VALUE BASED COMMISSIONING POLICIES for SHROPSHIRE CCG and TELFORD and WREKIN CCG

VERSION 1.2

Date effective from 1st July, 2019

Issued by:

NHS Shropshire CCG

NHS Telford & Wrekin CCG

Contents

Introduction

Since the CCGs operate within finite budgetary constraints the policy makes explicit the need for the CCGs to prioritise resources and provide interventions with the greatest proven health gain. The intention is to ensure equity and fairness in respect of access to NHS funding.

To do this, the policy provides the list of interventions 'not routinely funded' by the CCGs and the specified criteria required for the funding of certain other interventions. Please note that the policy guidance relating to these interventions should be read with reference to the principles detailed below.

Commissioners, general practitioners, service providers and clinical staff treating residents of Shropshire and Telford and Wrekin are expected to implement this policy. When interventions are undertaken on the basis of meeting criteria specified within the policy, this should be clearly documented within the clinical notes. Failure to do so will be considered by the CCGs as lack of compliance.

The CCGs explicitly recognise that for each of the interventions listed in this policy there may be exceptional clinical circumstances in which the CCGs would consider the funding of these interventions. It is not feasible to consider every possible scenario within this document. In cases where specified criteria are not met, applications may be considered on an individual basis through an Individual Funding Request (IFR) process. The IFR policy for Shropshire is available at www.shropshireccg.nhs.uk/policies. The IFR policy for Telford and Wrekin is available at http://www.telfordccg.nhs.uk/your-health/medicines-management/individual-funding-requests.

In considering individual cases the CCG applies following definition of exceptionality:

- Where care is not routinely funded by the respective CCG, evidence must be provided to show that the patient is significantly different to the population of patients with similar clinical needs who would also not be offered the treatment
- This should include evidence that the patient is likely to gain significantly more benefit from the treatment than would be expected for other patients not currently offered it

Exceptional clinical circumstances are defined as referring to a patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients with the same medical condition and at the same stage of progression as the patient. In making a case, therefore, the clinician must specify how this patient is clinically different from others currently excluded from treatment - either in reference to the clinical picture, the expected benefit, or both.

If patients choose to privately fund an intervention that is not normally funded by the CCGs, they will retain their entitlement to other elements of NHS care. For example, if they privately fund a cancer drug or cancer intervention not normally funded by the CCGs they will retain their entitlement to all the other elements of cancer care that other residents of Shropshire and Telford and Wrekin receive free of charge. However when patients are privately funding an intervention, they are responsible for all the costs associated with that intervention, including Consultant costs and diagnostics. They are therefore unable to receive a mixture of privately funded and the CCG's funded care within the same appointment or intervention – in line with national guidance, they cannot 'top-up' a CCG's funded appointment or intervention by paying for an additional intervention to be provided or monitored during the same

consultation. The relevant CCG policies can be found on the respective CCG websites in the 'commissioning' section.

This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding clinical and cost effectiveness. All efforts will be made to work with our main service providers to jointly review and update the policy.

Unless providers are notified otherwise, implementation of the policy will continue to be monitored by the Prior Approvals process, selected audit of interventions against the criteria and by the application of procedures within the Referral Assessment Service (RAS) for Shropshire patients. For Telford and Wrekin patients, the provider should not perform any of the procedures included in the policy without explicit consent from the CCG. Referrals via TRAQS can be considered as explicit consent and referrals received via any other route require prior approval.

Implementation will be supplemented by continual monitoring of activity against the interventions. If substantial growth in activity occurs providers will be expected to investigate & confirm to the CCGs that they are complying with the policy.

Please note that where any policies refer to children or adults, unless specifically stated otherwise within that individual policy, an adult is considered to be 18 and over.

2.1 Varicose vein interventions

Surgical interventions for the treatment of varicose veins are not funded unless ONE of the following criteria is met:

- Bleeding varicose veins **OR**
- Symptomatic (veins found in association with troublesome lower limb symptoms - typically pain, aching, discomfort, swelling, heaviness and itching) primary or symptomatic recurrent varicose veins **OR**
- Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency **OR**
- Superficial vein thrombosis (characterised by the appearance of hard, painful veins) and suspected venous incompetence **OR**
- A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks) **OR**
- A healed venous leg ulcer

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral and on request for prior approval for surgery.

2.2 Haemorrhoid surgery

Surgery for haemorrhoids (Haemorrhoidectomy) will be funded where the following criteria is met:

- Recurrent third or fourth degree internal haemorrhoids **AND**
- Persistent pain or bleeding **AND**
- Failed conservative treatment **OR**
- Symptomatic external haemorrhoids

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral and on request for prior approval for surgery.

2.3 Hernia Management & Repair in Adults

Patients with a suspected strangulated or obstructed hernia **should be admitted as emergencies.**

Primary Care clinicians should refer patients meeting ANY of the following criteria for assessment only in Secondary Care:

- All symptomatic patients with an overt or suspected inguinal hernia (patients with asymptomatic or minimally symptomatic inguinal hernias should not be referred)
- Irreducible and partially reducible inguinal hernias
- Patients with suspected Spigelian or Femoral hernias

Evidence of meeting the above criteria must be provided by Primary Care clinicians when making a referral to secondary care for assessment.

The CCG will fund surgery for all types of hernia in cases where:

- The patient has symptoms of incarceration, strangulation or obstruction

For patients without symptoms of incarceration, strangulation or obstruction, the following

criteria applies;

Femoral Hernia

- Surgery will be funded

Spigelian Hernia

- Surgery will be funded

Inguinal Hernia

Surgery will not be funded unless there is:

- Difficulty in reducing the hernia **OR**
- An inguino-scrotal hernia **OR**
- Pain with strenuous activity, prostatism or discomfort significantly interfering with activities of daily living

Abdominal (including incisional and umbilical) hernia

Surgery will not be funded unless:

- **Umbilical (adults) -** Surgical treatment will only be approved when one of the following criteria is met;
    - Pain/discomfort that causes significant functional impairment **OR**
    - Increase in size month on month **OR**
    - To avoid incarceration or strangulation of bowel **OR**
    - Patients are undergoing or plan to undergo peritoneal dialysis **OR**
    - The hernia is causing difficulty with the fitting of a stoma appliance, e.g. bag leaking or skin damage

