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Democratic and Members Support
Chief Executive's Department

Plymouth City Council
Ballard House
Plymouth PL1 3BJ

Please ask for Amelia Boulter
T 01752 304570
E amelia.boulter@plymouth.gov.uk
www.plymouth.gov.uk/democracy
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HEALTH AND WELLBEING BOARD

Thursday 5 February 2015
10 am
Warspite Room, Council House

Members:
Councillor Sue McDonald (Chair)
Councillors Ian Tuffin and Dr John Mahony.

Statutory Co-opted Members: Strategic Director for People, NEW Devon Clinical Commissioning Group representatives, Director for Public Health, Healthwatch representative, NHS England Devon Cornwall and the Isles of Scilly representative.

Non-Statutory Co-opted Members: Representatives of Plymouth Community Homes, Plymouth Community Healthcare, Plymouth NHS Hospitals Trust, Devon Local Pharmaceutical Committee, University of Plymouth, Devon and Cornwall Police, Devon and Cornwall Police and Crime Commissioner and the Voluntary and Community Sector.

Members are invited to attend the above meeting to consider the items of business overleaf.

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Tracey Lee
Chief Executive

HEALTH AND WELLBEING BOARD

PART I (PUBLIC COMMITTEE)

1. APOLOGIES

To receive apologies for non-attendance by Health and Wellbeing Board Members.

2. DECLARATIONS OF INTEREST

The Board will be asked to make any declarations of interest in respect of items on this agenda.

3. CHAIR'S URGENT BUSINESS

To receive reports on business, which, in the opinion of the Chair, should be brought forward for urgent consideration.

4. MINUTES (Pages 1 - 6)

To confirm the minutes of the meeting held on the 20 November 2014.

5. PLYMOUTH PLAN (Pages 7 - 8)

The Board to receive the Plymouth Plan.

6. CHILDREN AND YOUNG PEOPLE'S PLAN (Pages 9 - 10)

The Board will be provided with the Children and Young People's Plan.

7. PHARMACEUTICAL NEEDS ASSESSMENT

The Board to receive a verbal update on the Pharmaceutical Needs Assessment.

8. URGENT AND NECESSARY MEASURES (Pages 11 - 24)

The Board to receive an update on Urgent and Necessary Measures (now being referred to as Potential Interim Disinvestments).

9. WELLBEING SURVEY

Marketing Means will present the Wellbeing Survey to the Board.

10. EXEMPT BUSINESS

To consider passing a resolution under Section 100A(4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following item(s) of business on the grounds that it (they) involve the likely disclosure of exempt information as defined in paragraph(s) of Part 1 of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000.

PART II (PRIVATE COMMITTEE)

AGENDA

MEMBERS OF THE PUBLIC TO NOTE

that under the law, the Panel is entitled to consider certain items in private. Members of the public will be asked to leave the meeting when such items are discussed.

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Health and Wellbeing Board

Thursday 20 November 2014

PRESENT:

Councillor McDonald, in the Chair.
Dr Richard Stephenson, Vice Chair.

Ian Ansell – Office of the Police and Crime Commissioner, Kevin Baber – Plymouth NHS Hospitals Trust, Veryan Barneby – Voluntary and Community Sector, David Bearman - Devon Local Pharmaceutical Committee, Carole Burgoyne – Plymouth City Council, Peter Edwards - Healthwatch, Amanda Fisk - NHS England Devon Cornwall and the Isles of Scilly, Dr Paul Hardy - NEW Devon CCG, Councillor Dr. Mahony, Kelechi Nnoaham – Director of Public Health, Councillor Tuffin, Steve Waite - Plymouth Community Healthcare and Val Woodward – Voluntary and Community Sector.

Apologies for absence: C/Supt Andy Boulting - Devon and Cornwall Police, Jerry Clough - NEW Devon CCG, Anne James – Plymouth Hospitals NHS Trust, Clive Turner – Plymouth Community Homes and Lesley Gross and Tony Fuqua - Voluntary and Community Sector.

Also in attendance: Ross Jago and Amelia Boulter – Plymouth City Council and Sarah Ogilvie – Public Health.

The meeting started at 10.00 am and finished at 12.20 pm.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

24. DECLARATIONS OF INTEREST

There were no declarations of interest made.

