# Procedures of Limited Clinical Effectiveness (PoLCE)

## Introduction

From the outset it is important to realise that NCL's PoLCE policy is pretty opaque, and an inherent lack of clarity makes it difficult both to unpick and to understand. However, the underlying purpose of PoLCE is clear: to save money by limiting the range of treatments available to patients. Such restrictions create a dangerous precedent by undermining the traditional independence of GPs, an independence which up until now has allowed doctors to base treatment recommendations on their own clinical judgment of what is best for their patient in line with current practice.

It reassures patients to know that doctors are continually updating their clinical practice and recommending the best course of treatment available for their condition. To this end, NHS England commissions independent national clinical audits on an ongoing basis, with the aim of spreading good medical practice and highlighting shortcomings or variations in care. Nevertheless, in order for PoLCE to return the hoped-for £2 million p.a. saving for NCL, some treatments that are currently available are to be restricted after April 2019, if not withdrawn altogether. To achieve this saving, an administrative process called a Referral Management System will have the power to override doctors' discretion.

## Acronyms* and numbers

In NCL, PoLCE stands for Procedures of Limited Clinical Evidence (or Effectiveness), but the policy is also sometimes called, "Using NHS Money Wisely" and "Improving Health and Wellbeing by Supporting Clinical Decision-Making". NCL's latest iteration of PoLCE was influenced by a change of policy in Enfield, "Attention to Evidence-Based Medicine" (AEBM). London region has a parallel policy, "London Choosing Wisely Programme" (LCW), and NHS England nationally have "Evidence Based Interventions" (EBI). All are currently under development. In December 2018, NCL Joint Commissioning Committee adopted a new policy on PoLCE, including 29 treatment/treatment areas, NHSE listed 17 and London region listed 8.

On 7 March 2019 the JCC decided that NCL PoLCE would incorporate the new national and London-wide restrictions, claiming they had been mandated to do. It is possible that in doing so the CCGs which make up the JCC failed to exercise their statutory responsibilities. Significantly the 3 restrictions from NHSE London region (LCW) were previously abandoned by Enfield CCG after public outcry at the idea that hip, knee and cataract surgery was to be subject to rationing by raising access to treatment thresholds.

## The thin end of the wedge

Enfield opted to test their initial PoLCE policy on those procedures where the cost savings would be most rapid and effective in reducing the numbers of interventions. They were initially considering 192 procedures for cutting or rationing so, despite the reductions first to 29 and now to 17 treatment areas, the initial number and the increasing imperative to cut costs to meet key performance targets suggests that NCL's current PoLCE policy is merely *The Thin End of the Wedge*.

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Only referring patients for treatments which are clinically effective is obviously reasonable, but the effectiveness of some of the procedures already listed under PoLCE and the strict monitoring of doctors - which in turn questions doctors' independence when making treatment recommendations - all demonstrate the need for effective opposition before NCL's policy is put into practice.

**NCL's approach to PoLCE**

The 5 CCGs which together comprise the NCL STP footprint (Barnet, Islington, Camden, Haringey and Enfield) must implement PoLCE uniformly across the patch. NCL state that money saved on outmoded treatments will go to fund newer, alternative treatments which are more effective, but the accompanying emphasis on cost-saving undermines NCL's claims that the updating and improvement of clinical decision-making is well-intentioned business-as-usual. That NCL now intends to implement Enfield CCG's PoLCE policy consistently across the area supports this negative impression of PoLCE as part of a cost-cutting exercise.

**PoLCE: methods**

There are two ways PoLCE reduces numbers of elective interventions:

**1) Not routinely offering procedures where the risk of intervention outweighs the potential benefits, and**
**2) demanding the patient meets raised clinical criteria to be eligible for referral for elective treatment.**

**1)** Referrals for procedures proscribed under PoLCE *can* be made via Individual Funding Requests (IFR), but the referring doctor must make a case explaining why a particular patient would *uniquely* benefit from a particular procedure. That the patient is typical of a particular cohort who are proven to benefit is insufficient evidence, as that might open the floodgates to others with the same condition. This is an admission that there are effective interventions which are being denied, for example, for "symptomless hernias". The idea that early intervention prevents more serious symptoms developing which require more expensive (and possibly emergency) treatment later on has been abandoned. That patients with suspected cancer are exempt from PoLCE, because for them delay could be fatal, indicates that delays to treatment are designed into the policy.

**2)** Raising the criteria for referral is 2-pronged:

(i) Under PoLCE the common stipulation is that the patient's condition must be proven to inhibit normal activity and impact on quality of life. For example, with osteoarthritis of the hip or knee, the patient must have documented, debilitating pain for 6 months before they can be referred for joint replacement surgery. That means documentation of severe pain for at least 6 months *before* referral, i.e. before being put on a waiting list. This mitigates against stoical people/people who are time poor and cannot afford/get time off to see their GP, for example, who may well be one and the same. It also encourages people who can afford it to pay for private health care.