- **Incisional -** Surgical treatment will only be approved when both of the following criteria are met;
    - Patients who are undergoing or plan to undergo peritoneal dialysis **OR**
    - Pain/discomfort that causes significant functional impairment **AND** appropriate conservative measures such as weight loss have been tried first **OR**
    - The hernia is causing difficulty with the fitting of a stoma appliance, e.g. bag leaking or skin damage

Divarication of Recti /Ventral

- In symptomatic cases only

Laparoscopic hernia repair

- Laparoscopic hernia repair is commissioned only for bilateral hernia repair where the patient has bilateral hernias with external swelling on clinical examination OR for recurrent hernia
- NB Laparoscopic hernia repair is not commissioned for primary unilateral hernia repair or for impalpable hernias found incidentally during laparoscopic repair of a hernia on the other side

2.4 Tier 3 Weight Management

Patients may be referred for Tier 3 Weight Management where the following criteria is met:

- The patient is 18 years of age and over **AND**
- The patient has a BMI of 35 or over for at least 5 years with significant comorbidities **OR**
- The patient has a BMI of 40 or over for at least 5 years without comorbidities **OR**

- The patient has recent-onset type 2 diabetes with a BMI of 30 or over **OR**
- The patient has recent-onset type 2 diabetes with an Asian family origin

Evidence of meeting the above criteria must be provided by the referring clinician when making the referral.

2.5 Bariatric Surgery (Tier 4 Weight Management)

Bariatric surgery will only be funded where the following criteria is met:

BMI of 35 or over

- Patient has had significant comorbidities for at least 5 years **AND**
- Is over 18 **AND**
- Patient has recently completed a Tier 3 weight management programme for 12-24 months with a stabilisation period of at least 6 months before referral

BMI of 40 or over

- The patient has had a BMI of 40 or over for at least 5 years **AND**
- Aged 18 years or older **AND**
- Patient has recently completed a Tier 3 weight management programme for 12-24 months with a stabilisation period of at least 6 months before referral

Evidence of meeting the above criteria must be provided by Secondary Care when seeking a prior approval code to conduct surgery.

2.6 Circumcision

Surgery will be funded where one or more of the following criteria are met:

- Phimosis in children with spraying, ballooning and/or recurrent infection **OR**
- Adult Phimosis or paraphimosis **OR**
- Recurrent (>3 documented episodes) of balantitis or balanoposthitis **OR**
- Balanitis xertotica obliterans **OR**
- Dermatological disorders unresponsive to treatment **OR**
- Congenital urological abnormalities when skin is required for grafting **OR**
- Interference with normal sexual activity in adult males **OR**
- for UTI prevention in patients with abnormal urinary tract **OR**
- Risk of malignancy **OR**
- Significant local trauma

Evidence of meeting the above criteria must be provided by Secondary Care when seeking prior approval for surgery.

2.7 Cholecystectomy for Gallstones & Bile Duct Stones

Primary Care clinicians should refer patients for <u>assessment only</u> where there is;

- Suspicion of acute pancreatitis, cholecystitis or cholangitis in patients who are systemically unwell (**these should be emergency referrals) OR**
- Confirmation of symptomatic gallstones or bile duct stones supported by ultrasonography with or without abnormal liver function tests **AND**
- Abdominal or gastrointestinal symptoms that have been unresponsive to previous management such as analgesia and diet amendment

Evidence of meeting the above criteria must be provided by Primary Care clinicians when making a referral to secondary care for assessment.

Gallstones

The CCG will fund Cholecystectomy for symptomatic gallstones with episodes of:

- acute cholecystitis or cholangitis **OR**
- recurrent biliary colic **OR**
- gall stone induced pancreatitis **OR**
- obstructive jaundice due to gall stones

The CCG will not fund Cholecystectomy for patients with asymptomatic common gallbladder stones.

The CCG will fund Cholecystectomy, with clearance of the bile duct of gallstone(s), for patients with symptomatic or asymptomatic bile duct stones

Evidence of meeting the above criteria must be provided by Secondary Care when seeking prior approval for surgery.

2.8 Venous Angioplasty for Multiple Sclerosis

Venous angioplasty for the treatment of Multiple Sclerosis is not funded.

2.9 Primary Hyperhidrosis Treatment

Primary focal hyperhidrosis can be diagnosed when focal, visible, excessive sweating;

- Has lasted at least 6 months

And has at least two of the following characteristics;

- bilateral and relatively symmetrical
- impairs daily activities
- frequency of at least one episode per week
- onset before 25 years of age
- positive family history
- cessation of local sweating during sleep

Referral on to a specialist dermatology service is advised if the following has been tried in primary care and the problem has continued;

- Advice has been offered on; Modifying behaviour to avoid identified triggers, avoiding tight clothing and manmade fabrics, wearing moisture-wicking socks and using absorbent soles, and foot powder if primary plantar hyperhidrosis is the diagnosis
- Treatments have been tried in the primary care for at least 1-2 months but have not worked

Treatments that will be tried if the patient is referred to a specialist dermatology service are (in the following order);

- Treatment with specialised products

- Iontopherisis – a course of 7 sessions, to be followed by self-treatment
- Botulinum toxin
    - Botulinum toxin is commissioned for the management of axillary hyperhidrosis (except in cases of social anxiety disorder) which does not respond to antiperspirants and antihidrontics
    - It is not routinely funded for management of hyperhidrosis of the palms, soles of the feet, face or areas other than the axilla
    - NB it is not commissioned in people with social anxiety disorder because there is no good evidence for benefit and it may be harmful

Endoscopic thoracic sympathectomy (ETS) is to be considered as a last resort.

2.10 Anal Skin Tags

Removal is not routinely funded.

3.1 Insertion of Grommets

Surgery to insert grommets will be funded where the following criteria are met:

Children

- In children (under 18 years old) with acute otitis media when there have been at least 5 recurrences of acute otitis media, which required medical assessment and/or treatment, in the previous year (these episodes must be documented) **AND**
- The child has undergone specialist Audiology and ENT assessment
  OR
- In children (under 18 years old) with otitis media with effusion (OME) where:
    - The child has undergone specialist Audiology and ENT assessment **AND**
    - OME persists after a period of at least three months watchful waiting from the date that the problem was first identified by the GP to the date of referral **AND**
    - the child is 3 years or older **AND**
    - there is hearing significant hearing loss (of at least 25dB) - particularly in the lower tones (low frequency loss) - and evidence of a disability as a result of this hearing loss on at least 2 documented occasions (following repeat testing after 6-12 weeks) with either:
        - Delay in speech development **OR**
        - educational or behavioural problems attributable to the hearing loss **OR**
        - a significant second disability that may itself lead to developmental problems, e.g. Down's Syndrome, Turner's Syndrome or Cleft Palate

Adults

- In patients where there is significant negative middle ear pressure measured on two sequential appointments **AND**
- Significant on-going associated pain **OR**
- Unilateral middle ear effusion where a post nasal space biopsy is required to exclude an underlying malignancy

Evidence of meeting the above criteria must be provided by Secondary Care on request of prior approval for surgery. A prior approval code should be sought by the secondary care clinician to conduct a procedure.