25. CHAIR'S URGENT BUSINESS

Carole Burgoyne provided the Board with an update on the recent Ofsted Inspection. Plymouth City Council and partners underwent 4 weeks of intensive scrutiny and would like to take this opportunity to thank the officers and partners involved. The Board would be informed of the result when available and the full report would be published in January 2015.

Agreed that the Ofsted findings to be discussed at the next meeting of the Health and Wellbeing Board to review the positives and areas for improvements.

26. MINUTES

Agreed that the minutes of 4 September 2014 were confirmed.

27. **CORRESPONDENCE**

(a) Mental Health Crisis Care Concordat

The Board noted the correspondence from the Department of Health and Home Office on Mental Health Crisis Care Concordat. It was further reported that Carole Burgoyne and Amanda Fisk were part of an action set and recommend that this Board sign up to the concordat.

(b) Tobacco Pledge

The Board noted the Tobacco Pledge.

28. **HEALTHWATCH**

Peter Edwards, Healthwatch Plymouth provided a presentation to the Board. It was reported that –

(a) Healthwatch are the health and social care consumer champion and the local voice for Plymouth;

(b) Plymouth City Council commissioned Colebrook SW to host Healthwatch. The aim of the organisation is to gather information, views and experiences from local people in order to scrutinise services;

(c) Healthwatch is a key, statutory member of the Health and Wellbeing Board;

(d) the main strength of Healthwatch was its independence. As a statutory member of the Board, Helathwatch is able to influence change and can engage the public in a mature debate about the future of Health and Social Care Services.

In response to questions raised, it was reported that -

(e) it was an essential factor to facilitate back to the public the understanding of systems leadership and to have that debate;

(f) as Healthwatch were independent the public needed to have an understanding of how Healthwatch worked with organisations, in particular its critical friend role and how those organisations respond to recommendations made by Healthwatch;

In response to questions and comments raised, it was reported that -

(g) important questions had been raised which were critical to the future of the Board and required further discussion;

(h) the Plymouth On-line Directory (POD) was initially funded by the CCG and PCC and widely available in all libraries and GP surgeries and provides a wealth of information for the public to access. Involving the public was critical for this Board and how we consult and on what, we need to ensure we get this right from the start with our commissioners.

Agreed that further discussion on the questions raised by Healthwatch should be a key part of the Board's development in gaining a beneficial understanding of the complexities of the system and challenges.

29. **GOVERNANCE AND MEMBERSHIP**

Kelechi Nnoaham, Director for Public Health reported that it was important to get this right for children and young people. Whatever we do we must give regard to the voice of the child and creating a vehicle for greater voice for the child here. A formal establishment of the Children and Young People's Partnership (CYPP) as a subcommittee of this Board creates a mechanism for this Board to work with other partners across the life course of a child. It also sets out the protocol between the Children and Young People's Partnership, the Health and Wellbeing Board and Plymouth Safeguarding Children Board (PSCB) and begins to describe the mechanism across the three entities.

The following comments were made -

(a) that good start in life was crucial but there were other factors important to this Board and how many other boards would become sub committees of this Board?

(b) that there were possibilities of further partnerships to have a more statutory footing and this Board to consider over the next 12 months;

(c) one of the Ofsted requirements was to demonstrate the links between this Board, CYPP and PSCB and this formalises the arrangements.

Agreed that –

1. the working protocol between the Health and Wellbeing Board, Children and Young People's Partnership and the Plymouth Safeguarding Children Board.

2. the establishment of the Children and Young People's Partnership as a sub-committee of the Health and Wellbeing Board.

3. to appoint the Assistant Director for Education, Learner and Family Support as chair of the Children and Young People's Partnership and as a member of the Health and Wellbeing Board.

4. the addition of two provisional board meetings to the business meeting calendar.

30. **4-4-54**

Kelechi Nnoaham, Director for Public Health provided a presentation on 4-4-54. It was reported that the concept of 4-4-54 would move to Thrive Plymouth and was a positive choice for better health in a growing city. It was also reported that -

(a) there are 4 behaviours leading to 4 diseases which cause 54% of deaths in Plymouth;

(b) it was envisaged that mental health would be incorporated within Thrive Plymouth. They wanted a positive title and health and wellbeing would be adopted in all policies and thinking.

In response to questions raised, it was reported that -

(c) Thrive Plymouth was the framework for engagement with communities. Sitting under Thrive Plymouth would be an action plan to be developed and designed with communities;

(d) the importance of the expertise of the communities and the need to work together was important and people to have the power to change things;

(e) support from this Board was required to deliver Thrive Plymouth over the next 10 years. Thrive Plymouth would not change the culture of society in a moment.

