in mind that the NICE guidelines are recommendations and in some cases it may be clinically expedient to provide or continue a procedure – this can be done via the exceptions and individual funding routes.

Where discretion is used on whether or not to go beyond the guidelines then it would be extremely good practice to record/monitor the decisions. Where decisions trigger the individual funding request process, including appeals then CCGs would need to ensure that as part of this process, that they consider, alongside any clinical assessment, any Human Right or Equality Duty that may be being impinged.

7. Recommendations in Detail

- CCGs move to 3 cycles and raise age limit for IVF as part of meeting the PSED under advancing equality of opportunity (Gender Equality Act 2010 and Human Rights Article 16 (1)[4]).
- CCGs need to clarify guidance for same sex couples and the transgendered in relation to service over IVF and other concerns related to the focus group outcome.

[4] Article 16. (1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

(Transgender, eliminating discrimination, advancing equality of opportunity – Equality Act 2010).

- Glucose - In spite of clinical guidance suggesting that the continuous glucose meters in the management of diabetes was only beneficial to a narrow cohort of patients, public comments provided counter argument and evidence to this. From the comments it was clear that the treatment improved life chances for the members of public who responded. CCGs and health care practitioners need to keep in mind the 'exceptions funding route'. (Disability, Advancing equality of opportunity, – Equality Act 2010).
- Lycra suites – further clinical evidence is needed in relation to this subject (of whether they are workable) and has been requested by CCGs. There are some circumstances where they would clearly improve life chances and at such points CCGs should commission their use. This can be done through the exceptions funding route. (Disability, advancing equality of Opportunity- Equality Act 2010).
- Age bars. Concern was coming from the public at seeing age delineation in prescribing medication. Evidence was offered showing the success of the medication outside the restricted age. Caution needs to be advised. (Age, eliminating discrimination, Equality Act 2010).
- Clinical specific comments made by the general public must be considered by the relevant decision makers and clinicians. These comments fall outside the expertise and remit of this Equality Impact assessment but may be of significant interest.(annex 1)
- Transgender Recommendations- that high importance areas identified through the focus group are considered by local CCGs Individual Funding request decision makers under exceptional clinical needs, if the treatment is relevant to protected characteristic and life chances , then treatments should be approved. (Advance equality of Opportunity- Equality Act 2010- gender reassignment)
  Ensuring GPs and health professional understand the new interim guidance and pathway for gender dyphoria and how this interacts with the low clinical value policies
  Seek clarity from NHS England on any grey areas detected as a result of the feedback (Annex 2).
- Training & Briefings for all CCGs and people connected with individual funding request route on identifying equality and Human Rights implication (PSED Eliminate discrimination)
    - General briefings to help professional to be distributed by CCGs
    - Specific targeted Training to the individual funding request panel/s around Equality and Human Rights (especially considering the Bristol Judicial Review case)
    - Develop succinct guidance within the individual funding request policy
- Monitoring of decision making in relation to exemptions and individual funding requests (PSED - eliminate discrimination).
- Action plan for traction to ensure:
    - The above recommendation on clinical policy are formulated to ensure they are inculcated by all CCGs
    - The consultation process is reviewed under 'lessons learnt' to ensure the communities diverse voice is more fully heard and understood
    - Training, guidance and monitoring are embedded in to the individual funding practice.

Accepting the NICE guidance and consulting with interested parties incorporating their views in to decision making by following the above recommendations will ensure that Cheshire and Merseyside CCGs are compliant with the Public Sector Equality Duty.

End of Part One.

Part 2
Consultation Report:
Equality Data – Online Survey

1. Introduction

For full details of the consultation process and methodologies see report see individual consultation report on the commissioning policy review.

This section of the Equality Impact assessment will look in detail at:

1. Who replied
2. What was the general consensus
3. What issues were raised in relation to 'equality considerations'

2. Responders

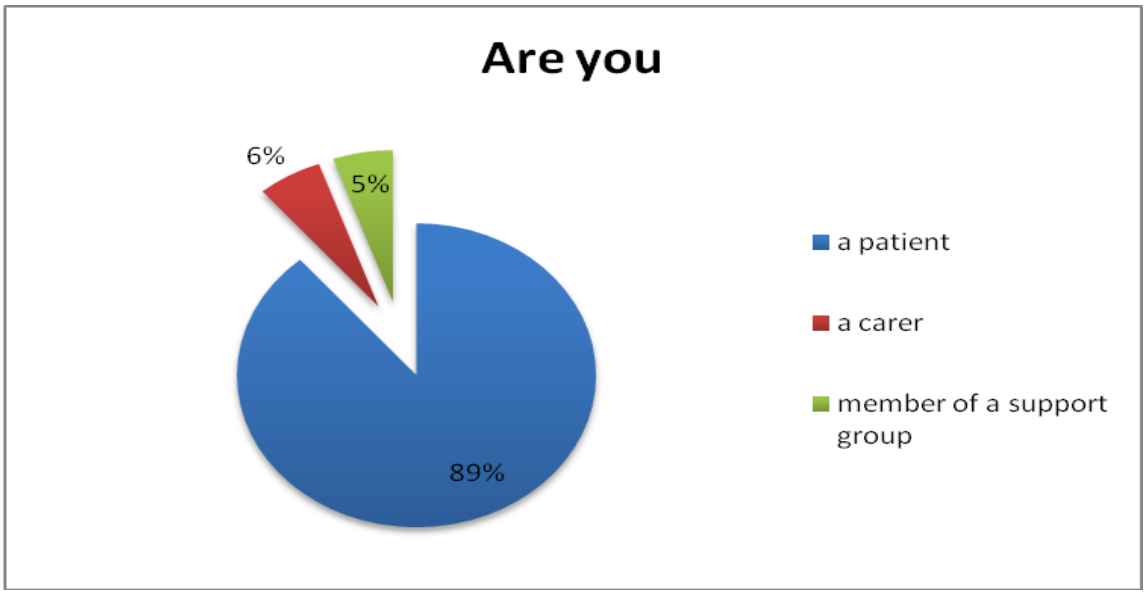
The online survey showed that 590 people entered the survey and gave answers to either all or some of the questions. The data below shows the number of respondents that give answers to particular equality questions. This is an important part of the survey to ensure that we can test whether there is a fair representation of the public and whether or not a particular view is coming from a particular group which would need to be specifically addressed. The survey was backed up by group meetings of particular groups, such as transgender to help identify issues that may be of concern to particular groups and identify any worries or concerns.

Cheshire & Merseyside = 291

Wirral = 255

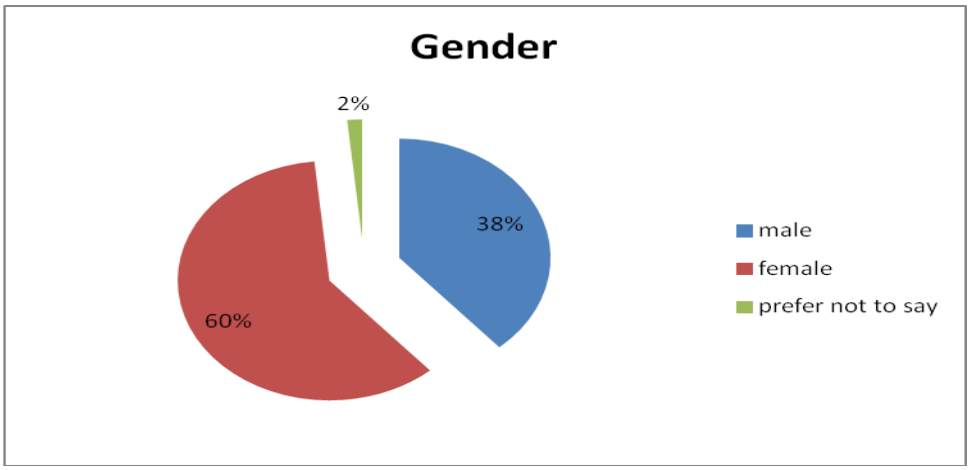
Liverpool = 44

The survey set up parameter in order to identify responders, the three broad areas where; patient, carer and member of support group of all the respondents, 516 selected one of the categories.



Of all responses, 439 give data identifying their gender:

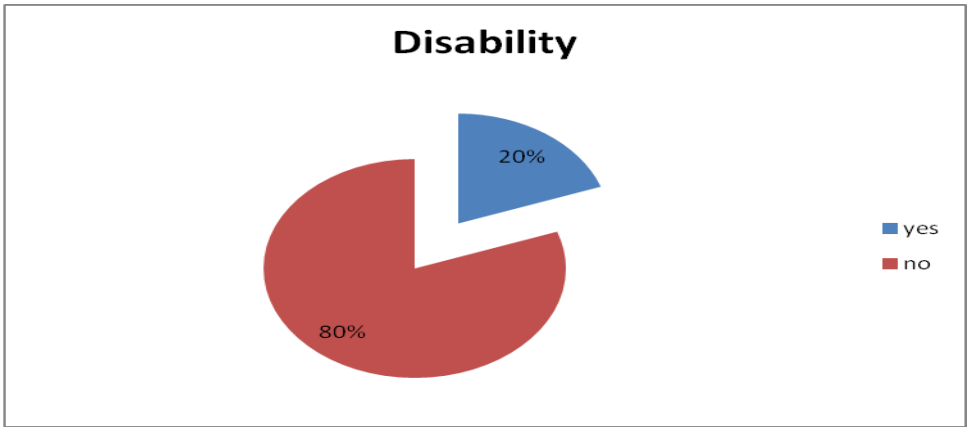
Gender[5]



There were no responders who identified as Transgender - however a focus group for Transgender was formed and reported in Part 1 of the EIA.

