SOLIHULL CCG GOVERNING BODY

PUBLIC BOARD

REPORT COVER SHEET

Meeting Date:	3rd August 2016
Report Title:	Birmingham, Solihull and Black Country Harmonised Commissioning Policies – Engagement Report and Final Draft of Policies
Prepared by:	Neil Walker – Chief Contract and Performance Officer
Presented by:	Neil Walker – Chief Contract and Performance Officer
Purpose of Report:	Upon establishment in 2013, the seven Clinical Commissioning Groups (CCGs) in Birmingham, Solihull and the Black Country adopted a set of policies from their predecessor Primary Care Trusts (PCTs) to ensure patients could continue to access clinical services under the same principles of access. The variation in the content and implementation of the adopted policies, however, created a 'postcode lottery' in terms of the availability of treatments in the different CCG areas. The Clinical Chairs' Network for seven Birmingham, Solihull and the Black Country CCGs agreed in autumn 2013 to develop a single core set of 21 commissioning policies (see Appendix 1 for full list of policies). Dudley CCG withdrew from the policy harmonisation process in 2015. Subsequently, a working group was established which included Clinicians (including General Practitioners) and commissioning managers from the six CCGs, along with colleagues from Local Authorities and Public Health. The working group reviewed the policies for procedures of lower clinical value (PLCV) with the aim of making them more consistent and fairer for patients across the CCG areas. This harmonisation working group has reviewed 21 policies in total, in accordance with national guidance and evidence from the PLCV working group. These policies were also reviewed to incorporate the most up-to-date published clinical evidence to ensure funded treatments are proven to have a clinical benefit for patients. Three CCGs; Birmingham CrossCity, Birmingham South Central and Solihull, decided to undertake a period of public engagement to ensure that patients and other stakeholders had the opportunity to give their views on the proposed new harmonised policies. The engagement period ran for six weeks, from 1 February to 14 March 2016. As well as members of the public feedback was received from both a range of local healthcare providers e.g. Heart of England NHS FT and Birmingham Children's Hospital NHS FT and professional bodies such as the Royal College of Surgery, the West Midlands Eye Health Network, Royal National Institute for the Blind and the Chartered Society of Physiotherapists.

	Throughout April to June 2016, the Harmonised Policies Working Group has been carefully reviewing all of that feedback to determine what changes to individual policies should be required. The table shows the different policies that were modified as a result of the Public and Professional Engagement Process.
Summary/Problem:	See above.

Option/Solution:	On the basis of the above the results of the Birmingham and Solihull CCGs' Public Engagement the proposed changes to the January 2016 draft suite of 21 Treatment Policies are now being presented in detail on pages 28-34 of this report and in summary in the table below.

Policy	Access Criteria Change?	General Text Change?
Adenoidectomy	✓	No change
Cosmetic Surgery	✓	✓
Back Pain	✓	✓
Botox for Hyperhidrosis	No change	No change
Cataracts	✓	✓
Cholecystectomy	No change	No change
Male Circumcision	No change	No change
D&C for Menorrhagia	No change	No change
Blepharoplasty	No change	✓
Ganglion	✓	No change
Grommets	✓	No change
Haemorrhoidectomy	No change	✓
Hip Replacement	✓	No change
Hysterectomy for HMB	No change	No change
Hysterectomy for Menorrhagia	No change	No change
Groin hernia repair	✓	No change
Knee Replacement	✓	No change
Penile implant	No change	✓
Tonsillectomy	No change	✓
Trigger Finger	No change	No change
Varicose Veins	✓	✓

Recommendation:	For the Governing Body to: 1. Note the report and supporting appendices; and 2. Approve the proposed detail of the 21 commissioning policies as recommended by the Quality, Safety and Experience sub-committee at its meeting on 26th July 2016 (Appendix 4)
Action required:	For decision [X] For Approval [X] For Information [ ] For Assurance [X]
Time required:	15 minutes

Background

Upon establishment in 2013, the seven Clinical Commissioning Groups (CCGs) in Birmingham, Solihull and the Black Country (see below) adopted a set of policies from their predecessor Primary Care Trusts (PCTs) to ensure that patients could continue to access clinical services under the same principles of access.

The variation in the content and implementation of the adopted policies, however, created a 'postcode lottery' in terms of the availability of treatments in the different CCG areas.

The Clinical Chairs' Network for seven Birmingham, Solihull and Black Country CCGs agreed, in autumn 2013, to develop a single core set of 21 commissioning policies (see Appendix 1 for full list of policies). Dudley CCG withdrew from the policy harmonisation process in 2015.

Subsequently, a working group was established which included Clinicians (including General Practitioners) and commissioning managers from the six CCGs, along with colleagues from Local Authorities and Public Health.

The working group reviewed the policies for procedures of lower clinical value (PLCV) with the aim of making them more consistent and fairer for patients across the CCG areas.