Agreed that the Health and Wellbeing Board support and endorses the approach for Thrive Plymouth for the next 10 years.

31. **PLYMOUTH REPORT**

Rob Nelder, Public Health Consultation provided a presentation to the Board. It was reported that -

- Current JHWS will be superseded by health element of 'Plymouth Plan' ;
- Plymouth Plan is a strategic plan which looks ahead to 2031;
- Already been used extensively to inform the integration process;
- Specifically the report is being used to inform the ongoing development of the commissioning strategies for Children and Young People;
- Wellbeing, Complex Needs and Community;
- Used to inform the Equality Impact Assessment for Thrive Plymouth/4-4-54 (i.e. protected characteristics section);
- The Plymouth Plan needs to be publicised, circulated and used widely.

The Chair thanked officers involved in the production of the Plymouth Report.

It was reported that Plymouth was data rich and need to convert the intelligence into information that can be applied.

Agreed that the Health and Wellbeing Board note the report.

32. WELLBEING SURVEY

This agenda item was withdrawn from the agenda.

33. PHARMACEUTICAL NEEDS ASSESSMENT

David Bearman, Devon Local Pharmaceutical Committee and Sarah Ogilvie, Public Health Consultant reported that they had commenced the consultation and the Pharmaceutical Needs Assessment would come to the next Board for sign off by 1 April 2015.

Agreed that progress is noted to date and recommend all partners to engage with the consultation process and final report to come back to the Board in February 2015.

34. EXEMPT BUSINESS

There were no items of exempt business.

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PLYMOUTH PLAN

Health and Wellbeing Board discussion points

Thursday 5 February 2015

The Plymouth Plan is a ground-breaking plan which looks ahead to 2031 and sets a shared strategic direction of travel for the long-term future of the city. An important principle is that local people and communities of geography, identity and interest are at the heart of the plan.

The Plymouth Plan is being published in two parts;

1. Part one sets out an overarching strategy for future change and growth in the city.
2. Part two will set out detailed policies for different areas of Plymouth (Published for consultation in the autumn of 2015).

The aim of today's discussion is to review the draft content and tease out any significant issues/areas of conflict which need addressing, but also to identify areas of common interest and where individual organisations can see themselves working together to deliver change on the ground.

More specifically, does the content of the plan reflect your organisations aspirations and ongoing priorities? Are there any gaps or weaknesses in the content, i.e. anything that you feel is missing and should be added or reviewed?

The Board need to feel comfortable with the content of the Plymouth Plan and that it accurately reflects the current health and Wellbeing Strategy.

AREAS TO FOCUS ON BEFORE THE MEETING;

This is to help you focus the discussion on the most relevant content, but a wider knowledge of the content and the linkages would be useful.

Module 2 - Philosophy and themes; the key things that underpin and connect the plan (pg.10 of the Plan)

The Plan is guided by one or more of five complementary principles. Their role is to anchor the plan; they demonstrate confidence and openness about the basic values and beliefs that create the conditions to drive the city forward.

1. **Roots**: People feel like they belong in Plymouth and care for their own and the city's future (pg.10 of the Plan)

2. **Opportunity**: People have the opportunity and ability to contribute to and benefit from being part of the city's future (pg.10 of the Plan).

3. **Power**: People have confidence that they can influence decisions that affect them and power is distributed in a way that makes the most of individual and the collective as appropriate (pg.11 of the Plan).

4. **Flourish**: Individuals, communities and businesses thrive and there is an environment that is creative, diverse and open to new ways of doing things (pg.11 of the Plan).

5. **Connections**: People mix physically and socially, so they can interact, learn from each other and work together (pg.12 of the Plan).

The plan is structured by modules and sets out the strategic outcome, strategic objective, supporting policies and measures of success for each module.

Module 5 – How Plymouth will become a healthy city (pg.35 of the Plan)

Strategic outcome; People in Plymouth live in happy, healthy, safe and aspiring communities, where social, economic and environmental conditions and services enable choices that add quality years to life and reduce the gap in health and wellbeing between communities.

Strategic objectives: healthy city (pg.36) and growing city (pg.53 – 54).