Disability[6];

We asked respondent whether they considered themselves to be disabled of all respondents, 430 selected either yes or no as follows:

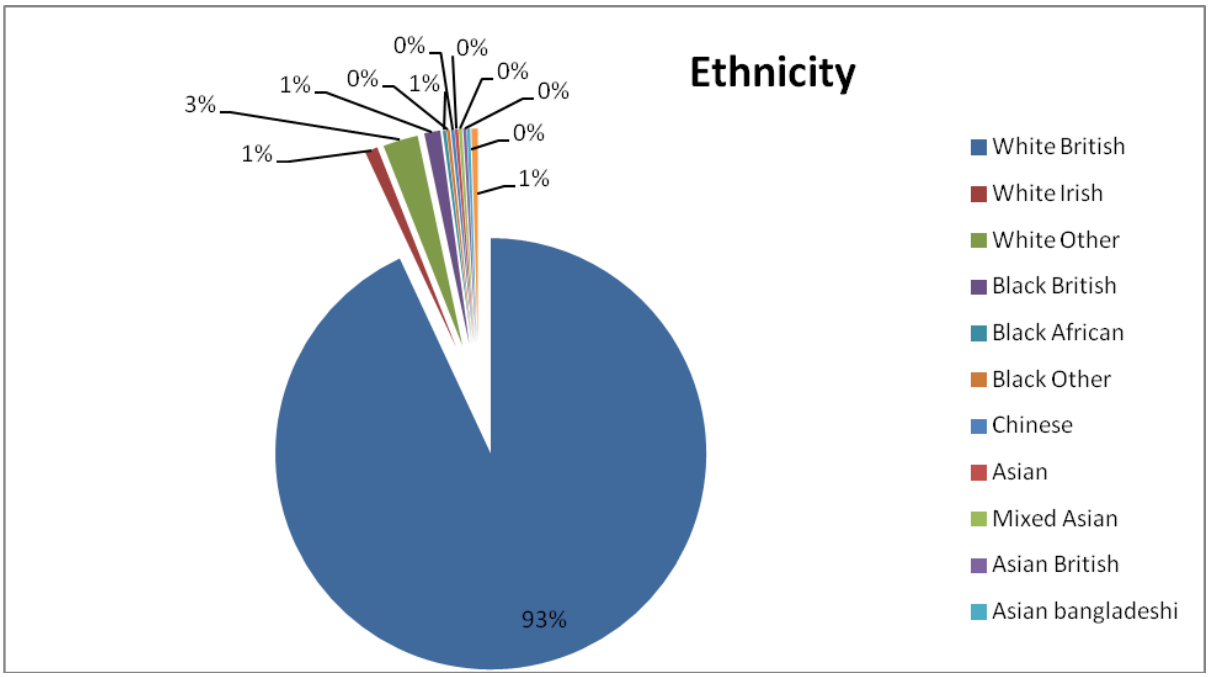


[5] The questionnaire did have facility to select male to female transgender and female to male transgender but none were selected

[6] The survey made it clear that we were using the definition of disability as defined in the Equality Act 2010

Ethnic Origin[7]

Of those who responded 417 ansered the questions on 'ethnic origin'. 'White British' was the largest group with which people identified (where the chart indicates 0%[8] the numeric value is 1).

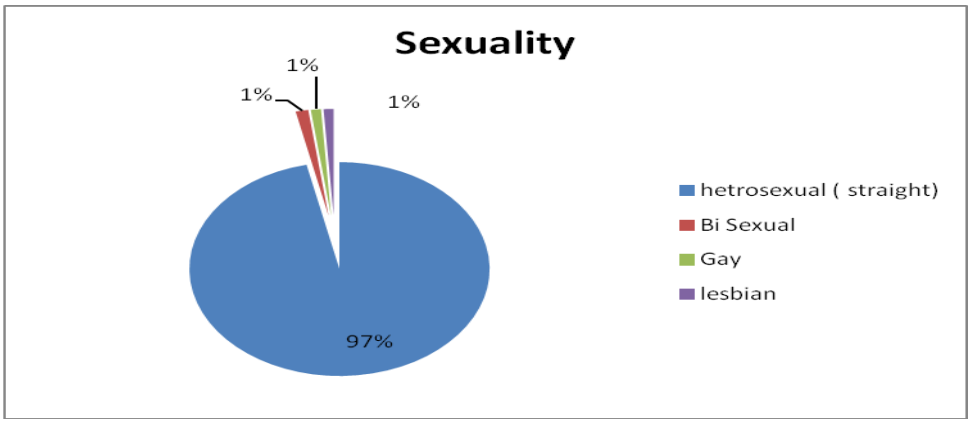


The data shows a particularly low response from BME . Given the survey was a random survey (anyone could respond) there is an under response from BME community.

Sexuality

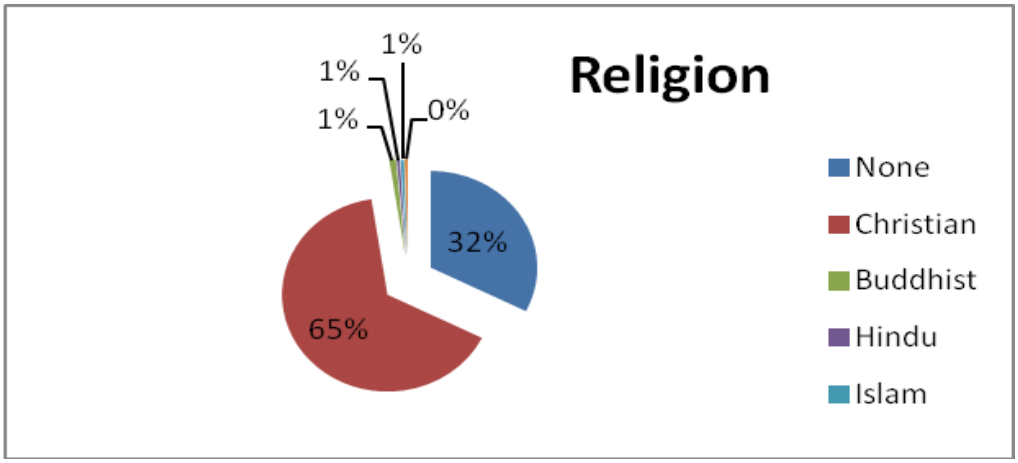
367 responders selected sexuality. Given the survey was a random survey (anyone could respond) there is an under response from the LGBT community.

[7] All ethnic origin categories where used in the survey – this chart shows those with a response 0% equals 1 for the purposes of this chart.



Religion[9]

408 responders selected a category under 'religion'

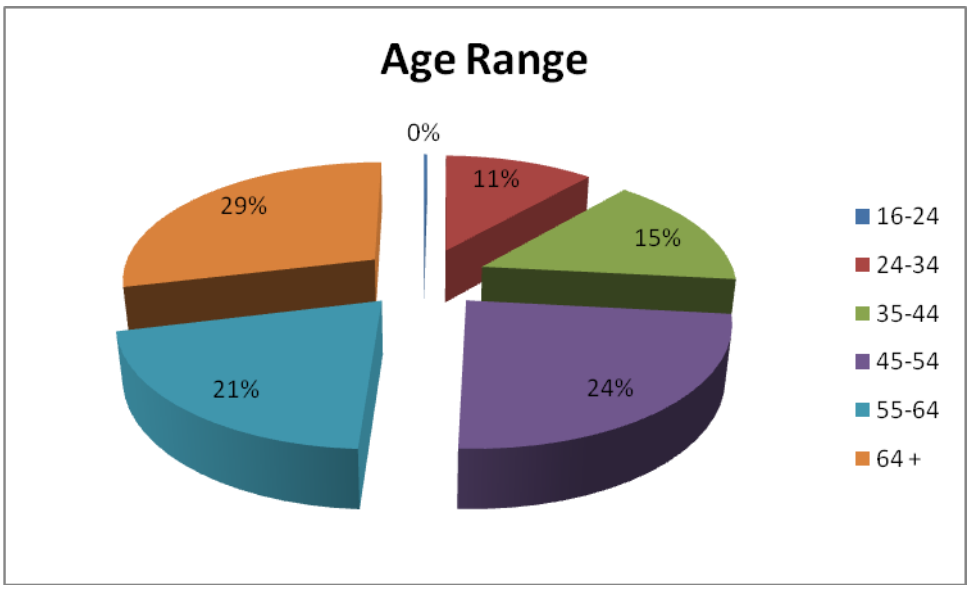


Similar to the under representation from BME, on the religious question there was little reporting of being 'Islam'.

[9] All religions were given as an option. The chart only shows those that were selected, including 'none religion' where the chart indicates 0% the actual number of respondents for this category was 1.

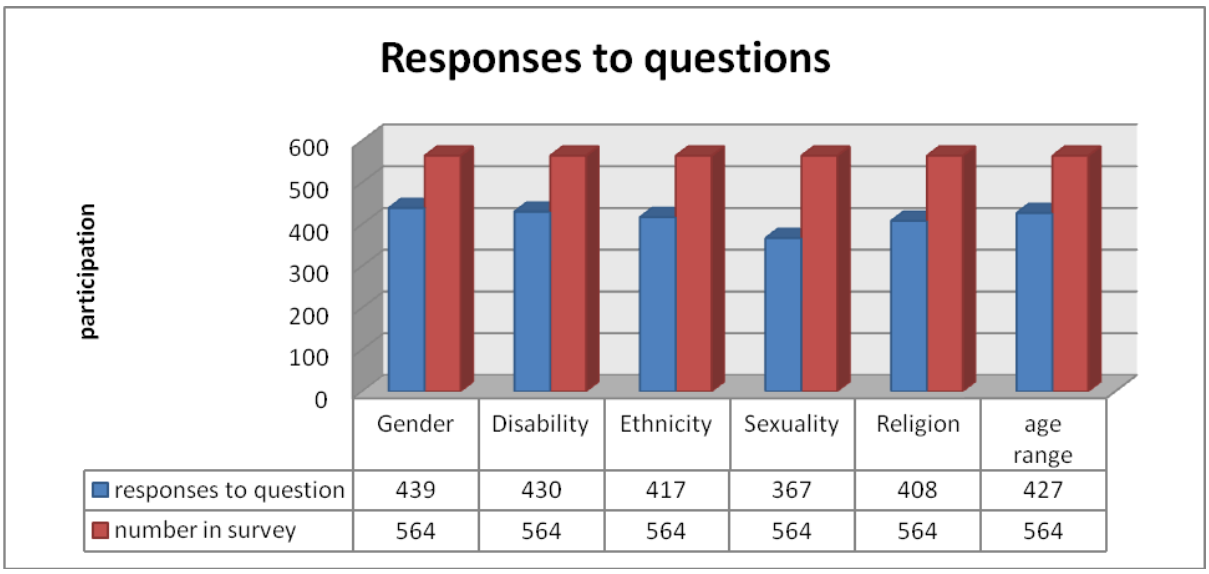
Age Range

427 responders indicated their age range. (0% equals 1 person). There is an under representation in 16 – 34 age range. The biggest age group responders were the 64+ Age range.