3.2 Adult Snoring Surgery (in the absence of Obstructive Sleep Apnea (OSA))

Surgery for snoring is not funded.

Reference: NHS England Evidence Based Intervention Policy – Category 1

3.3 Tonsillectomy for Recurrent Tonsillitis

Please note this guidance only relates to patients with recurrent tonsillitis.
This guidance would not be applied to other conditions where tonsillectomy should continue to be funded.
For example: Obstructive Sleep Apnoea / Sleep disordered breathing in Children; Suspected Cancer (e.g. asymmetry of tonsils); Recurrent (i.e. more than one episode) Quinsy (abscess next to tonsil); Emergency Presentations (e.g. treatment of parapharyngeal abscess)

Tonsillectomy surgery for recurrent tonsillitis will only be funded where the following criteria are met:

- Sore throats are due to acute tonsillitis **AND**
- The episodes are disabling and prevent normal functioning **AND**
- The patient has experienced seven or more, documented, clinically significant, adequately treated sore throats in the preceding year **OR**
- Five or more such episodes in each of the preceding two years **OR**
- Three or more such episodes in each of the preceding three years **OR**
- The patient has a medical condition where episodes of tonsillitis can be damaging to health or tonsillectomy is required as part of the on-going management
  (For example: Acute and chronic renal disease resulting from acute bacterial tonsillitis; As part of the treatment of severe guttate psoriasis; Metabolic disorders where periods of reduced oral intake could be dangerous to health; PFAPA (Periodic fever, Apthous stomatitis, Pharyngitis, Cervical adenitis); Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous)

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral and on request for prior approval for surgery. A prior approval code should be sought by the secondary care clinician to conduct procedure.

3.4 Ear Wax Removal / Microsuction of External Auditory Canal

The removal of ear wax should be carried out via ear irrigation within Primary Care (NICE NG98).

Microsuction or referral to Secondary Care to remove earwax will be funded where a patient has at least ONE of the following contraindications to ear irrigation in Primary Care:

- A minimum of two attempts at irrigation of the ear canal in Primary Care are unsuccessful **OR**
- The patient has previously experienced complications following irrigation of the ear canal in Primary Care or it has been repeatedly ineffective **OR**
- There is a history of a middle ear infection in the last six weeks **OR**
- The patient has undergone any form of ear surgery (except grommets that have extruded at least 18 months previously and the patient has been discharged from the ENT Service) **OR**
- The patient has a perforation or there is a history of a mucous discharge in the last year **OR**
  - The patient has a cleft palate (repaired or not) **OR**

- In the presence of acute otitis externa with pain and tenderness of the pinna **OR**
- Foreign body or vegetable matter that could swell on irrigation

Evidence of meeting the above criteria must be submitted by the referring clinician on referral into secondary care.

Note: If removal of earwax within Secondary Care is required to carry out a procedure or to gain a view of the tympanic membrane this is considered as part of the overall outpatient tariff and no additional payment will be made.

If secondary care wish to carry out this procedure for reasons outside the above note, they will need to submit evidence to confirm the patient meets the above criteria upon requesting a prior approval code.

4.1 Hip and Knee Replacement Surgery

Hip & knee replacements will only be funded where patients meet the criteria set out below. All referrals will be triaged and audited by the MSK Triage and Assessment Service.

Patients should NOT be referred for surgery unless they meet a the relevant criteria below:

- The patient has a BMI less than or equal 35 supported by measurements taken in Primary Care, or BMI over 35 including weight loss management for 6 months **AND**
- The patient has accessed NHS funded physiotherapy **AND**
- The patient has trialled analgesics and/or NSAIDS and these have failed to alleviate the patients' pain and disability **AND**
- The patient suffers from pain and disability that significantly interferes with the patients' daily life and/or ability to sleep

OR

- The patient has a BMI less than or equal 35 and the destruction of their joint is of such severity that delaying surgical correction would increase technical difficulty of the procedure.

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral and on request for prior approval for surgery. A prior approval code should be sought by the secondary care clinician to conduct procedure.

4.2 Hip Resurfacing Techniques (primary resurfacing arthroplasty of joint)

Except in the following, Metal on metal (MoM) hip resurfacing techniques are not routinely funded;

- Who otherwise qualify for a primary total hip replacement (see Section 4.1) **AND**
- are likely to outlive conventional primary hip replacements

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral and on request for prior approval for surgery. A prior approval code should be sought by the secondary care clinician to conduct procedure.

4.3 Femeroacetabular Surgery for Hip Impingement / Arthroscopy of Hip

Open or arthroscopic femeroacetabular surgery for hip impingement will be funded if ALL of the following criteria are met:

- Pain – motion or position related, in the hip or groin **AND**
- Positive clinical signs – impingement test and restricted range of motion **AND**
- Labral tear or impingement has been confirmed on diagnostic imaging **AND**
- The patient has completed a trial of conservative therapy

Evidence of meeting the above criteria must be provided by Secondary Care clinicians when requesting prior approval for surgery. A prior approval code should be sought by the secondary care clinician to conduct procedure.

4.4 Bunion Surgery

Surgery to remove bunions will only be funded where the following criteria is met:

- The patient has been assessed by the MSK Triage and Assessment Service AND/OR the Community Podiatry Service **AND**
- Conservative measures have failed to benefit after 3 months (these include trying accommodative footwear, considering orthoses and using appropriate analgesia) **AND**
- The patient suffers from severe pain on walking (not relieved by chronic standard analgesia) that causes significant functional impairment **OR**
- Severe deformity (with or without lesser toe deformity) that causes significant functional impairment OR prevents them from finding adequate footwear **OR**
- Recurrent or chronic ulceration or infection

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral and on request for prior approval for surgery. A prior approval code should be sought by the secondary care clinician to conduct procedure.