Also PoLCE demands that "conservative"/non-invasive treatments, such as physiotherapy have to be exhausted and proven ineffective before referral for surgery can be made. A course of physiotherapy is of course very time-consuming, OK perhaps for the leisured classes, but not for people whose work entails a lot of standing and who are not allowed time off for doctors' appointments or lose pay as a result.

It is also relevant to point out that middle class people are typically more skilled at playing the system - more likely to go to their doctor sooner and expect/demand better treatment - which further exacerbates any differentials in health outcomes.

(ii) Patients must be referred to weight loss and/or smoking cessation services prior to referral for surgery, again extending the time prior to referral for treatment. For women, a high BMI is an indicator of poverty, so this aspect of PoLCE mitigates against people who are from a lower socio-economic position (although not exclusively). Although Enfield's demand that people with a high BMI lose weight before joint replacement surgery was thrown out for the time being due to the lack of sufficient weight loss support services, or physiotherapy to help with mobilisation and pain management, this caveat has now been abandoned across NCL as a whole. Simply abandoning patients until they have suffered long enough on their own cannot be justified.

**Avoiding and overriding public consultation**

Historically running a deficit and consequently being put "in special measures" by NHSE, Enfield CCG needed to find new areas where cost-cutting would produce rapid results. In 2015-16 they published a leaflet for patients on PoLCE policy, detailing elective procedures no longer routinely available, and they undertook a public consultation which resulted in significant changes to the policy. The decision made by the JCC in December 2018 in effect to implement the Enfield changes across the other four boroughs was done without public consultation. It is arguable that this is another breach of CCGs' statutory duty to consult the public before a significant change in services.

NCL claims that the Joint Health Overview and Scrutiny Committee (JHOSC) has agreed that the changes could proceed without further public consultation, but the JHOSC denies that is the case. NCL's efforts to avoid further public consultation indicates a recognition of the unpopularity of PoLCE and their consequent desire to proceed behind closed doors - hence Islington Keep Our NHS Public's campaign to raise public awareness!

Another argument NCL put forward for not consulting the public is the lay person's lack of medical knowledge and difficulty understanding medical terminology. However, the public's angry response in Enfield amply demonstrated NCL's assault on common sense - hip and knee replacements and hearing aids are effective!

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**Conclusion - the role of Islington KONP**

PoLCE can be seen to increase inequality of health outcomes in the population due to it's unequal impact on different socio-economic groups. By eroding the universal cradle to grave safety net for certain groups, cynics could argue that with PoLCE, the NHS demonstrates that people who suffer from diseases caused by self-imposed, "feckless" behaviour are not worth spending "taxpayers" money on. And people who can afford it will be pushed all the more towards private health care.

IKONP's campaign must expose PoLCE as fraudulent: PoLCE is not simply based on clinical evidence of effectiveness, but designed to manage patient demand and reduce the level of expressed need. As one of an increasing number of challenges to traditional NHS values, mobilising the public by raising awareness is the most effective way to fight this!

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*** Other acronyms explained:**

**NCL STP**

**NCL** - North Central London.

Comprises Barnet, Islington, Camden, Haringey and Enfield health commissioners and providers. Clinical Commissioning Groups commission health and care services from providers. Providers can be NHS hospitals, social enterprises, voluntary organisations or private sector companies.

**STP** - Sustainability and Transformation Partnership.

England is divided into 44 "STP footprints" each serving a population of about 1.5-1.8 million. They were set up with no basis in statute so have no formal legal powers of their own. Nonetheless, the national bodies, especially NHS England, control the purse strings so they demand and usually get compliance from STPs. STPs were meant to be bodies which pulled together partnerships with providers and local authorities, but the speed at which they were set up meant that this did not fully happen.

**CCG - Clinical Commissioning Group.**

Replaced Primary Care Trusts. Set up under the Health and Social Care Act (2012). The CCG board is elected by all of the GP practices in the area and has some additional lay members and clinician representatives. Responsible for commissioning most of the hospital and community NHS services in a given area. Barnet, Islington, Camden, Haringey and Enfield are NCL's CCGs. CCGs were given statutory powers and responsibilities and duties by the 2012 Act, including the requirement to put all of the services they commission out to competitive tender, and to consult the public about significant service changes

**JCC - Joint Commissioning Committee of the CCGs in NCL**

The Committee consists of representatives from all five CCGs in NCL, including both GPs and lay members. NCL senior management staff are included. Representatives from Healthwatch and Public Health attend. Meetings are normally held every 2 months and the public can attend.

**JHOSC - Joint Health Overview and Scrutiny Committee**

Joint committee formed of councillors in the five boroughs. Holds the CCGs and the STP to account in public meetings every two months. CCGs statutorily required to appear in front of it to explain actions

**Healthwatch, role of**

Government-funded body with local branches (Barnet, Islington, Camden, Haringey and Enfield) set up to represent patients' interests in their locality, but not allowed to campaign on behalf of patients. Two members of local Healthwatch branches can attend JCC meetings but are not allowed to vote.

Enfield Healthwatch are the most aware of the outcomes of financial cutbacks due to their longer engagement with PoLCE. Haringey Healthwatch are similarly actively engaged in challenging the JCC.

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