Rate of Response

Not all participants in the questionnaire responded to every question and non of the equality categories recieved a full response. The highest responses where given to age and gender (the most familiar and often asked questions), the lowest reponse was given to sexuality, however, even here there was a significant rate of response whihc shows people are willing to disclose information.



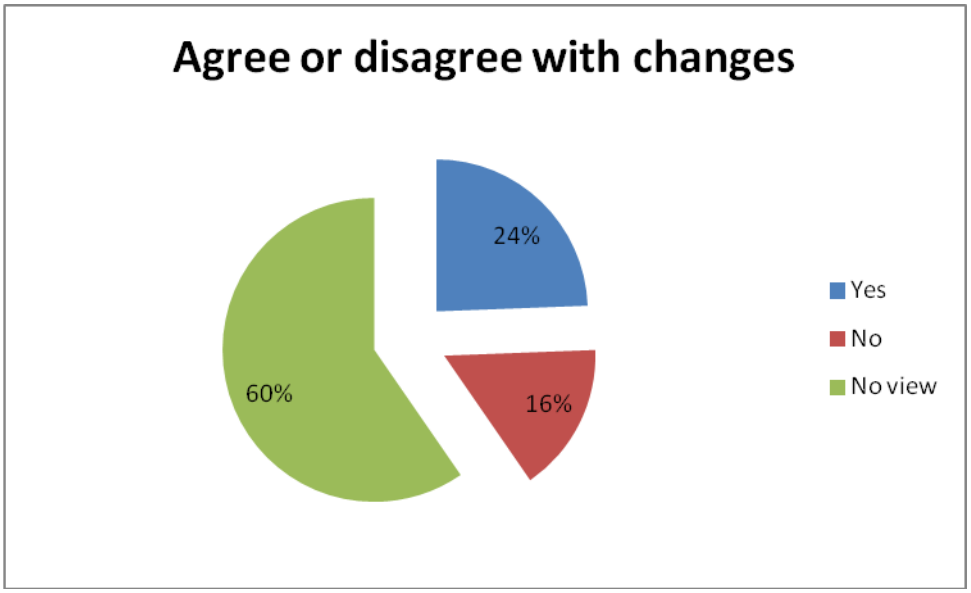
	Gender	Disability	Ethnicity	Sexuality	Religion	age range
responses to question	439	430	417	367	408	427
number in survey	564	564	564	564	564	564

End of section 1

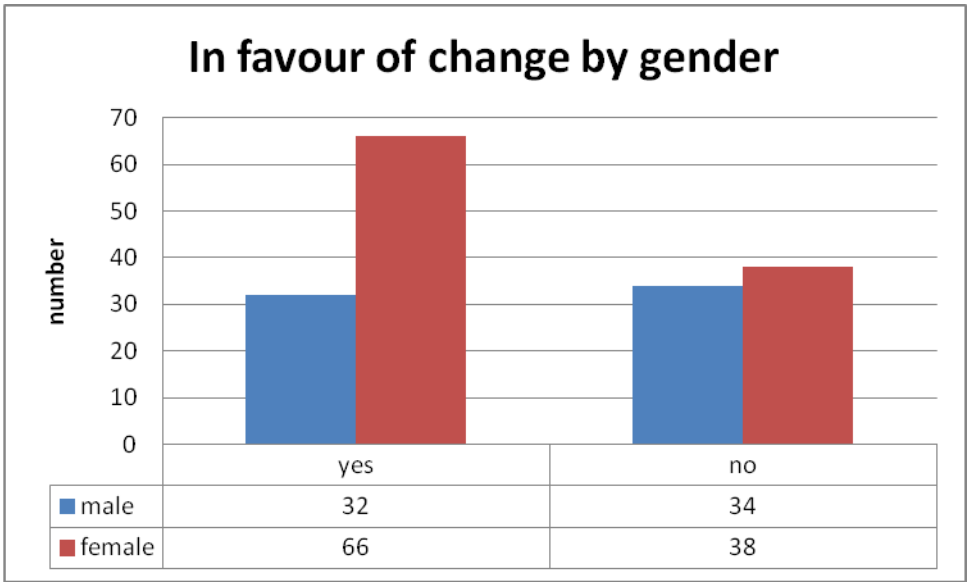
Section 2:

General Consensus

On the quesiton of whether or not respondents agreed with the need to adopt the changes recommended by NICE on the low clinical value there were 235 that expressed a definate view of either 'yes ' or 'no' and 347 (well over half the respondess) that did not answer the question one way or another. Out of those that answered there was a clear view to accept the changes.



When those that either siad 'yes' or 'no' where analysed by gender we could see that a larger proportion of women voted Yes than men.



Section 3 – Equality Issues

As part of the survey if responders didn't agree or wanted to comment on the changes then at 'question 12'[10] they were encourgaged to leave comments – its expected that only a small minority of respondents will leave comments.

The comments could be roughly broken down in to several types of response headings:

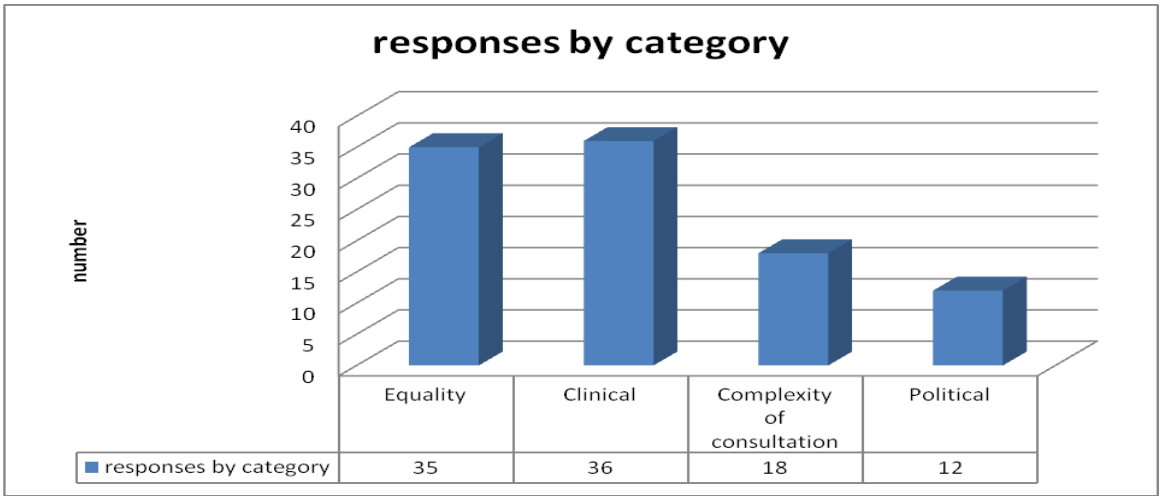
1**. *Political*** – comments clearly worrying about privatisation and rationing in the NHS.

2. ***Equality*** – Comments that clealry focus on equality issues (these are the main focus of this report).

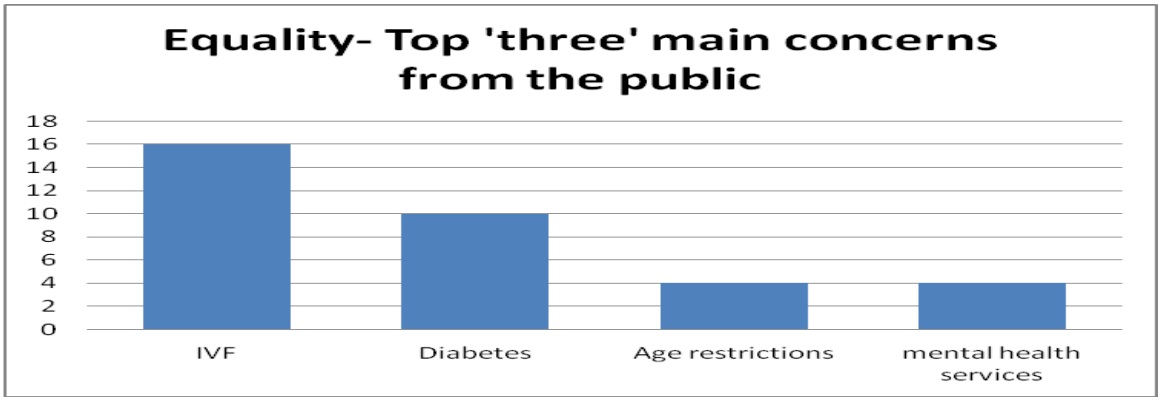
3. ***Consultation process*** – comments expressing concern over the amount of material and the complexity of the material.

4. ***Clinical Comment*** – comments that give their experiences of using serivces or advice on treatments- in some instances providing contra evidence to the NICE guidline.