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Plymouth's Children and Young People's Partnership Plan 2015 – 2020

Our Vision

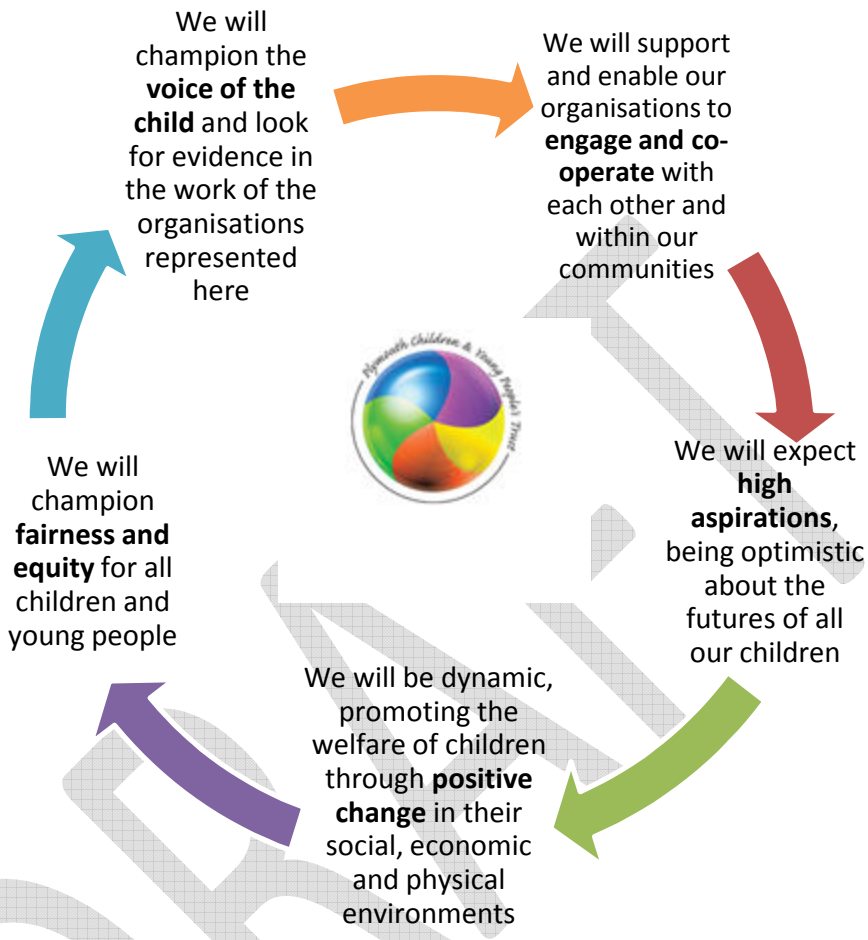
Britain's Ocean City: A great place to grow up where children and young people are happy, healthy and aspiring

The Role of Children and Young People's Partnership

We will scrutinise the strategies, plans and initiatives surrounding the children and young people's agenda in the city and hold the delivery of these to account in order to ensure we are collectively meeting their needs. We will:

1. Expect that strategies and plans and commissioning arrangements are built around a secure understanding of the **needs** of children and young people in the city;
2. Review the progress of key **strategies and plans** in place, which support the delivery of our vision and objectives;
3. Provide support and challenge to the **partnership arrangements** in place to scrutinise those strategies and plans;
4. Ensure that our **commissioned services** are delivering expected outcomes; and
5. Enable **organisational relationships** to forge so that we have a better understanding of the whole children's agenda in Plymouth.

Our Values



Our Objectives

RAISE ASPIRATIONS	DELIVER PREVENTION AND EARLY HELP	DELIVER AN INTEGRATED EDUCATION, HEALTH AND CARE OFFER	KEEP OUR CHILDREN AND YOUNG PEOPLE SAFE
Ensure that all children and young people are provided with opportunities that inspire them to learn and develop skills for future employment	Intervene early to meet the needs of children, young people and their families who are 'vulnerable' to poor life outcomes	Ensure the delivery of integrated assessment and care planning for our children with additional needs	Ensure effective safeguarding and provide excellent services for children in care

There are current strategies and plans which aim to affect change across all our outcomes. These are:

- Integrated Commissioning Plan;
- Integrated Health and Wellbeing Transformation – Co-operative Children and Young People Services;
- Child Poverty Strategy;
- Plymouth Plan;
- Fairness Commission Recommendations; and
- Health and Wellbeing Strategy.