4.5 Carpal tunnel syndrome release

The CCG will fund surgical release of the carpal tunnel if the following criteria are met;

- Patients must have been assessed by the MSK triage and assessment service **AND**
- The patient has acute severe symptoms that persist for more than 4 months after conservative therapy with local corticosteroid injection and nocturnal splinting **OR**
- There is neurological deficit or median nerve denervation, e.g. sensory blunting, muscle wasting or weakness of thenar abduction **AND**
- Severe symptoms significantly interfering with daily activities and sleep which have been assessed by the MSK Triage and Assessment Service

Evidence of meeting the above criteria must be provided by either Primary Care clinicians or the MSK Triage and Assessment Service prior to referral for surgery.

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral and on request for prior approval for surgery. A prior approval code should be sought by the secondary care clinician to conduct procedure.

4.6 Dupuytren's contracture release in adults

The CCG will fund limited fasciectomy surgery for Dupuytren's Contracture where the following criteria are met:

- The patient has been reviewed by the MSK Triage and Assessment Service **AND**
- Alternative conservative management has been tried for a minimum of 3 months and failed
  AND
- The patient has severe disease, defined as fixed flexion greater than 60˚ at the metacarpophalangeal joints (MCPJ) or greater than 30˚ at the proximal interphalangeal joint 9PIPJ) **OR**
- The patient has moderate (Notable) functional impairment 30-60˚ fixed flexion at the MCPJ and less than 30˚ at the PIPJ to severe disease and has not responded to or has a clinical indication making them not suitable for needle fasciotomy **OR**
- there has been a rapid progression over 12 weeks

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral and on request for prior approval for surgery. A prior approval code should be sought by the secondary care clinician to conduct procedure.

The CCG will not fund radiation therapy for Dupuytren's Contracture.

4.7 Trigger finger release in adults

Surgery for the release of Trigger Finger is not funded unless the following criteria is met:

- The patient has been reviewed by the MSK Triage and Assessment Service
  AND
- The patient has failed to respond to conservative measures including splinting for a minimum of 3 weeks and, as a minimum, one steroid injection **AND/OR**
- the finger is permanently locked in the palm **AND/OR**
- the patient has previously had 2 other trigger digits unsuccessfully treated with appropriate non-operative methods **AND/OR**
- The patient has a confirmed diagnosis of diabetes

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral and on request for prior approval for surgery. A prior approval code should be sought by the secondary care clinician to conduct procedure.

4.8 Wrist Ganglion Excision

Wrist ganglion excision will only be funded where the following criteria is met:

Wrist ganglia

- Aspiration of the ganglion has failed to resolve the pain or tingling/numbness; **AND**
- Restricted hand function

Seed ganglia at the base of a digit

- The ganglion is causing the patient pain; **AND**
- Puncturing and/or aspiration of the ganglion using a hypodermic needle has failed to relieve symptoms;

Mucous cysts at the DIP joint

- Recurrent spontaneous discharge of fluid; **AND/OR**
- Significant nail deformity

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral and on request for prior approval for surgery. A prior approval code should be sought by the secondary care clinician to conduct procedure.

4.9 Knee Arthroscopy

Washout and Debridement in osteoarthritis

- Will not routinely be funded unless there is clear history of mechanical locking (as opposed to morning joint stiffness, giving-way or XRay evidence of loose bodies)

Diagnostic and therapeutic arthroscopy for other conditions

Will not routinely be funded unless the following criteria are met;

- Clinical examination by a consultant specialist or an MRI scan has demonstrated clear evidence of an internal joint derangement (meniscal tear, ligamentrupture or loose body) **AND**
- Where conservative treatment has failed **OR**
- Where it is clear that conservative treatment will not be effective **OR**
- Knee pain with diagnostic uncertainty following an MRI scan **OR**
- Suspected malignancy, infection, nerve root impingement, bony fracture or avascular necrosis **OR**
- Clear history of trauma

Reference: NHS England Evidence Based Intervention Policy – Category 1

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral and on request for prior approval for surgery. A prior approval code should be sought by the secondary care clinician to conduct procedure.

4.10 Autologous Cartilage Transplantation of the Knee

Autologous Cartilage Transplant will not be funded by the CCG.

4.11 Arthroscopic shoulder decompression for subacromial shoulder pain

Arthroscopic shoulder decompression surgery will not be funded unless the following criteria are met:

- The patient has received NHS funded physiotherapy for a minimum of 3 months **AND**
- Appropriate analgesia has been unsuccessful in controlling pain **AND**
- The patient has been assessed by the MSK Triage and Assessment Service

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral and on request for prior approval for surgery. A prior approval code should be sought by the secondary care clinician to conduct procedure.

4.12 Extracorporeal Shockwave Therapy

Extracorporeal shockwave therapy for refractory Achilles tendinopathy and/or refractory plantar fasciitis will not be funded

4.13 Spinal Fusion for non-specific back pain

Spinal fusion surgery for the management of low back pain will not be funded as per NICE guidance

4.14 Spinal Decompression

Spinal decompression surgery will only be funded where all of the following criteria are met:

- The patient has a confirmed diagnosis of Sciatica with supporting radiology **AND**
- Conservative measures such as self-management, exercise, psychological therapy and NSAIDs have been tried over a period of 6 months and have failed to improve pain and/or function

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral/request for prior approval for surgery.

5.1 Spinal Injections for Management of Back Pain

The following spinal injections for the management of back pain are NOT commissioned:

- Facet Joint Injections
- Therapeutic Medial Branch Blocks
- Intradiscal Therapy
- Trigger Point Injections of any sort
- Epidural steroid injections
- Any other spinal injections not specifically covered above.

The following injections are commissioned only where ALL of the listed criteria is met:

Diagnostic Medial Branch Block Injections

- Medial Branch Block Injections will be commissioned only as a diagnostic procedure prior to Radiofrequency Denervation. One Medial Branch Block Injection only will be funded.

Radiofrequency denervation will be commissioned only where ALL of the following criteria is met:

- The patient is aged 18 or over.
- All conservative measures, including physiotherapy, exercise and pharmacological treatments have been undertaken and have failed.
- The patient is receiving treatment from a Pain Management Multi-disciplinary Team.
- The patient has received a successful (>70% improvement on a validated assessment tool) Medial Branch Block Injection.
- Treatment must be under X-ray guidance.

Not more than one denervation per joint per year will be funded.

Reference: NHS England Evidence Based Intervention Policy – Category 1

Repeat radiofrequency denervation is only permitted at a minimum interval of 12 months. Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral and on request for prior approval for this intervention. A prior approval code should be sought by the clinician conducting the intervention.