There were 101 comments left by the responders:



In looking at the 'equality issues' there were clealry patters of concern:



[10] **Q12 If you do not agree with the planned changes to the draft policy please briefly tell us why? (250 word limit)**

Section 3 Written responses from the online survey concerning 'Equality Issues'

Response Text to Q12	Categories	Protected Characteristic	PSED	Issue for Consideration by CCG
Infertility treatment should be supported.	Equality Issue	Gender	Advance	*Support for three cycles*
Warrington CCG should fall in line with NICE guidance for the maximum number of cycles with respect to IVF (three). One funded cycle (despite increasing from 0) is not good enough considering success rates of treatment meaning follow on cycles are typically 'a given'. I feel the pressure of only being funded for 1 cycles is actually detrimental to the process as it places more stress and anxiety on to a patient pre and post ivf knowing that failure will not only be a tough situation to deal with but also have a massive financial impact following this that many struggle to afford. This also falls behind neighbouring CCG's who offer at least two cycles.	Equality Issue	Gender	Eliminate & Advance	*Support for 3 cycles but a clear request that ALL CCGs support the NICE recommendation*
? possible age discrimination rather than based on clinical or scientific evidence base	Equality Issue	Age	Eliminate	*CCGs note that there are funding routes based on individual needs via 'exceptions and individual funding requests' Age bars are for guidance only.*
I would assert that this is contrary to the Equality Act 2010, which you should know came into force in October 2012. There is no evidence to support that the withholding of Orthodontic Treatment to those aged 18 or over will any way benefit them positively and there is therefore no basis for managing their needs differently and hence discriminating against them.	Equality Issue	Age	Eliminate & Advance	This questions the bases for an age related cut off
I agree that the things proposed are useful, but I also think that Foot Care for older people needs to be included.	Equality Issue	Age	Eliminate	*For consideration*

I m not really clear as what is proposed by my ccg as whether those 40 plus qualify for Ivf however as someone whose life has been deeply affected by infertility I would strongly support the Ivf being available up to ages 42	Equality Issue	Gender/ Age	Advance	Wants to extend age range for IVF to 42
I do not support the changes to 7.1 or 20.3 considering that these do not constitute a significant impact on the quality of the health of the population and therefore are not priority for additional expenditure	Equality Issue	Gender	Advance	*This person disagrees that these treatments should be given at all.*
Equality across boroughs when it comes to awarding infertility cycles would save much heartache for childless couples who end up living in the 'wrong' area. Specifically, being eligible for three cycles consistently across commissioning areas would be much fairer and give childless couples a chance. Whilst I understand that budget is limited, equality is preferable to the current situation where depending on your post code some couples are only eligible for one cycle	Equality Issue	Gender	Eliminate & Advance	Support for IVF 3 cycles but wants all CCGs to support the NICE recommendation

I think CGM should be offered more widely, particularly where it's been proven to improve blood sugar control. As someone who has had type 1 diabetes for 36 years, it is not just about getting a good HBA1C reading, it is also about the day to day control and how you reach that end target. It's no good having a great HBA1C but having debilitating hypos constantly. Having temporarily used CGM last year, I found that not only did it improve my HBA1C overall but more importantly it helped me to get rid of some of the fluctuating glucose levels I was experiencing and helped me to have less hypos. The trend graphs on the CGM were invaluable in helping me to keep track on what my glucose levels were doing, and how my body reacts to different foods. It helped me to avert hypos or highs by looking at these trends. By downloading the data onto my PC I could pinpoint where I needed to make changes to my basal. The alarms on the CGM, particularly for low sugars, gave me greater confidence – so instead of going to bed with higher levels than I should for fear of a hypo during my sleep, I felt happier to have lower levels knowing that the alarm would wake me up if my sugars did dip too low. And seeing the trends throughout the night I was able to make adjustments to prevent highs and lows.	Equality Issue	Disability/Age	Advance	Offers evidence to suggest that CGM is a useful process especially for younger people.
Assisted Conception is expensive, not very successful, extremely stressful and more emotionally driven than clinically. It has also overreached the limits of ethics and the law. It must be tightly controlled both within and outside the NHS (where it is also highly profitable). Whilst hysterectomy has been the commonest operation on females, used far too liberally, there are now many alternatives and the clinicians should be allowed to judge when it is necessary and justified.	Equality Issue	Gender	Eliminate	*This person disagrees that these treatments should be given at all.*
Insufficient information on CCG decision re funding for CG monitors for adult T1 diabetics.	Equality Issue	Disability	Eliminate	

On reading the summary documents, it is difficult to understand what changes the CCG is planning to make. However, for infertility treatment for example, if the suggestion is that the access to this for couples will be restricted, this might be considered unfair. Also, for patients undergoing gender reassignment, it might be considered unfair if they could not access penile implants. The policy summary isn't specific on what the "circumstances" are when penile implants will be accessible and therefore it it difficult to judge whether the changes are appropriate.	Equality Issue	Transgender & Gender	Eliminate	*This person questions whether there is equality in treatment especially when the request comes from a transgender perosn/need – develop clear guidance/further information on same sex couples and AI*
19.1 - not sure that I fully understand the wording of the proposals, but I wanted to say that, as a 69 yr. old gay man with Type 2 diabetes, I still have/want an active sex life. Fortunately, medication helps me if I need it, but I would value the option of an implant if it became necessary, as I find my sex life impacts quite strongly on my emotional and mental state. (Gardening and house maintenance don't always fulfil my needs!) 19.2 - As someone who was circumcised at birth, I don't think that this should be offered on the NHS for social, cultural or religious reasons. (My only worry is that this might lead to unauthorised, poorly supervised circumcisions being carried out, with resultant risk of damage and/or infection, similar to the problems arising from Female Genital Mutilation.)	Equality Issue	Gender	Advance	

My son has used CGM on a couple of occasions supervised by the Paediatric Department at COCH. On one occasion we used it to identify glucose movements overnight and as a result I have programmed his insulin pump more effectively. On the second occasion he used it for his first overnight school trip away, the fact that the system sounds an alarm when his blood sugar goes high or low gives him, and his teachers, confidence that he wont die (his words!). (He had never spent a night away from his parents and is 12 years old). I very much support the use of CGM where there is a medical need and as part of the overall treatment plan. I don't think that frequent use of CGM by individual patients is necessary.	Equality Issue	Disability/Age	Advance	*Offers evidence to suggest that CGM is a useful process especially for younger people*
I understand that funding is extremely limited with CCGs, LAs, etc but to continue with a policy that prevents couples where one or both partners have children from previous relationships from having free fertility treatment on the NHS is ridiculous. The CCG need to consider the amount of funding that is wasted in others areas of it's business then perhaps it may find extra savings. The majority of the population who need fertility treatment are unable to raise £5-6k for IVF treatment without getting into debt which in turn has negatives consequences and pressures on other resources in the NHS such as depression and anxiety.	Equality Issue	Gender	Advance	*This person disagrees with the criteria for being allowed IVF - especially if one of the partners already has children from a previous relationship*

CGM is a relatively new technology and there is not a great range of research yet to support use. In our case it has completely restored a sense of 'normality' to our family. our son's HBA1C is improved, his blood glucose control is much better (and within tighter margins) and lows greatly reduced. He is eating a wider range of foods, performing better at school and is happier (Bgs are within range, he feels better) and more independent. He participates confidently in a wider range of activities which previously have caused difficult blood sugars. We are getting better sleep as we are not constantly testing through the night due to highs/lows at bedtime/ in the night. We have been able to deal with teen growth spurts and consequent changes to insulin pump basals very confidently, quickly and pro-actively. We could not have done this for him without CGM.	Equality Issue	Disability/Age	Advance	*Offers evidence to suggest that CGM is a useful process especially for younger people*
My daughter is waiting for CGM and the new changes may affect how long she has to wait or even if she can have one.	Equality Issue	Disability/Age	Advance	*Offers evidence to suggest that CGM is a useful process especially for younger people*
I don't believe IVF treatment should be offered more than once on the NHS but agree with the BMI and smoking arrangements within the policy. Varicose Veins - Agree that the service should be extented to those in pain. Penile dysfunction - Agree that treatments should be extended for severe structural disease and malformations.	Equality Issue	Gender & Disability	Advance	*This person disagrees with three cycles for IVF*

We use the sensor on an occasional basis to help us to adjust basal rates when B**** has had a growth spurt or when her insulin needs change, the sensor information is much more accurate to help us to do this. We also use the sensor when she is ill or when we are away, for example at new year we stayed with friends and she therefore was staying up late and doing different activities than normal, the sensor allowed us to pick up on several hypos before she became too low and made it easily ear to put on temporary backgrounds and adjust the basals to maintain control, without this she would have had to be removed from the other children, or would have had severe hypos or severe hypers and then been unable to join in family activities the following day as she tends to take a good 24-48 hrs to recover when hypos or hypers are severe. When we last changed her pump, we stayed with Medtronic purely as there pump had a sensor which we did not want to loose despite it having some downsides such as not being waterproof, which is a problem with swimming water polo and kayaking which she does weekly.	Equality Issue	Disability/Age	Advance	*Offers evidence to suggest that CGM is a useful process especially for younger people see recommendations*
I have read the basic version and the end comment "The impact for patients is that they may not receive a Botulinum toxin A treatment." I have seen very good result from the use of Botulinum toxin for spasticity post stroke and am concerned about patients not being able to get this treatment. It can make such a difference to someone's life and make them more able to care for themselves. This will enhance their self esteem and self image thus reducing depression and consequently medication in another area.	Equality Issue	Disability	Advance	