There are also key strategies, plans and city wide initiatives that we will particularly review progress of, under each outcome. These are likely to change frequently over the life of our plan. Currently these are:

▪ Plymouth Employability and Skills Plan; ▪ People, Communities and Institutions: Local Economic Strategy; ▪ Mayflower 400	▪ Early Intervention and Prevention Strategy; ▪ Framework for working with Citizens and Communities; ▪ Families with a Future; ▪ *Maternity Strategy.*	▪ Special Educational Needs and Disability strategy.	▪ CSC/PSCB Ofsted Improvement Plans; ▪ Plymouth Safeguarding Children Board Challenges; ▪ Children Social Care 10 Wishes Action Plan.

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Northern, Eastern and Western Devon Clinical Commissioning Group

Status update to Plymouth Health and Wellbeing Committee regarding NEW Devon CCG potential interim disinvestments

Recommendation: The committee should consider and note the current position in relation to disinvestments.

1. Executive Summary

1.1 In October NEW Devon CCG published a list of services which it was considering for disinvestment. The need to consider de-prioritising certain services was a consequence of prioritising urgent services, particularly over the winter period.

1.2 That list of services was subject to clinical review during November and Equality & Quality Impact Assessment. Recommendations were reached to limit certain treatments on the basis of evidence and impact. These were due to be 'Interim Commissioning Positions' in force for a 12 to 18 month period, during which time fuller consultation and more detailed review would take place. The outcome in that 12 to 18 month period would be to either amend, revoke or make permanent the Interim Positions as Clinical Policy.

1.3 However, in the course of the last two months, and following feedback and engagement, the CCG's approach has altered. The services under review are believed to be amenable to referral *guidance* to clinicians, rather than enforced policy on the whole. For clarity, enforced restrictions on services via Interim Commissioning Positions are now not being implemented. Instead we will develop guidance for clinicians during the final quarter of 14/15. For a few measures, covered in this paper, we will move to a full policy position during April via the usual Clinical Policy Committee infrastructure and governance.

This paper was originally requested as an account of the process and impacts associated with Interim Commissioning Positions. Given the alteration in approach away from enforced restrictions, the paper provides an update on the current status of previously proposed measures as a basis for discussion with Devon Health and Wellbeing Scrutiny Committee.

2. What has been decided? Measures under consideration and their current status

2.1 Table 1 lists areas for which the CCG had intended Interim Commissioning Positions. The table also displays the way in changes to service provision in those areas will now be considered.

2.2 These measures were generated from a clinically-led workshop of 18 GPs from across Devon, the CCG Director of Nursing, CCG Clinical Chair, an out-of-area secondary care consultant member of the CCG's Governing Body and Public Health consultants from Devon and Plymouth. A summary of the clinical rationale associated with these is provided at Appendix A.

Table 1. Proposed Interim Commissioning Positions and their status under the revised implementation approach

Area under consideration for Interim Commissioning Position	Summary of proposed Interim Commissioning Position	How this clinical area will now be progressed
Weight loss in obese patients prior to routine surgery	Where surgery is not immediately clinically necessary and where weight loss would be beneficial for clinical outcomes and/or peri-operative risk, a requirement for patients to achieve 5% weight loss if they have a Body Mass Index > 35.	To be developed as Referral Guidance to clinicians with supporting services for patients.
8 weeks smoking cessation prior to routine surgery	Where surgery is not immediately clinically necessary, a requirement for patients to cease smoking for 8 weeks prior to their operation.	To be developed as Referral Guidance to clinicians with supporting services for patients.
Funding of 2nd hearing aid	Unless other sensory or disabling factors exists, 2nd hearing aids would not be routinely funded.	Not being pursued as a commissioning position or policy. Further work to understand whether contractual levers exist to identify any Supplier-led demand for hearing aid services.