5.2 Epidural Injections

Epidural injection for pain management will only be commissioned after referral to a pain management service and in line with NICE guidance, which says 'Consider epidural injections of local anaesthetic and steroid in people with acute and severe sciatica'.

A maximum of 2 injections per patient in their lifetime is permitted

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral and on request for prior approval for this intervention. A prior approval code should be sought by the clinician conducting the intervention.

5.3 Trigger Point Injections including Botulinum Toxin (Botox)

Trigger Point Injections

Trigger point injections are not funded.

Botulinum Toxin (Botox)

Botulinum Toxin (Botox) is not routinely funded for pain management purposes except for the treatment of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine) where ALL of the following criteria has been met:

- The patient has not responded to at least three prior pharmacological prophylaxis therapies **AND**
- The patient is appropriately managed for medication overuse.

Treatment should be stopped where the patient has not adequately responded to treatment (defined as a reduction in headache days of at least 30% per month after 2 treatments) or where the patient's condition has changed to episodic migraines (defined as fewer than 15 headache days per month).

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral/request for prior approval for this intervention. A prior approval code should be sought by the clinician conducting the intervention.

5.4 Spinal Cord Stimulation for Chronic Pain

Spinal Cord Stimulation for chronic pain is not funded unless ALL of the following criteria are met:

- The patient has chronic pain of neuropathic origin **AND**
- The patient has continued to experience chronic pain (measuring at least 50 mm on a 0–100 mm visual analogue scale) for at least 6 months despite appropriate conventional medical management **AND**
- The patient has received a successful trial of stimulation as part of an assessment by a Pain Management Multi-disciplinary Team

If different spinal cord stimulation systems are considered to be equally suitable for a patient, the least costly should be used.

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral/request for prior approval for this intervention. A prior approval code should be sought by the clinician conducting the intervention.

5.5 Low Back Pain

The CCG does not commission the following investigations or treatments for patients with low back pain with or without sciatica:

Orthotics

- Belts or corsets
- Foot orthotics
- Rocker sole shoes

Manual therapies

- Traction

Electrotherapies

- Ultrasound
- Percutaneous electrical nerve simulation (PENS)
- Transcutaneous electrical nerve simulation (TENS)
- Interferential therapy

Spinal fusion for people with low back pain
Disc replacement in people with low back pain

5.6 iFuse Implant System for Chronic Sacroiliac Joint Pain

iFuse Implant Systems are not routinely funded.

Any request for this treatment would need to be submitted via an Individual Funding Request

6.1 Treatment for Erectile Dysfunction

Surgical treatment for erectile dysfunction is funded where the following criteria are met:

- Diabetes **OR**
- Multiple sclerosis **OR**
- Parkinson's disease **OR**
- Poliomyelitis **OR**
- Prostate cancer **OR**
- Prostatectomy **OR**
- Radical pelvic surgery **OR**
- Severe pelvic injury **OR**
- Renal failure treated by dialysis or transplant **OR**
- Single gene neurological disease **OR**
- Spinal cord injury **OR**
- Spina bifida

In patients with Peyronie's disease and erectile dysfunction is not responding to medical treatments, the surgical correction of the curvature with concomitant penile prosthesis implantation should be considered

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians either prior to referral or on request for prior approval for surgery.

6.2 Dilatation and curettage (D&C) for heavy menstrual bleeding in women

Dilation and curettage for the treatment of Menorrhagia is not funded

Reference: NHS England Evidence Based Intervention Policy – Category 1

6.3 Hysteroscopy for menorrhagia

Hysteroscopy for heavy menstrual bleeding (HMB) is indicated if there is failed medical management, symptoms suspicious of pathology (such as intermenstrual bleeding (IMB)) or a scan suggestive of uterine pathology, i.e. fibroids and polyps.

6.4 Hysterectomy +/- Oophorectomy

Hysterectomy is not routinely funded for the management of menorrhagia unless ONE of the criteria below are met;

- A prior trial with a levonorgetrel intrauterine system (IUS), e.g. Mirena (unless contraindicated) has failed to relieve symptoms **AND/OR**
- Other less invasive treatment options have been tried and failed (e.g. non-steroidal anti-inflammatory agents, transexamic acid, endometrial ablation, uterine-artery embolism) unless contra-indicated

Evidence of meeting this criteria must be provided by Secondary Care clinicians when seeking prior approval. A prior approval code should be sought by the clinician conducting the procedure.

6.5 Intrauterine Systems (IUSs e.g. Mirena Coils)

Levonorgestrel intrauterine devices e.g. Mirena should be fitted in primary care **UNLESS**

- Specific medical issue prevents fitting or removal by primary care
  OR
- It is fitted as part of contraception provided in conjunction with a termination of pregnancy
  OR
- The decision to fit the IUS is made as part of an operative procedure
  OR
- There has been one or more failed attempts to fit in primary care

Note: In the event of an appropriately trained clinician being unavailable in primary or community care, the CCG should be notified as soon as possible and referrals into Secondary Care in these instances will be considered on a case by case basis.

Evidence of meeting the above criteria must be provided by the Referring Clinician prior to referral. Evidence of meeting the above criteria must be provided by the Clinician conducting the procedure. A prior approval code must be sought by Secondary Care clinicians if one is not issued on referral from primary care.

6.6 Reversal of Female Sterilisation

Reversal of female sterilisation is not routinely funded

6.7 Reversal of Male Sterilisation

Reversal of male sterilisation is not routinely funded

6.8 IVF
The existing detailed Shropshire IVF policy can be found on the Shropshire CCG website at www.shropshireccg.nhs.uk/policies-and-reports/our-policies/clinical-commissioning-policies/ The Telford and Wrekin CCG policy can be found at www.telfordccg.nhs.uk/your-health/medicines-management/policies/clinical-commissioning/2377-fertility-policy-approved-august-2015/file

6.9 Routine Doppler Ultrasound Of Umbilical & Uterine Artery In Antenatal Care
Routine doppler ultrasound of umbilical and uterine arteries is not routinely funded for low risk pregnancies