My son has type 1 diabetes and has an hb1ac that is at best 11.0+ he has ADHD but is unable to take methylphenidate medication as (along with other side effects) it interferes with his appetite causing more problems with his blood glucose levels. I have been unable to access CBG monitoring for him to date and believe the proposed changes will put this treatment even further out if reach. It is my belief that a short period of CBG monitoring would benefit him greatly as his sleeping patterns make it very difficult to monitor his BG effectively.	Equality Issue	Disability/Age	Advance	*Offers evidence to suggest that CGM is a useful process especially for younger people*
I having been caring for my daughter who was diagnosed at age 2 with type 1 diabetes, she is now six years old. I am pleased she has the insulin pump as I know this is the best possible treatment for her condition. Despite the pump her diabetes is still very difficult to control. She can have several hypos in a day and she often has many high blood sugars. It is 24/7 with diabetes. When we have trialled the sensor we have been able to see her hypos coming and stopping them before she gets dangerously low, because L**** has so many hypos she can get really low before she feels the physical symptoms . This is particularly worrying especially as I have to leave her in school. The sensor also helped us intervene before her bloods get to high. Once the sensor was calibrated well it saved her having her finger pricked constantly, getting her down to just two tests a day. It was very valuable to us.	Equality Issue	Disability/Age	Advance	*Offers evidence to suggest that CGM is a useful process especially for younger people see recommendation section*
Fertility services and varicose veins should still be readily available on the NHS without restrictions.	Equality Issue	Gender	Advance	
support new infertility policy and move in line with NICE	Equality Issue	Gender	Advance	*the comment supports the move for three cycles, see recommendations*

My daughter has type 1 Diabetes. Continuous Glucose Monitoring has been vital for my daughter especially to gather information about what is happening to her glucose levels during the night. My daughter has severe learning difficulties and severe communication difficulties so having access to this type of equipment has meant health professionals give better support and more person centred advice. I have friends too who struggle to understand their diabetes and how best to control their blood sugars and I know they too have valued the help and support that wearing a CGM system has given when they are at a loss to know how to control their erratic blood glucose levels. Diabetes is on the increase and those who have the condition especially young people like my daughter and her carers need as much support as they can possibly get. It would be detrimental to my daughter and friends if this piece of equipment was no longer funded for use by those who need it most.	Equality Issue	Disability/Age	Advance	*Offers evidence to suggest that CGM is a useful process especially for younger people*

ADHD and paediatric services need to be higher on the agenda, recent cuts to the number of clinicians and paediatricians available are significantly impacting on services and available support	Equality Issue	Age & Disability	Eliminate & Advance	Please note disability and children services are raising concerns of service users.
I believe the NICE guidance 156 should be adopted in full.	Equality Issue	Gender	Advance	*support for 3 cycles but a clear request that ALL CCGs support the NICE recommendation*

I would like to see the shift to 3 rounds as with each patient the reasons and problems for infertility are many. The drugs used may need to be tweaked from the first round as it is not predicted how the patient will react to them and so can be more of a trial run for many. The second round is not always likely to have a positive outcome as it is down to many variables, which can produce success in one area but failure still in another. Liverpool is still not set up to do tests for immune problem and other factors that can cause problems in fertility - this is offered in most private practices world wide. Also the choice to only put back one embryo also has a setback for those unable to afford more than 2 courses of treatment. I feel in the case for unexplained infertility in couples there is not a quick fix as there is no obvious reason for problems which can be looked into and therefore according to my embryologist at Liverpool - throw mud at a wall and it will eventually stick! in other words the more goes with fresh and frozen embryos the better.	Equality Issue	Gender	Advance	*support for 3 cycles but a clear request that ALL CCGs support the NICE recommendation*

Varicose veins have been the subject of a new NICE guideline and I do not believe that your proposals are compatible with the NICE guidelines. Having had my varicose veins operated on at Clatterbridge, it has had a major positive impact on my working life. They used to ache terribly and as I work on my feet all day I was unable to do a proper days work. I have never had an ulcer or phlebitis and the new NICE guidelines make it clear that there is benefit from varicose vein surgery in all symptomatic patients. You should apply the NICE guidelines in the same way that you expect hospitals to apply them.	Equality Issue	Age	Advance	*CCGs& health professionals may need to consider individual circumstances via individual funding request route*
I feel there is an necessary change to the bariatric service as currently there is n facility for CBT which is a qualifying need for bariatric surgery without this you can never qualify for surgery . Hence there is a blockage in the system where only people with a BMI over 50 will qualify I feel this is prejudices of people with a slightly lower BMI and denying them surgery. This I view as a major change requirement	Equality Issue	Disability	Eliminate & Advance	*In form relevant CCG of potential gap in service – health professionals may need to consider individual circumstance funding route.*

Backward policy with no regard for patients	Equality Issue		Eliminate	*monitor patient satisfaction levels with service*
I think IVF should be available to the older age group but think that two cycles on the NHS is more than a fair portion of the NHS funds available when there are still insufficient life saving kidney machines and life saving cancer drugs and treatments.	Equality Issue	Gender	Advance	*This person disagrees with three cycles for IVF*
It is not at all clear what NHS provision now exist in these areas ie exactly what routine NHS care is available for eating disorders etc- is in patient specialist care available?- if it is and is sufficient to meet need, then private provision should not be necessary and not used.	Equality Issue	Disability	Eliminate & Advance	*Funding provision is available for eating disorders i through specialist commissioning (NHS England) Local CCG funding should take account of this on individual basis.*
I agree in general to evidence based changes in treatments. I am not convicted that gender reassignment surgery, specifically penile implants have a medical justification, so should not be commissioned.	Equality Issue	Gender/ Transgender	Eliminate & Advance	*This individual doesn't support the NICE guidance*.
Please can it be considered that IVF treatment be available in order for family's to create a sibling?	Equality Issue	Gender	Advance	*request is currently outside NICE guidance*

END OF COMMENTS.

ANNEXES :

1. Responses by online users.
2. Transgender forum report and concerns from Transgender community.

Annex 1

Responses by online users.

These are the comments left by online survey responders to Q12 (tell us why you disagree with NICE guidelines) many of the comments answer this indirectly but none the less, in terms of transparency and completeness have merit and information **that needs to be viewed before 'committee decision making'** . **Whilst all comments need to be read, those highlighted need particular attention**.

The comments can be roughly broken down in to several types of response headings:

1. ***Clinical Comment*** – comments that give their experiences of using serivces or advice on treatments- in some instances providing contra evidence to the NICE guidline (page 1 -10 below)
2. ***Political*** – comments clearly worrying about privatisation and rationing in the NHS (page 11 – 12 below)
3. ***Consultation process*** – comments expressing concern over the amount of material and the complexity of the material being consulted upon (page 13 – 15 below)
4. ***Equality*** – Comments that clealry focus on equality issues (these are reported in Part 2 of the Equality Analysis report and not below)

Clinical Comments

Comments classed as 'Clinical comments' are comments with a clear view on what should and shouldn't be funded, comments that give medical back stories, comments that suggests alternative ways of working as clinicians/practitioners. (all personal identifiers, other than first names, have been removed in accordance with the Data Protection Act)

Comment	Type
Bariatric surgery is a waste of NHS resources. They should be referred to a gym or a boot camp style camp where they are given a strict diet and made to exercise. No fertility treatment should be given as this is NOT an illness. There are plenty of children waiting for adoption. No silicone implants should be carried out. No laser tattoo removal should be done.	clinical comment
I fully support the planned changes.	clinical comment

As diagnosis of lipoma is ultimately a histological one this guidance is potentially at variance with the NICE guidance on the early detection of Sarcoma's , my own mother died from a sarcoma misdiagnosed clinically as a lipoma and was in curable by the time the " criteria" for its removal was reached .	clinical comment
Most changes seem minor to say the least. In general I think money should be spent on serious physical and mental illness and not conditions like infertility and gender change. Regarding varicose veins I do believe that treatment should be available before ulcers develop, rather than waiting for things to get worse. (And I write as someone who has had Varicose veins for 30 years since pregnancy and has not yet gone to the GP requesting treatment because the severity is unchanged).	clinical comment
The whole process is disingenuous. How can we decide whether to implement a policy that redirects resources from existing budgets when we have no idea where the money will be spent, how disproportionate the cost may be to treat 1 patient, and how this may differ for the different treatments in question.	clinical comment
Anal Fissure- I believe that expert guidance and best practice involves the trial of use of Botox prior to surgical 'anal stretch' which can result in degrees of more permanent faecal incontinence. It would appear preferable to have a Policy that allowed the use at a particular stage in treatment or am I misinformed and there is evidence to the contrary that I am not aware of? Hyperhidrosis- What are the alternative treatment strategies, after the routine therapies, the Committee propose to offer this cohort of patient for whom this is a considerable psychological and social impediment. Isn't surgical intervention associated with irreversible complications and time limited response? Again- isn't a tightly considered 'position in treatment' preferable?	clinical comment

Cataract surgery should be rationed simply by a visual acuity test. Patients should be offered it if: Cataract is adversely affecting their daily living. They fully understand the risks and benefits of surgery and They want to have, and are fit enough for surgery. Some people can pass the visual acuity test but some effects of a cataract can make their life very difficult e.g. Lorry drivers affected by bright light.	clinical comment
I'm undiagnosed for this, but I regularly get multiple "red flag" symptoms of cauda equina, the treatment of which is generally recommended to include emergency surgical intervention within a very short time frame to relieve pressure on the nerves in the spinal column - this is to prevent permanent nerve damage and life-long disability. The new guidance seems to steer away from this except for "exceptional circumstances" - but the delay caused while trying to define whether a patient falls into this category may result in permanent damage.	clinical comment
Expect a "can do" ethos from the NHS. Before reducing services explore improving performance and effectiveness. Too many examples of poor management and professional standards, not getting it right first time, and inefficient use of capital assets.	clinical comment
Myself and my partner have no children, my partner is unable to father a child naturally due to severe infertility (No active sperm) and would require treatment to father a child! This change would mean that we would only be given to opportunity to have one child if at all! The change would also only allow 2-3 attempts at ICSI and with his current the success rate is very limited within the first 2-3 attempts.	clinical comment
I do agree with change. However not all has been discussed around a table with the relevant questions asked.	clinical comment