Ear microsuction for the removal of wax	Unless for the treatment of infection or due to other factors which make ear syringing in primary care clinically inappropriate, no routine funding of wax removal by microsuction.	To be developed as Referral Guidance to clinicians with non-hospital alternatives developed for patients.
Criteria for cataract surgery	Enhancement of policy to bring in to line with more restrictive policies from elsewhere in the UK. Driving level vision to be funded (for drivers and non drivers). Tighter restrictions than currently for the 2nd eye.	To be considered by the usual Clinical Policy Committee route to arrive at a policy for the treatment of cataracts.
Shoulder surgery	Prior approval by a CCG clinical panel required for shoulder surgery in recognition of poor evidence associated with shoulder surgery.	No interim position being adopted. Further work ongoing with the British Orthopaedic Association, Chartered Society of Physiotherpists and local clinicians to define best practice pathways to be commissioned.
Use of Avastin in the treatment of Wet Age-Related Macular Degeneration (Wet AMD)	A switch to the treatment recommended by the World Health Organisation for this condition. Requires a CCG position as the drug is unlicensed for that purpose in the UK, the manufacturers not having applied for a license.	This remains the CCG's commissioning intention. Work ongoing with local trusts and with other CCGs to develop the implementation.
Shockwave therapy in the treatment of tendinopathies	Interim suspension of this service, in recognition of equivocal evidence and it not being universally available.	No interim position being taken. Referral guidance for clinicians being developed.

Appenidx A: Summary evidence in relation to urgent & necessary measures

1. The clinical rationale for the areas of disinvestment which were being considered by NEW Devon CCG is provided below. Please note that these follow a rapid review process to support what had been intended as Interim Commissioning Positions (ie temporary policy) but which will now be developed predominantly as clinical guidance to clinicians.

Use of Avastin in the treatment of Wet AMD

Smoking cessation prior to routine surgery

Weight loss prior to routine surgery

Second hearing aids

Cataracts

Ear microsuction

Suspension of shockwave therapy for tendinopathies

Prior Approval for shoulder surgery

2. Use of Avastin in the Treatment of Wet AMD

The use of bevacizumab (Avastin) rather than ranibizumab (Lucentis) or aflibercept (Eylea) in the treatment of Wet AMD reflects the following:

- Bevacizumab is the World Health Organisation's recommended treatment for Wet AMD[1].

- Although the manufacturers of bevacizumab report that it has a higher molecular weight and a higher particulate rate than they would specify for use in the eye, the Cochrane Collaboration's 2014 review of nine non-industry funded RCTs concluded that, "Health Policies for the utilisation of ranibizumab rather than bevacizumab as a routine intervention for neovascular AMD for reasons of systemic safety are not sustained by evidence."[2]

- The IVAN head to head trial of ranibizumab and bevacizumab in the UK found no difference in frequency in safety outcomes between bevacizumab and ranibizumab.[3]

- The IVAN trial found the effectiveness of bevacizumab to be neither better nor worse than ranibizumab in its measure of clinical effectiveness (ie best corrected distance visual acuity BCVA).[4]

- Ranibizumab has been found not to be cost-effective in comparison with bevacizumab[5], both in classic AMD and where the disease is minimally occult or occult with no classic lesions[6].

- Novartis and Roche, manufacturers of ranibizumab and bevacizumab, have been found guilty in Italy of 'cartelising' the pricing of the two drugs, creating an artificial distinction between them which directs demand to the higher priced drug[7].

- The Royal College of Ophthalmologist's recent challenge to the NHS to be able to use bevacizumab rather than ranibizumab in the treatment of Wet AMD[8, 9]should be noted.

- The CCG also noted that in another condition, pharmacological management of neuropathic pain, NICE (CG173, 2013) recommends unlicensed use of a medication in the presence of a licenced alternative. Three of the four drugs recommended by NICE do not have a specific licence for the purpose recommended and off-label use is noted in the guidance.

3. Smoking cessation prior to routine surgery

Eight weeks' smoking cessation is to apply prior to routine surgery. Procedures deemed to be immediately clinically necessary are excluded from this requirement.

Evidence considered by the CCG includes:

- A 2010 Cochrane review[10] on the interventions for preoperative smoking cessation suggests that stopping smoking four to eight weeks before surgery may reduce the risk of:
  - wound-related, lung and heart complications
  - prolonged bone fusion time after fracture repair
  - prolonged stay in hospital after surgery

- On the subject of the exact period of smoking cessation that is beneficial, most research finds that two months is of most benefit[11, 12, 13, 14].

- Providing pre-operative counselling and support for smokers awaiting surgery leads to a high quit rate compared to no support[15]. Therefore the preoperative period is a good period to offer smoking intervention.