6.10 Elective Caesarean Section for Non-Clinical Reasons
Not routinely funded

7.1 Laser Surgery for Short Sight (Myopia)
Laser surgery for correction of short sight is not routinely funded

7.2 Cataract Surgery
This policy applies to both first and second eyes, with a best corrected visual acuity of 6/12 or worse in the affected eye being used as the threshold for cataract surgery. Cataract surgery will be funded if one or more of the following criteria are met: • Visual acuity is 6/12 or worse **OR** • Patients who are still working in an occupation in which good acuity is essential to their ability to continue to work (e.g. watchmaker) **OR** • Patients with posterior subcapsular cataracts and those with cortical cataracts who experience problems with glare and a reduction in acuity in bright conditions **OR** • Patients who need to drive at night who experience significant glare due to cataracts which affects driving **OR** • Patients who have difficulty with reading due to lens opacities **OR** • Patients with visual field defects borderline for driving, in whom cataract extraction would be expected to significantly improve the visual field **OR** • Patients with significant optical imbalance (anisometropia or aniseikonia) following cataract surgery on the first eye **OR** • Patients with glaucoma who require cataract surgery to control intra ocular pressure **OR** • Patient with diabetes who require clear views of their retina to look for retinopathy **OR** • Patients with wet macular degeneration or other retinal conditions who require clear views of their retina to monitor their disease or treatment (e.g. treatment with anti-VEGFs) Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral/request for prior approval for surgery. A prior approval code should be sought by the clinician conducting the procedure.

8.1 Abdominoplasty or Apronectomy

Abdominoplasty (Apronectomy or Tummy Tuck) surgery will be funded where the following criteria is met:

- Age 19 years or over **AND**
- Starting BMI greater than 40 **OR** greater than 35 with co-morbidity **AND**
- Patients with current BMI less than or equal to 26 where weight has been stable for 12 months and there is evidence of significant functional disturbance **OR**
- the patient has maintained this weight loss for at least 18 months

Exceptions to general criteria;

- patients with a starting BMI of above 40 (or above 35 if co-morbidity) would be eligible for apronectomy if they have achieved a BMI of below 40 with evidence of weight reduction and evidence of significant functional disturbance
- Patients with current BMI of less than or equal to 26 where weight has been stable for 12 months and there is evidence of significant functional disturbance

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral/request for prior approval for surgery. A prior approval code should be sought by the clinician conducting the procedure.

8.2 Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat

Buttock thigh and arm surgery will NOT routinely be funded except where:

- Age 19 or over **AND**
- Significant functional disturbance (both physical and psychological) **AND**
- Starting BMI above 40 or above 35 with co-morbidity **AND**
- Current BMI of 26 or less AND weight stable for 18 months

Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral/request for prior approval for surgery. A prior approval code should be sought by the clinician conducting the procedure

8.3 Liposuction

Not routinely funded

Cosmetic liposuction is not available but may be used as a technique in the management of true lipodystrophies, lymphoedoema or lipomas, or as part of other surgery e.g. thinning of transplanted flap

8.4 Breast Augmentation

Breast augmentation/enlargement is the most popular cosmetic procedure. It involves inserting artificial implants behind the normal breast tissue to improve its size and shape.

Referrals should only be made for women with;

- Complete absence of breast tissue (amastia) **OR**
- Absence of breast tissue unilaterally **OR**
- Significant degree of asymmetry of breast shape and/or volume

OR

- Where clinically indicated to manage complications of breast surgery originally carried

out under the NHS

OR

- Surgery may be supported when there is a pathological condition relating directly to the implant

The minimum age for surgery is 19 years of age and evidence that pubertal growth of breasts has ceased must be documented

8.5 Breast Asymmetry

Patients will be considered eligible for surgery to correct breast asymmetry if the following criteria are met and normal diagnostic tools are available;

- Aged 19 years or over **AND**
- There is a natural absence of breast tissue unilaterally where there is no ability to maintain a normal breast shape using non-surgical methods (e.g. padded bra) (patients with Poland's Syndrome meet this criterion) **AND**
- There is a difference of at least 3 cup sizes **AND**
- Where relevant, treatment of the underlying cause of the problem has been undertaken (including advice, support and professionally fitting bra service) **AND**
- If asymmetry relates to a reduction surgery, then the patient's BMI is ≤ 27 for one year as measured and evidenced in the patient's clinical records

Note - breast reduction of the larger breast should be the preferred option for patients considering surgery

8.6 Breast Lift (Mastopexy)

Not routinely funded

8.7 Breast reduction

The NHS will only provide breast reduction for women if all the following criteria are met:

- The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain
- In cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided
- Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps)
- Breast reduction planned to be 500gms or more per breast or at least 4 cup sizes
- BMI should be < 35 with evidence of weight loss in the last 12 months
- Woman must be provided with written information to allow her to balance the risks and benefits of breast surgery
- Women should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking

Women should be informed that breast surgery for hypermastia can cause permanent loss of lactation

8.8 Revision Mammoplasty (including prosthesis removal or replacement)

Revision mammoplasty is a cosmetic procedure which will not be funded unless the implants were provided by the NHS and there is risk of harm from leakage or rupture.

8.9 Inverted Nipple Correction

Correction of inverted nipple is a cosmetic procedure which is not supported and will not be funded

8.10 Male Breast Reduction Surgery for Gynaecomastia

This will only be considered in the following circumstances;

- Surgery to correct gynaecomastia may be considered if the BMI is in the normal range (18.5 – 24.9) and when the reduction to be obtained will be significant i.e. greater than 100g per side (estimated), or where there is gross asymmetry
- Individuals who are taking sport performance-enhancing drugs, in whom the gynaecomastia is potentially drug induced, should be refused surgery unless such drugs have not been taken for more than 12 months and they meet the criteria above

8.11 Repositioning of nipple

Repositioning of the nipple is a cosmetic procedure which is not supported and will not be routinely funded.

Repositioning of the nipple following trauma will be considered on an individual case basis via the Individual Funding Request (IFR) route. Trauma is defined as any physical damage to the breast or nipple caused by violence or accident.