The cataract policy does not comply with NICE or Royal College guidance (I am familiar with both these sets of guidance). If this one doesn't comply with NICE guidance how can I be sure that any of them do? The way it doesn't comply is by suggesting there is some agreed level of sight loss at which the procedure is of benefit. Also for the cataract policy, in the list of people affected you have not included optometrists. It says it affects family doctors who refer people for these procedures but in most areas it is actually optometrists who refer for eye conditions. This comment applies to all of the ophthalmic policies. I don't know, but would guess, that dentists are the most likely group of healthcare professionals to pick up oral conditions and refer for those - have you included them where appropriate. These are just the areas I know about - so how can I be confident you have included all appropriate healthcare professionals in the consultation for the other disease policies?	clinical comment
All agreed as decisions of local GPs to refer should be based on latest evidence (but then the hospitals should be CLOSELY monitored on whether they are delivering these rather than monitoring be faced on outcomes or complaints and number of referrals.	clinical comment
Prostatism is an overly vague term. It is not clear from the document under exactly what conditions any more specificaly defined illness would not be treated with surgery.	clinical comment
I agree in principle with what needs to be completed.	clinical comment
There are two topics I do not agree with: 7.1 Infertility services 1.1 Bariatric surgery	clinical comment
Although I agree with the planned changes I accept that funds are limited and as such it may not be feasable to treat minor cosmetic cases.	clinical comment

The policy makes no distinction between adults and children. CGM is likely to benefit much greater number of children than adults. CGM would result in lower costs for test strips (2 tests per day to calibrate rather than 8 or more per day for many children) This would save approx £650 p.a.to offset against cost of CGM. Provides information of overnight control and alerts for hypo and hyperglycaemia, improving carers sleep. Some test once or twice during the night, or more often if child has poor control.	clinical comment
As an over-arching principle, I believe that priority should be given to treating patients who have a serious condition that has, or is likely to have, a major impact on their quality of life or their life expectancy. I believe that the rarity of the condition (i.e. the size of the population group benefiting) is irrelevant at the point of delivery. The high cost of development of treatments for rare conditions will already have been borne if a treatment is currently available.	clinical comment
Reduction of pain in nerves, joints - back pain - is crucial. Acute pain especially if prolonged is a terrible, tragic business - everything possible needs to be done (in line with evidence available) to reduce the pain suffered, short of over drug use.	clinical comment
The planned changes should be gently brought into service, after looking at costs.	clinical comment
these are not as urgently needed where as the NERVOUS SYSTEM is essential for each and everyone of so this has to be treated as the vital organ followed by EYE CONDITION here again the eye is very sensitive and we only have 2 so if treatment is delayed it could be very detrimental Then EAR NOSE THROAT each and everyone of us relies on our senses and further this is needed more by the young that have still got a life ahead of them in comparison to only having a few years.	clinical comment
Having a BMI limit of 25 is an obstacle many people will not be able to achieve.	clinical comment
I agree in part but not completely.	clinical comment

Yes, but I have a problem with Wirral Hospitals and the quantity of medication they provide for the patients they discharge. Specifically those who are on monitored dosage systems. When representatives of Wirral Hospitals spoke at a Voice of Wallasey meeting several years ago they stated that patients would be discharged with four weeks medication. This does not happen with MDS patients which I regard as more important than none MDS patients as the logistics involved in providing continuing medication to these patients means that a two week supply that they are actually provided with is barely enough.	clinical comment
I partly disagree, services available in GP practices such has physio, podiatry, and etc. should remain there.	clinical comment
I need to be assured that the patients' views have been taken into account. In one survey there were only 10 comments received and for such a large population this can hardly be described as representative. I do not agree with only comments made by those 10 respondents being quoted in the survey review by the CCG . More effort needs to be made in getting comments and views from a wider group of patients if patient participation is part of the resources which go to create the strategy.	clinical comment

My daughter Angela has written a letter to be presented or read out at the meeting on Wednesday 9th April at the dermatology unit at clatterbridge, she has explained why she cannot be present in her letter. I also am having difficulty trying to attend due to total knee replacement 3 weeks ago, I would like to express my views as Angela's parent and next of kin. Regarding what this unit has meant to me. Angela was diagnosed with Psoriasis with arthritis at the age of 20 and at that stage still living at home, I do not know where we would be today if the dermo unit was not available to have helped , Angela has had several visits over the years, at this stage her condition is under control using biological drugs, but the idea of needing the help and expertise of this unit ever again and it not being available is devastating. It is not only a life saver for the patient but also for the rest of the family, to see the change once Angela was admitted to the unit when her condition was critical and her skin in such an advanced stage of flare up, was unbelievable it is such a sanctuary for people with extreme skin disorders, and as a mother I ask those who are making these decisions to really think hard on the effect this will have on those in need of such help, it will never survive in the community it is unmanageable in lots of severe cases unless it is 24- 7 on a dermatology unit for a given period, I have nursed in the community in the past and I do think that chronic skin disorders that are presented as inpatient on the unit are totally unmanageable on a stay at home visit daily concept. It is surely out of the remit of community nursing, Angela has had stays of up to 4 to 5 weeks on the unit in the passed, the fact that her condition is now under control with drugs and as a 37 year old has a wonderful career and is totally independent has definitely been a major contribution of the unit. Please take all patient's views and that of their families into serious consideration before reaching your decision.	clinical comment
I want to see more support for the hospital and less schemes aimed at gps making money hosting services in the community.	clinical comment
Why is Wirral planning to de commission and re design the Rheumatology department when it does not appear as a priority for any change ? Or do they think they will have worked through the rest and have spare capacity ? Or are their motivations entirely different ?	clinical comment
I find it disconcerting the document re sleep apnoea comments on treatment modality BiPAP. This is not used in osahs unless there is an overlap syndrome or type 2 Resp failure	clinical comment
My surgery works fine never have a problem so why change.	clinical comment

No need for extended access to own GP above current extended hours.	clinical comment
Closer working between primary and secondary care are essential - this will not be achieved by pulling out services from the hospital. Any savings made should be reinvested into the health economy and not profits for private providers.	clinical comment
Postcode lottery springs to mind. There is also risk to patients when the G.P's hold back on treatment to save money/ give less effective treatment. The commissioning of private physiotherapy causes huge issues of patient duty of care when there are NHS Ohysios and O.T's working in the same surgeries! The savings in the NHS trust are 'Estates' led, staff are being moved around and placed in buildings that are not fit for purpose and being asked to hot desk. There are plans to halve the IT available for them and to start charging for car parking for community clinical staff who are required to run their cars in order to fulfill their community duties. There are proposals to use office space in central Birkenhead and provide parking on another site. I have done a calculation that if this were to go ahead we would incurr a loss of face to face clinical time with patients at a cost over 18 weeks between 33 staff of over £133,000.00 in income generation. The loss in clinical face to face hours with patients would be 1,782 hours which will also lead to delays in seeing patients. There have been 'consultations with managers but morale within the staff groups is very low. We have not had a pay rise in some years now, the cost of fuel is escalating and the charges to park for work purposes will cause real hardship to some staff. May I also say that the Essential car users allowance has been removed and there is a ceiling now which some staff have exceeded already that results in a sharp drop in pennies per mile.	clinical comment
Patients should be referred to a specialist service.	clinical comment

Political Comments:

I feel this is the first step of the privatisation of our beloved N.H.S . I worked in the NHS for 42 yrs and dealt with a myriad of changes during that period, some excellent, some not so. All of these changes in some way benefited both the service users and employers within the service. Of course, if the present government had not implemented Billions of pounds from the NHS, there would be no reason to go down the path of PRIVATISATION. So much for Mr. Cameron's statement that " the N H S will be SAFE in his hands". Maybe the people should have a IN-- OUT Referendum re the NHS.	political comment
Any reduction of services however well intentioned is not on.	political comment
It appears that the policy is based on cost reduction and not patient choice or benefit to the well being of patients. This document has not been widely distributed to the general public. Most people I have spoken to have not heard anything about it.	political comment
No privatising of the N.H.S	political
Keep things as there are this is privatisation by the back door	political
I do not think it should be either or, There is unlimited money for flooding, billions for nuclear weapons. Any culture that puts spending on systems for death ahead of spending on health is perverse	political
I am very concerned by the CCG and would like to know if any of the governing body have financial interests in the private clinics that have been set up in opposition to our local hospital	political
I feel that the NHS should be the main/preferred provider of healthcare	political
This is a way of privatisation and it will not benefit service users. If the Practice runs out of funds what then? If the practice cannot offer certain treatment to services users because the treatment is expensive, who pays that? Cancer treatments are based on post code - who pays in this case for expensive treatment? GP are not Finance Managers and doctors second. They are health professionals who must concentrate on medical issues and not management of systems and finances.	political
Great care should be taken to avoid back door privatization.	political
This is your way of introducing and corruptly being complicit in making it easy for big business to infiltrate the local NHS services to profit from peoples illness.	political

Doctors, are under enough pressure as it is now you are making them make decisions which are financial and not medical which is what they have been trained for. Our area is an area of deprivation and it has one of the highest heart problems of the North West. We need a Doctor to judge medically what is needed not be a accountant for which he has not been trained.	Political

Complex consultation: all consultation processes by their nature are complex and don't suit everyone – however, the 'Commissioning of low clinical value' was especially technical and 'technical orientated' consultations can be particularly difficult for interested parties to follow, understand and grasp. Many comments where left on the web site raising concerns. These comments will be used to help inform and design further consultations.

Complex Consultation Comments:

The comments on the consultation have been 'picked up' and will be incorporated in to further consultation processes.