- Compared with non-smokers and ex-smokers, smokers are more likely to stay longer in hospital, be admitted to an intensive care unit or die in hospital. A helpful NHS review, The Clinical Case for Smoking Cessation before Surgery[16], is provided by the UK National Smoking Cessation Conference. Specific risks include:
  - impaired pulmonary function such as increased mucus production, and damage to the tracheal cilia which impedes the clearance of the mucus leading to postoperative respiratory complications such as chest infection
  - impaired wound healing leading to increased risk of wound infection after surgery
  - an increase in the risk of cardiovascular complications such angina pectoris, strokes, graft failures and DVT after surgery
  - post-operative complications relating to the gastrointestinal system
  - post-operative impairment of antimicrobial and pro-inflammatory functions
  - post-operative complications relating to the musculoskeletal system such as reduction in bone fusion after fracture and operative treatment

4. Weight loss prior to routine surgery

- A Body Mass Index of 35 is considered by the CCG to be trigger for a patient's weight being a problem in terms of surgical risk and outcomes. We note that NICE uses a threshold of a BMI of 35 in recommending bariatric surgery in some individuals. We note that NHS England uses a threshold of a BMI of 30 in its policy for knee arthroplasty for armed forces personnel and their dependents.

- The CCG's position is that a BMI of 35 should trigger a requirement for weight loss. That weight loss should be five per cent or to below a BMI of 35, whichever is the lesser weight loss. Thereby balancing what is realistic for an individual patient with benefits likely to be gained.

- Procedures that are deemed to be immediately clinically necessary are exempt from the weight loss requirement. Patients whose medical condition or treatment encourage weight gain can be exempted from the weight loss requirement.

- Key considerations regarding surgical risk and obesity include:

- a nearly 12-fold increased risk of a post-operative complication after elective breast procedures[17]
- a 5-fold increased risk of surgical site infection (SSI)[18]
- an increased risk of SSI as much as 60% when undergoing major abdominal surgery[19]
- a higher incidence of SSI (up to 45%) when undergoing elective colon and rectal surgery[20]
- an increased risk of bleeding and infections after abdominal hysterectomy[21]
- a higher incidence of peri-operative deep venous thrombosis and pulmonary embolism[22]
- increased risk of complication after elective lumbar spine surgery[23, 24]
- an increased risk of restrictive pulmonary syndrome, including decreased functional residual capacity (for morbidly obese patients)[25]

- The CCG's earlier decision encompassed hip and knee arthroplasty only. That decision drew on the following rationale:

  - In February 2014, NICE updated its guidance on the management of Osteoarthritis, (NICE CG177) recommending exercise as a core treatment in the management of people with osteoarthritis who are obese and overweight

  - The NICE guidance is explicit on this point irrespective of age, comorbidity, pain severity or disability

  - NICE considers this a "strong recommendation". NICE defines a strong recommendation as,: "…when we are confident, that for a vast majority of patients, an intervention will do more good than harm, and is cost effective."26

  - Other sources cite worse outcomes associated with orthopaedic surgery where there is a high BMI[27, 28], including worse revision rates in obese patients29

  - For knee replacement, although patients make a gain with that procedure regardless of starting weight, their outcomes are lesser than with a healthier BMI. In follow-up studies, morbidly obese patients have been shown to have worse scores for pain and function into the long term along with higher revision rates30

  - This group or patients has also been shown to have higher short term risks of complications31 and can have a lesser chance of improvement32

  - The NHS England commissioning policy in respect of knee replacement in the armed forces stipulates the following conditions for funding knee arthroplasty33:

- There is evidence that conservative means have failed to alleviate pain and disability AND
- Symptoms have a substantial impact on quality of life AND
- Symptoms are refractory to non-surgical treatment AND
- The prostheses used are standard AND
- The patient is a non-smoker AND
- The patient has a BMI < 30.

- That NHS England policy also states that, "referral should be made before there is prolonged and established functional limitation and severe pain." This is also the CCG's position.

5. Restriction of second hearing aids

In deciding to restrict funding for second hearing aids for adults, the CCG considered the following research:

- Rapid Evidence Review found no large scale studies comparing one hearing aid with two[34]. Some small scale studies showing similar benefit but as many showing no benefit.

- The CCG went on to consider what might be generalisable research on the correction of hearing loss. In the case of cochlear implants, Authors from the Medical Research Council Institute of Hearing Research reports unilateral implants having the greatest gain. The unilateral QALY in 2002 was assessed at £16,744 versus no intervention, and a bilateral versus unilateral QALY of between £62k and £69k (depending on whether the second implant was given simultaneously or later.[35] This in contrast to the NICE QALY threshold for investment which is in the range £20k - £30k. Although the cost of intervention between cochlear implants and hearing aids is different, the ratio of benefit between first and second ear correction was considered to be a useful illustration.