8.12 Labial Trimming and Cosmetic Genital Procedures

Labial trimming and other cosmetic genital procedures are not routinely funded

8.13 Labiaplasty

Requests for labiaplasty will be considered for the following indications:

- Where repair to the labia is required after trauma **OR**
- In cases of female genital mutilation

8.14 Vaginoplasty

Requests for Vaginoplasty will be considered for the following indications:

- Congenital absence or significant development/endocrine abnormalities of the vaginal canal
- Where repair of the vaginal canal is required after trauma

8.15 Hymenorrhaphy

Hymenorrhaphy, or hymen reconstruction surgery, is a cosmetic procedure and is not routinely funded

8.16 Pinnaplasty

The following criteria must be met:

- The patient must be under the age of 19 years at the time of referral, where the child rather than the parent alone expresses concern **AND**
- Referral is only indicated when there is obvious deformity or ear asymmetry

Patients seeking pinnaplasty should be seen by a plastic surgeon following assessment

Patients under 5 years of age at the time of referral may benefit from referral with their family for a multi-disciplinary assessment that includes a child psychologist

8.17 Blepharoplasty

Not routinely funded, except for cases where:

- The patient's field of vision is significantly obscured by this condition **OR**
- Documented clinical observation of poor eyelid function leading to discomfort, e.g. headache worsening at end of day and/or evidence of chronic compensation through elevation of the brow **OR**
- In cases of severe congenital ptosis

8.18 Face Lift or Brow Lift

Not routinely funded. These procedures will be considered for the treatment of:

- Congenital facial abnormalities
- Facial palsy (congenital or acquired paralysis)
- Brow Ptosis affecting vision
- To correct the consequences of trauma
- To correct deformity following surgery

NB these procedures will not be funded to treat the natural process of aging.

8.19 Hair Depilation (Hair removal)

Not routinely funded

8.20 Hair Grafting - male pattern baldness

Hair grafting for male pattern baldness is not routinely funded

- Correction of hair loss (alopecia) is only available under the NHS when it is a result of previous surgery or trauma including burns

8.21 Removal of Tattoos

Tattoo removal is not routinely funded

8.22 Removal of benign skin lesions

This policy refers to the following benign lesions when there is diagnostic certainty and they do not meet the criteria listed below;

- benign moles (excluding large congenital naevi)
- solar comedones
- corn/callous
- dermatofibroma
- lipomas
- milia
- molluscum contagiosum (non-genital)
- epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts)
- seborrhoeic keratoses (basal cell papillomata)
- skin tags (fibroepithelial polyps) including anal tags
- spider naevi (telangiectasia)
- non-genital viral warts in immunocompetent patients
- xanthelasmata
- neurofibromata

The benign skin lesions, which are listed above, must meet at least ONE of the following criteria to be removed;

- The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires 2 or more courses of antibiotics (oral or intravenous) per year
- There is repeated infection requiring 2 or more antibiotics per year
- The lesion bleeds in the course of normal everyday activity
- The lesion causes regular pain
- The lesion is obstructing an orifice or impairing field vision
- The lesion significantly impacts on function e.g. restricts joint movement
- The lesion causes pressure symptoms e.g. on nerve or tissue
- If left untreated, more invasive intervention would be required for removal
- Facial viral warts
- Facial spider naevi in children causing significant psychological impact

The following are outside the scope of this policy recommendation:

- Lesions that are suspicious of malignancy should be treated or referred according to NICE skin cancer guidelines.
- Any lesion where there is diagnostic uncertainty, pre-malignant lesions (actinic keratoses, Bowen disease) or lesions with pre-malignant potential should be referred or, where appropriate, treated in primary care
- Removal of lesions other than those listed above.

Referral to dermatology or plastic surgery:

- The decision as to whether a patient meets the criteria is primarily with the referring clinician. If such lesions are referred, then the referrer should state that this policy has been considered and why the patient meets the criteria
- Requests for treatment where a patient meets the criteria do not require prior approval or an IFR
- This policy applies to all providers, including general practitioners (GPs), GPs with enhanced role (GPwer), independent providers, and community or intermediate services
- Lipomas on the body > 5cms, or in a sub-facial position, with rapid growth and/or pain. These should be referred to Sarcoma clinic

8.23 Repair of Lobe of External Ear (Split earlobes)

Not routinely funded

8.24 Resurfacing Procedures: Dermabrasion, Chemical Peels and Laser Treatment

Unless the following criteria is met, resurfacing procedures including dermabrasion, chemical peels and laser treatment is not routinely funded:

- Post-traumatic scarring (including post-surgical)

8.25 Rhinoplasty

Not routinely funded.

Rhinoplasty is not normally commissioned unless there are significant functional problems. Patients with isolated airway problems (in the absence of visible nasal deformity) may be referred initially to an ENT consultant for assessment and treatment

- Post traumatic rhinoplasty
- Complete congenital conditions, e.g. cleft lip and palate
- Airway problems

8.26 Scars and Keloids

Scar Revision

Scar revision will only be considered after 2 years (to allow completion of the natural healing process) where one of the following criteria are met:

- scars that interfere with function following burns trauma **OR**
- serious scarring of the face - scars that are ragged and more than 2cm in length **OR**
- severe post-surgical scarring interfering with activities of daily living **OR**
- as an incidental part of another procedure

Keloid Scars

Funding will only be considered for keloid scars on the face and where evidence is presented of:

- significant pain or pruritus (itching) **OR**
- physical disability due to contraction, tethering or recurrent breakdown

Funding will not be available for keloid scars secondary to body piercing procedures.

8.27 Botox Injection for the Ageing Face

Botox Injection for the ageing face will not normally be funded

8.28 Congenital Vascular Lesions

Not routinely funded with exception of;

- Facial and/or neck port wine stains in adolescents or adults
  OR
- Paediatric haemangiomas which:

- Threaten life or function, including compromising eyesight, respiration, cardiac or hepatic function **OR**
- Other internal lesions sited in an area liable to scar **OR**
- Large facial haemangiomas that have failed to regress by school age **OR**
- Lesions which show a tendency to bleed or to become infected **OR**
- Kasabach-Merritt syndrome (coagulopathy)

8.29 Chalazia removal
Incision and curettage (or triamcinolone injection for suitable candidates) of chalazia should only be undertaken if at least one of the following criteria have been met: • Has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks **OR** • Interferes significantly with vision **OR** • Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy **OR** • Is a source of infection that has required medical attention twice or more within a six month time frame **OR** • Is a source of infection causing an abscess which requires drainage **OR** • If malignancy (cancer) is suspected, e.g. Madarosis/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions

9.1 Therapeutic Community Method Treatment for Borderline Personality Disorder
This is not routinely funded

10.1 Inpatient (Residential) Pain Management or Cognitive Behavioural Therapy Programmes
Inpatient (residential) placements for ‘pain management programmes’ or cognitive behavioural therapy is not funded

10.2 Complementary Medicines/Therapies
Complementary medicines/therapies will not be funded. Following NICE recommendations, the CCG will no longer fund acupuncture

Standard Operating Procedure for the management of Prior Approval Funding Requests (Shropshire CCG)

Introduction

This Standard Operating Procedure describes how NHS Shropshire CCG operates a 'prior approval' approach in order to apply its policy for Value Based Commissioning (VBC) (formerly Procedures of Limited Clinical Value - PLCV).