Comment	Type
You have not suggested " Don't Know" as a response, because I do not fully understand what is being said. You have indicated the changes to previous policies very clearly by the colour coding, but this the first time the general public have seen the document. The full criteria document is not designed for the patient, therefore to comment is not readily done. I suspect you will see this in the response figures. It is difficult to get at the implications of the policies. As regards medications , what are you talking about. Which medications are you supporting or not supporting.	too complex consultation
This document is too complicated for Joe Public to understand. I would ask that you consider the following: All treatments should be available, cost should not come into it. This shoddy Government can't afford to go private. Secondly, when one becomes an OAP, we are still human beings - this is not a third world country.	too complex consultation
Populist views is not the way to make selections on such a diverse set of options of which some e.g. penile implants should never be classified in the same category as infertility	too complex consultation

I mostly agree, but I am very conscious of how this information is going to be shared with patients, will it mostly when its too late when people are sitting in the consultation room? In many cases it is a case of too little information given too late.	too complex consultation
Insufficient information to comment. Neither the existing criteria or the proposed criteria is provided. In conjunction with an existing Continuous Glucose Monitoring user a draft criteria has been produced for your consideration- it has been forwarded to xxxxx Engagement & Involvement Manager, St Helens Clinical Commissioning Group due to space limitation here	too complex consultation
I think there should be more consultation first and these changes need much nore explanation. I realise the need for cuts but I do not think the details are clear enough for me to give my comments on them.	too complex consultation
At a superficial level it looks OK but with the proviso that I do not have sufficient information to make a decision	too complex consultation
Where is it to read?	too complex consultation
I think you need to distinguish clearly what is meant by commissioning and other forms of CCG procurement e.g. 3rd sector funding in relation to complementary therapies provision.	too complex consultation
Document not available to me to comment on.	too complex consultation
what changes?	too complex consultation
No, the reason being there is insufficient information provided in most documents for me to be in a position to make an informed decision. There needs to be specific information as to what the changes are.	too complex consultation
Could not find a copy of the CCG policy document. Tried various methods of enquiry on the search panels of all pages directed to, to no avail. Therefore unable to agree or disagree with any statements made in the planned changes to draft policy.	too complex consultation
I do not have enough knowledge of the impact of the proposals to make an informed comment I will therefore have to trust the CCG that they are making the correct proposals.	too complex consultation

Even after reading the planned changes I do not feel qualified to make such a comment. As stated earlier patients have to put their trust in the professionalism of the medical practitioners to make the most appropriate choices without loss of quality of care.	too complex consultation
Could not find document	too complex consultation

Annex 2

Transgender Focus Group

The focus group took place on the 20th May 2014 and lasted for approximately 2 hours 40 minutes
The E&D lead for the Cheshire and Merseyside Commissioning Support Unit facilitated and met representatives of the transgender community across the north of England including specific reps from:

- In Trust Merseyside
- Trans Youth
- Spirit level

This information has also been sent to Intrust Merseyside for wider distribution across Cheshire and Wirral transgender community groups for further comments which can continue to inform the future EIA delivery action plan, once recommendations have been noted by decision makers across all CCGs.

The focus group met because it was expected that low numbers from the transgender community were expected to contribute to the on line and survey and a new interim The Gender Dysphoria Protocol & Service Guidelines 2013/14 (http://www.england.nhs.uk/wp-content/uploads/2013/10/int-gend-proto.pdf) adopted by NHS England impacts and interacts significantly with a substantial number of the low clinical value policies under review.

Previous to this focus group previous meetings and discussions took place with a representative of In trust Merseyside to determine which policies the focus group concentrated on. This selective and focussed approach was also steered by the Gender Dysphoria Protocol, which highlights issues governed by specialist commissioning routes and those ***non-core treatments*** (highlighted below), which is the responsibility of local CCG commissioning,

Findings and Outcomes of the Group

The group feedback has been categorised by the key below and comments have been included against relevant policies using the original policy document used during the public consultation.

Ensure that key messages and areas that require further clarity were forwarded to NHS England

1- High importance – disadvantages trans patients and transition and advances equality of opportunity (Equality Act 2010- Gender reassignment).
2- Medium importance and further clarity will be requested from NHS England in relation to the Gender Dysphoria Protocol and service Guidelines.
3- Low only occurs in rare circumstances.

Key recommendations from this exercise are included in the main recommendation section of the EIA but will include;

- Recommendations that high importance areas are agreed by local CCGs Individual Funding requests if the treatment is relevant to protected characteristic and life chances (Advance equality of Opportunity- Equality Act 2010- gender reassignment).
- Ensuring GPs and health professional understand the new interim guidance and pathway for gender dyphoria and how this interacts with the low clinical value policies.
- Seek clarity from NHS England on any grey areas detected as a result of the feedback.
- Support training and briefings that need to be distributed or delivered to health professional who refer patients and decision makers who form the panel in relation to Individual Funding Requests.
- Information to be included in the So What document Re Commissioning Policy Review.

The CSU and CCGs would like to sincerely thanks the individual and groups involved who took part in the focus group session and the wider engagement and feedback process for their time effort and expertise

Procedures not exclusive to gender reassignment ("non-core" procedures)
Some patients may require other medical procedures as part of the process of transforming their body to be more congruent with their gender. Other procedures that are not considered within the Gender Reassignment Protocol can only be considered by the patient's Clinical Commissioning Group (CCG). Examples of such procedures are given in the table below.

"Non-core" surgical procedures are not routinely commissioned by the NHS and can only be provided on an exceptional clinical need basis.

Patients will only be referred for this surgery following a clinical assessment by their GIC and where a symptomatic or functional requirement for surgery has been identified. All cases will be referred to the patient's GP's CCG for consideration and assessment against CCG Policy. Access criteria will consider age, body mass index (BMI), impairment of function, and psychological distress.

Referral for consideration does not necessarily mean that surgery will be offered.

This must be communicated to the patient. Treatments that may be sought through the CCG Policy

Condition	Comment
Breast augmentation (augmentation mammoplasty)	This should only be considered where there is a clear failure of breast growth in response to adequate hormone treatment. Review of breast development in anticipation of breast augmentation surgery should be made no earlier than after the completion of 18 months of adequate hormone treatment. It should be made clear to patients during individual treatment plan discussions that assessments of the appropriateness of breast augmentation will be made no earlier than after the completion of 18 months of adequate hormone treatment.
Facial Feminisation Surgery (FFS)	Treatments may include: - Thyroid chondroplasty / Tracheal shave (reducing size of larynx) - Rhinoplasty (nasal surgery) - Facial bone reduction - Blepharoplasty / Facelift
Lipoplasty/Contouring	Liposuction and/or body sculpture.
Gamete storage	Using similar protocols as with those receiving radiotherapy and other gamete damaging procedures

Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.

Focus Group responses and importance are incorporated onto the actual policy document below

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Comments
3.	***Dermatology***		
3.1 High	Skin Resurfacing Techniques (including laser dermabrasion and chemical peels)	Only be commissioned in the following circumstances: <u>Severe</u> scarring following: • acne once the active disease is controlled. • chicken pox. Or • trauma (including post-surgical). Procedures will only be performed on the head and neck area..	Impacts on Transwomen – currently under the new pathway 8 sessions are covered by the GI clinic. Many Trans people feel the need to come to the GP after 8 sessions often because 8 is not enough. Works much more effectively with younger Transwomen. CCG should under the right circumstances approve more treatments locally
3.3 NEW	Treatments for Hypo-pigmentation	NHS Cosmetic Camouflage is commissioned. This is provided by Changing Faces formerly the Red	Trans-men can be subject to severe acne due to hormone treatments. Trans community would like the CCGs to consider this treatment and be referred to

	meduim	Cross	NHS beauticians – during gender reassignment Trans people need to demonstrate they are living in their chosen sex in society – in this treatment is not provided it can causes issues of safety and/or isolation in their own homes.
5.2	Pinnaplasty – for Correction of Prominent Ears Low	May be commissioned in the following circumstances: The patient should be between 5 and 19 years of age. Patient assessed by plastic or ENT surgeon who has the option to refer, when appropriate to a specialist paediatric psychologist. If there is evidence of psychological distress likely to be alleviated by surgery, prior approval is not required . Incisionless otoplasty is not commissioned.	Prominent ears could impact on young Trans women who have difficulty growing their hair long.

5.7 High	Rhinoplasty - Surgery to Reshape the Nose.	This procedure is NOT available under the NHS on cosmetic grounds. Only commissioned in any of the following circumstances: • Objective nasal deformity caused by trauma. • Problems caused by obstruction of nasal airway. • Correction of complex congenital conditions e.g. cleft lip and palate.	Transwomen, particularly elderly transwomen, urge the CCG to consider this treatment. Particularly those who have not accessed hormone therapy.

5.8 NEW High	Surgery of Laser Treatment of Rhinophyma	Not routinely commissioned.	Should not be refused for an older trans women – again linking to hormone use which can trigger this condition.

10	***Gynaecology***		
10.1	Surgical Procedures – for the Treatment of Heavy Menstrual Bleeding Hysterectomy	Hysterectomy not commissioned unless all of the following requirements have been met: • An unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena) unless medically contra-indicated or the woman has made an informed choice not to use this treatment. • The following treatments have failed, are not appropriate or are contra-indicated in line with NICE guidance. - Tranexamic acid or nonsteroidal anti-inflammatory drugs or combined oral contraceptives. - Norethisterone (15mg) daily from days 5 to 26 of the menstrual cycle, or injected long-acting progestogens. - Endometrial ablation has been tried (unless patient has fibroids >3cm).	Covered in the Gender Reassignment Care Pathway
	D&C (Dilatation and curettage)	Dilatation and curettage not commissioned as a diagnostic or therapeutic procedure.	