- The CCG noted too that two hearing aids are supported by leading hearing loss groups with greater usefulness seen in dynamic and noisy situations. This consideration was influential in the decision to exempt patients with other sensory conditions or who may rely on discernment of social cues to a greater extent, such as autism with hearing loss, in order not to disproportionately impact these groups of patients.

6. Threshold for cataract surgery

- The CCG considered that DVLA standards to represent a reasonable proxy for necessity of corrected eyesight. The CCG's interim commissioning position applies the 6/12 driving standard equally to drivers and non-drivers but will also correct vision at an earlier stage of sight loss required by DVLA for some specialist vehicles.

- The CCG also notes the November 2014 Health Technology Assessment[36] from the NIHR which reviewed three Randomised Controlled Trials of clinical effectiveness, three studies of cost-effectiveness and ten studies of Health Related Quality of Life (HRQoL). The RCTs assessed visual acuity, contrast sensitivity, stereopsis and several measures of HRQoL. Improvements in binocular visual acuity and contrast sensitivity were small and unlikely to be of clinical significance. Stereopsis was improved to a clinically meaningful extent following second-eye surgery. Studies did not provide evidence that second-eye surgery significantly affected HRQoL, apart from an improvement in the mental health component of HRQoL in one RCT.

7. Restriction of ear microsuction

- The CCG noted other policies in place in the UK, bringing its policy into line with others, restricting its use to treatment of infections and anatomical abnormalities. Polices vary from allowing referral if two attempts at irrigation have been unsuccessful in primary care, coupled with hearing loss or pain, to refusing referral unless for ongoing treatment of a mastoid cavity or due to an anatomical abnormality (with exceptionality required for other funding requests). The CCG opted for parity with the most restrictive of these current UK policies.

- There is limited evidence that ear irrigation improves hearing and symptoms[37].

- Although there is consensus that ear irrigation is effective at removing wax, BMJ Clinical Evidence found no randomised controlled trials comparing ear irrigation alone to no treatment[38].

- A more recent systematic review and economic evaluation of different methods of earwax removal found the evidence on the effectiveness of different methods of irrigation or mechanical removal was equivocal[39].

- The CCG noted that the rationale for referral to secondary care following unsuccessful irrigation (or if contraindicated) is to enable the use of specialist treatments; although there are no systematic reviews or

randomized controlled trials on mechanical methods of removing earwax (other than irrigation), most Ear Nose and Throat specialists consider microsuction to be a standard treatment to enable the tympanic membrane to be seen[40].

8. Suspension of shockwave therapy

- The CCG noted that Extracorporeal Shockwave Therapy (ESWT) is not currently offered CCG-wide.
- The CCG noted the NICE appraisal of ESWT [41] [42, 43, 44] identifies that clinical outcomes are equivocal, that the procedure should be done accompanied by audit and that patients should be advised of uncertainty of outcomes.
- The CCG decision was therefore to suspend shockwave therapy for tendinopathies and bursitis. This to be accompanied by a review with secondary care to identify clinically effective and cost-effective pathways for tendonitis which may be commissioned in the future.

9. Prior approval of shoulder surgery

- The CCG noted a number of indications for shoulder surgery with equivocal outcomes compared with other treatments. Therefore it was decided to establish an Interim Commissioning Position to require prior approval for shoulder surgery with a view to developing a more comprehensive policy and commissioned pathways working with surgeons, physiotherapists, GPs and radiologists during 2015/16.
- In particular, the CCG noted the following:
  - Impingement. Little evidence from RCTs that surgical intervention is better than conservative treatments[45]
  - Frozen shoulder. Generally poor quality evidence; trials have small numbers and risk of bias. Steroid injection with physiotherapy seems to be the most effective interventions. There is limited evidence for arthrographic distension and capsular release[46, 47]
  - Shoulder replacement for OA/RA. No conservative vs operative RCTs were found but total arthroplasty thought to have better outcomes than hemiarthroplasty[48]. Follow up studies suggest that arthroplasty is associated with an improvement in pain and shoulder score (9, overall physical function improvement seems to be related to obesity, 10). The size of the improvement varies from study to study e.g. in a registry study from Denmark, mean improvement was just above the minimal clinically important difference, for total arthroplasty whereas the results for hemiarthroplasty are more equivocal[49]

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