The CCG VBC Policy sets out in detail what clinical procedures are within the scope of the Operating Procedure and also the relevant criteria for approval. The current version of the CCG VBC Policy can be easily accessed on the 'Pathways & Guidelines' page of the Shropshire CCG website.

This Operating Procedure applies to all routine procedures which make up the VBC policy and to all Providers commissioned by the CCG. This Operating Procedure has been operational within the CCG from 3 October 2016 and will be amended as and when necessary.

The following apply to the Prior Approval process;

- All applications for a permission to treat code from the provider should be directly related to a current GP referral for the same, or related, condition – the only exception is a Consultant to Consultant referral that fits the CCG policy
- Any code issued by the CCG is only intended for the procedure for which it was issued, it does not confer permission to treat for any other procedure

Background

The CCG VBC Policy is well-established. It has been in operation since 2011 and is updated through a controlled process. However, in 2016 it became apparent that there was no process in place to monitor compliance. It is common practice elsewhere in England for CCG Commissioners to operate a prior approvals process for VBC/PLCV.

The CCG gave formal contractual notice to its Providers that it intended to apply a prior approvals approach to all VBC for patients referred on or after 3 October 2016.
The CCG also wrote to all GP Practices in October 2016 to communicate this change in approach.

CCG Referral Assessment Service (RAS)

The CCG Referral Assessment Service (RAS) operates as the decision-making centre for this process. RAS is a secure call-centre facility located on the William Farr House site.

RAS & its staff are authorised to handle & store patient-identifiable clinical information. RAS Triage Nurses are familiar with the CCG VBC Policy and are supported by GP Clinical Leads for contentious or ambiguous cases.

Referral Process

The CCG acknowledges that each Provider has its own Access Policy & internal procedures. Access to RAS is by way of secure NHS email (rasteam@nhs.net).

The CCG expects that all VBCs identified in hospital clinics will require prior approval before treatment. On receipt of such a request, RAS staff will assess whether the referral relates to a VBC procedure and if so, whether the criteria for treatment are met.

If the criteria are met, the RAS team will issue a unique code and pass this on to the provider on the IADT form at the point of onward referral. The provider must record this number and reference it in all future communications.

There other response that RAS will issue is 'notobv' meaning that it is not obvious whether the GP referral relates to a VBC procedure. This does NOT act as an authorisation code for a VBC if subsequently identified in hospital, but asks the provider to assess the patient. The provider may then request a treatment code from RAS if the patient does meet VBC criteria.

If the criteria for treatment are not met, RAS will return the referral for the clinician to advise the patient. In cases where approval has not been sought, the CCG will NOT pay for the treatment.

Content of Referrals

The CCG expects that all referrals will provide sufficient information to permit a RAS Triage Nurse to identify the referring clinician and the VBC procedure sought, and also to assess whether or not the VBC criteria have been considered and are met in full.

The request does not have to be a 'file of evidence' and the CCG are not setting out to disbelieve any clinician. However, as Commissioners the CCG intends to exercise its contractual right to prior approval.

The provider must supply evidence as to how the procedure meets the VBC criteria. The provider can choose to use a template based on the VBC policy that reflect the explicit criteria and also permit descriptive text to support the referring clinician's recommendation. The CCG may request to see the clinic letter that shows explicitly how the case meets the criteria.

Requests for additional information

If further information is required to support the funding application the RAS team will request this from the requesting clinician. The response time for dealing with Prior Approval applications is suspended until the information is received.

Where further information is required the requesting clinician will be asked to respond with the necessary information within 10 working days. If the information requested is not received within this period the application will be rejected on the grounds of insufficient information.

Consequences of undertaking activity without Prior Approval

All providers of NHS care have a responsibility for ensuring that prior approval procedures are only undertaken where the relevant clinical criteria are met and funding has been agreed through the CCG's prior approval process. If prior approval has not been granted the procedure should not be undertaken.

On any occasion where a provider undertakes prior approval activity where a prior approval application has not been submitted, or where a prior approval application has been submitted but has been rejected, in accordance with Service Condition 29.22 of the NHS Standard Contract that provider will not be paid for the activity.

On any occasion where a provider undertakes a prior approval procedure having sought prior approval, but where the CCG failed to respond within 10 working days of receipt of the request (excluding any period where this timescale was suspended), in accordance with Service Condition 29.26 of the NHS Standard Contract, PA will be assumed to have been granted and the provider will be paid for the activity.

Escalation & Dispute Resolution

In the event of a dispute over the need to treat, the CCG offers a structured process of discussion & escalation with our RAS Triage Nurses and an internal panel that includes GP Clinical Leads. This panel meets every 2 weeks and can consider any cases that are not appropriate for an Individual Funding Request (IFR) panel. These escalations, disputes and discussions are logged within the RAS IT system.

Payment & Reconciliation

In terms of monthly submission and payment, the CCG & CSU will adopt a strict policy of 'no authorisation code – no payment' for patients referred after the active date of the contractual notice that was operational from 3rd September 2016.

The CCG & CSU wish to see VBC compliance monitoring & payment linked with the monthly SUS return. Accordingly, in discussion with its main Providers (SaTH and RJAH), the CCG & CSU expect that the SUS return will contain the VBC authorisation code.

If a Provider does not submit to the CCG via SUS, the CCG & CSU expect relevant submissions and/or invoices to include authorisation codes.

Challenges

As part of the challenge process the CCG will raise monthly challenge on 'frozen' data for all patients where a VBC procedure has been performed but a prior authorisation code has not been given. In line with contractual guidance, the Trust has 5 operational days to respond to the queries. The CCG will confirm in 10 operational days if the response from the Trust is valid. Final response letter sent to the Trust and challenge will be closed.

Audit (may be updated if PA process changes)

The CCG may wish to perform quarterly audits in-year of the Provider compliance with the CCG PLCV Policy and this Operational Procedure. The CCG expects that Providers will co-operate fully in those audits and carry out any audits jointly. Following the audit a summary report will be produced indicating the compliance against the VBC Policy. If the audit indicates non-compliant activity the CCG will withhold the monies payable to the Trust.

Change log for version 1

Date	Change
02/07/2019	Section 6.3 ‘Hysteroscopy for menorrhagia’ updated in line with feedback from partners and changed in line with NICE guidance
09/07/2019	Section 4.5 ‘Carpal tunnel syndrome release’ updated in line with feedback from partners and changed in line with national policy