11 Specialist commissioning Gender dysphoria High	Treatment of Gender Dysphoria	Patients with Gender Dysphoria issues should be referred to the Gender Identity Clinic (GIC) at Charring Cross. It is no longer necessary to access local services for assessment. Core surgery is commissioned by NHS England but there are a number of non- core treatments which will need consideration for funding by the CCG. These requests should be made by the GIC only and considered on an individual basis.	Written changes to policy, GPs under the new pathway can directly refer patients to the Gender Identity Clinic. This includes charring cross, Leeds, Nottingham and Sheffield. Trans community would like wider referrals to the Abacus service (currently commissioned by Liverpool CCGs) This services are vital in providing holistic support to patients and will avoid drop outs from the GICs.
16	***Plastic & Cosmetic Surgery***		
16.1 medium	Reduction Mammoplasty - Female Breast Reduction	Commissioned only if all of the following circumstances are met: Musculo-skeletal symptoms are not due to other causes. And There is at least a two year history of attending the GP with the problem. And Other approaches such as analgesia and physiotherapy have been tried. And The patient is suffering from functional symptoms as a result of the size of her breasts (e.g. candidal intertrigo; backache). And The wearing of a professionally fitted brassiere has	Addressed in the new pathway

		not helped. And Patients BMI is <25 and stable for at least twelve months. And There is a proposed reduction of at least 500g per side. And It is envisaged there are no future planned pregnancies. Unilateral breast reduction is considered for asymmetric breasts of three or more cup size difference as measured by a specialist.	
16.2 High	Augmentation Mammoplasty - Breast Enlargement	Only commissioned in the following circumstance: The BMI is <25 and stable for at least twelve months. And any of the following: Unilateral breast enlargement is considered for breasts of three or more cup size difference as measured by a specialist. . Congenital absence i.e. no obvious breast tissue. In special circumstances reconstructive surgery may be appropriate for tubular breast abnormality.	Trans community may refute the BMI stipulation for this service to be commissioned, this is a local CCG procedure and there needs to be greater awareness amongst GPs. Trans community recommend this is commissioned to support gender reassignment. There are further clinical options to breast enlargement and these should be made clear to the transcommunity.
16.3	Removal and/or Replacement of	Revisional surgery will ONLY be considered if the NHS commissioned the original surgery and	Same response as 16.2

High	Silicone Implants - Revision of Breast Augmentation	complications arise which necessitates surgical intervention , such as: Capsule contraction causing significant deformity or Implant rupture. If revisional surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them will be based upon the clinical need for replacement and whether the patient meets the policy for augmentation at the time of revision.	
16.4	Mastopexy - Breast Lift	Not routinely commissioned May be considered as part of other breast surgery to achieve an appropriate cosmetic result subject to prior approval.	Same response as 16.2
16.5 High	Surgical Correction of Nipple Inversion	This is not routinely commissioned. .	Transmen, sometimes Transmen receive surgery which is “botched”, it is highly recommended that CCGs support this if the surgery has a disfiguring effect.
16.6 High/	Male Breast Reduction Surgery for Gynaecomastia.	Not routinely commissioned except on an exceptional basis where all of the following criteria are met: True gynaecomastia not just adipose tissue. AND Underlying endocrine or liver abnormality excluded. AND Not due to recreational use of drugs such as steroids	Transmen

		or cannabis or other supplements known to cause this. AND Not due to prescribed drug use. AND Has not responded to medical management for at least three months. AND Post pubertal. AND BMI <25kg/m2 and stable for at least 12 months. AND Patient experiences pain. AND Experiences significant functional impairment.	
16.7 high	Hair Removal Treatments including Depilation Laser treatment or Electrolysis –for Hirsutism –	Routinely commissioned in the case of those undergoing treatment for pilonidal sinuses to reduce recurrence. In other circumstances only commissioned if all of the following clinical circumstances are met; • Abnormally located hair-bearing skin following reconstructive surgery located on face and neck.	Impacts on Transwomen – currently under the new pathway 8 sessions are covered by the GI clinic. Many Trans people feel the need to come to the GP after 8 sessions often because 8 is not enough. Works much more effectively with younger Transwomen Works less effectively with older Trans patients with grey hair.

		• There is an existing endocrine medical condition and severe facial hirsutism. 1. Ferryman Gallwey Score 3 or more per area to be treated. 2. Medical treatments have been tried for at least one year and failed. 3. Patients with a BMI of>30 should be in a weight reduction programme and should have lost at least 5% body weight. All cases will be subject to individual approval by the IFR Team and must be accompanied by an opinion from a secondary care consultant (i.e. dermatologist or endocrinologist). Photographs will also be required to allow the PCTs to visibly asses the severity equitably. Funded for 6 treatments only at an NHS commissioned premises.	
16.8 NEW	Surgical treatment for Pigeon Chest	This procedure is not routinely commissioned by the NHS on cosmetic grounds.	N/A
16.9 High	Surgical revision of Scars.	Funding of treatment will be considered only for scars which interfere with function following burns, trauma, treatments for keloid, or post-surgical scarring.	Impacts on Transwomen
16.10 Low	Laser Tattoo Removal	Only commissioned in any of the following circumstances: • Tattoo is result of trauma inflicted against the patient's will. • The patient was a child and not responsible for his/her actions at the time of tattooing. • Inflicted under duress • During adolescence or disturbed periods (only in very exceptional circumstances where tattoo causes marked limitations of psycho-social function).	Male to female transition Masculine tattoos

		An individual funding request will be required.	
16.11 Low	Apronectomy or Abdominoplasty (Tummy Tuck).	Not routinely commissioned other than if all of the following criteria are met: The flap hangs at or below the level of the symphysis pubis. Patients BMI is <25 and stable for at least 12 months. (Some allowance may be made for redundant tissue not amenable to further weight reduction). Bariatric surgery (if performed) was performed at least 3 years previously. AND any of the following: Causes significant problems with activities of daily life (e.g. ambulatory restrictions). Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics. Poorly-fitting stoma bag. (If the patient does not fulfil all of the required criteria, an IFR should be submitted detailing why exception should be made) IFR information ***must*** contain the following information; • Date of bariatric surgery (where relevant). • Pre-operative or original weight and BMI with dates. • Series of weight and BMI readings demonstrating weight loss and stability achieved.	Trans men who have had children Exceptions to be considered

		• Date stable weight and BMI achieved. • Current weight BMI. • Patient compliance with continuing nutritional supervision and management (if applicable). • Details of functional problems. • Details of associated medical problems.	
16.12 medium	Other Skin Excisions/ Body Contouring Surgery e.g. Buttock Lift, Thigh Lift, Arm Lift (Brachioplasty)	Not routinely commissioned. If an IFR request for exceptionality is made, the patient must fulfil all of the following criteria before being considered. Patients BMI is <25 and stable for at least 12 months. (Some allowance may be made for redundant tissue not amenable to further weight reduction). Bariatric surgery (if performed) was performed at least 3 years previously. AND any of the following: Causes significant problems with activities of daily life (e.g. ambulatory restrictions). Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics. IFR information ***must*** contain the following information; • Date of bariatric surgery (where relevant). • Pre-operative or original weight and BMI with dates.	Clarity on the national pathway on this issue

		• Series of weight and BMI readings demonstrating weight loss and stability achieved. • Date stable weight and BMI achieved. • Current weight BMI. • Patient compliance with continuing nutritional supervision and management(if applicable). • Details of functional problems. • Details of associated medical problems.	
16.13 High	Treatments to correct Hair Loss for Alopecia.	Only commissioned in either of the following circumstances: • Result of previous surgery • Result of trauma, including burns Hair Intralace System is not commissioned. Dermatography is not commissioned. NHS wigs will be available according to NHS policy.	Transwomen significant issue – hormone therapy can cause hair loss Recommend that it is provided in the right circumstances to Trans patients as well as highlighting other alternative options for treatment which could be funded on the NHS
16.14 high	Hair Transplantation	Commissioned only in exceptional circumstance, e.g. reconstruction of the eyebrow following cancer or trauma. Dermatography may be an acceptable alternative in eyebrow reconstruction.	As above
16.15 High	Treatments to correct Male Pattern Baldness	This is not routinely commissioned.	As above
16.16 medium	Labial Reduction Surgery	This is not routinely commissioned.	Included on the new care pathway but greater clarity needed
16.17 Low	Liposuction	Liposuction is sometimes an adjunct to other surgical procedures e.g. thinning of a transplanted flap. Not commissioned simply to correct fat distribution. May be commissioned as part of the management of	Transmen, liposuction of potential “dog ears” i.e excessive fat distribution Funded by exceptions- IFR

		true lipodystrophias or non-excisable clinical significant lipomata. An individual funding request will be required.	
16.18 High/ medium	Rhytidectomy - Face or Brow Lift	This procedure is not available under the NHS on cosmetic grounds. Routinely commissioned in the following circumstances: • Congenital facial abnormalities. • Facial palsy. • Treatment of specific conditions affecting the facial skin, e.g. cutis, laxa, pseudoxanthoma elasticum, neurofibromatosis. • To correct consequences of trauma. • To correct deformity following surgery.	Transwomen – this can be commissioned by specialist commissioning or local CCGs there needs to be greater clarity within the pathway.
medium	Radiotherapy Collagenase injections	These procedures are not commissioned.	Transwomen – feminine lips exceptions
19	***Urology***		
19.1 NEW	Circumcision	This not offered for social, cultural or religious reasons. However certain CCGs may have individual policies. Indicated for the following condition; ➢ balantis xerotica obliterans. ➢ traumatic foreskin injury/scarring where it cannot be salvaged. ➢ 3 or more episodes of balanitis/balanoposthis. ➢ Pathological phimosis. ➢ Irreducible paraphimosis. ➢ Recurrent proven Urinary Tract Infections (UTIs) with an abnormal urinary tract.	n/a
19.2	Penile Implant: A surgical procedure to	Not routinely commissioned.	Similar treatment on the new pathway – Phalloplasty but greater clarification is needed.

Medium	implant a devise into the penis .	 59 PenileImplants.pdf See attached sheet.	
19.3 NEW	Reversal of Male Sterilisation medium	The NHS does not commission this service. Patients consenting to vasectomy should be made fully aware of this policy. Reversal will be only considered in exceptional circumstances such as the loss of a child.	Transwomen – after transition and how this interacts with fertility policys Dealt with through exceptions route- IFR

Footnote: Draft commissioning policy document shared for engagement and comments

END OF ANNEXES