This harmonisation working group reviewed 21 policies in total, in accordance with national guidance and evidence from the PLCV working group. These policies were also reviewed to incorporate the most up-to-date published clinical evidence to ensure funded treatments are proven to have a clinical benefit for patients.

Three CCGs; Birmingham CrossCity, Birmingham South Central and Solihull, decided to undertake a period of public engagement to ensure that patients and other stakeholders had the opportunity to give their views on the proposed new harmonised policies. The engagement period ran for six weeks, from 1 February 2016 to 14 March 2016.

Throughout April to June 2016, the Harmonised Policies Working Group has been carefully reviewing the feedback received during the engagement period to determine what modifications to individual policies might be required.

The following Clinical Commissioning Groups (CCG) and their respective Local Authority Public Health Commissioners have worked collaboratively to develop this harmonised core set of commissioning policies:

- NHS Birmingham CrossCity CCG
- NHS Birmingham South Central CCG
- NHS Sandwell and West Birmingham CCG
- NHS Solihull CCG
- NHS Walsall CCG
- NHS Wolverhampton CCG

The policy aims to improve consistency by bringing together the different policies across Birmingham, Solihull and the Black Country into one common set. This helps us to stop variation in access to NHS services in different areas (which is sometimes called 'postcode lottery' in the media) and allow fair and equitable treatment for all local patients.

CCGs have limited budgets; these are used to commission healthcare that meets the reasonable requirements of its patients, subject to the CCG staying within the budget it has been allocated. By using these policies, we can prioritise resources using the best evidence about what is clinically effective, to provide the greatest

proven health gain for the whole of the CCG's population. Our intention is to ensure access to NHS funding is equal and fair, whilst considering the needs of the overall population and evidence of clinical and cost effectiveness.

What are Procedures of Lower Clinical Value (PLCV)?

Procedures of Lower Clinical Value (PLCV), as a term, is nationally recognised in the NHS, but does not communicate well with Clinicians or the public.

National evidence tells us that:

- some procedures such as cosmetic surgery, have low evidence of clinical necessity/effectiveness, but other procedures such as hip replacements and cataract surgery national evidence shows such procedures have a higher level of clinical necessity/effectiveness.

National clinical evidence is continually changing and therefore, NHS Commissioners must periodically review and update all their commissioning policies accordingly.

It is acknowledged that we need to find a better descriptor such as *'Clinical Treatment Policies' or simply 'Commissioning Policies'.*

PLCV cover a range of types of clinical treatments which may include:

- procedures that are identified as being relatively ineffective (e.g. grommets and myringotomy, and certain spinal procedures for back pain)
- identified cosmetic procedures
- effective procedures in mild cases where the balance between benefit and risk is close (e.g. cataract surgery and primary hip or knee replacement)
- effective, but where other cost-effective alternatives should be tried first (e.g. hysterectomy for heavy menstrual bleeding)

Harmonisation Policy Clinical Working Group Approach and Membership

- A joint working group established across Birmingham, Solihull and Black Country
- Representatives included GPs, Public Health, Medicines Management, Pathway Design, Contracting and Individual Funding representatives from each CCG and Local Authority
- List of 21 policies agreed for review (covering 45 procedures)
- Equality Impact Assessments for each policy
- Engagement with patients/public, interested Clinicians and other bodies

The approach of the Working Group has been:

- Reviewing historical PCT policies to ensure a consistent and fair approach to reduce the 'postcode lottery' that can result from having different policies across a geographical area
- Developing a standardised set of policies where all participating CCGs had previously had these policies in place
- Determining procedures that do not meet the CCG's clinical criteria for commissioning services and/ or because particular criteria need to be met for the intervention. These need to be set out and demonstrated prior to approval for funding

- Updating policies in accordance with national guidance and evidence by the clinical working group and Public Health colleagues
- Evidencing that policies were drafted based on robust clinical evidence
- Streamlining policies for the agreed services across the CCGs in Birmingham, Black Country and Solihull.
- Undertaking equality impact assessments on each policy.

Aims of the Policy Review included:

- Fairness and equity for patients by removing the 'postcode lottery'
- Clinically robust and national evidence based
- Efficiency – ensure we invest in treatments which are clinically proven and provide health benefit to patients

Each CCG was asked to provide a Commissioning Lead and a Clinician to participate in the working group. It took some time to establish agreed representation from each CCG but it was recognised that participation from each CCG was essential to its success.

Below, is a list of members of Policy Harmonisation Working Group. *Please note that not all individuals listed below have participated in the working group over the full life of the project.*

Name	CCG	Professional Role
Adnan Masood	Birmingham CrossCity CCG	GP
Ahmed Ahsan	Birmingham CrossCity CCG	GP
Alison Hughes	Birmingham CrossCity CCG	Quality and Safety
Gemma Caldicott	Birmingham CrossCity CCG	Communications and Engagement
Karen Ennis	Birmingham CrossCity CCG	Medicines Management
Mark Dasgupta	Birmingham CrossCity CCG	Medicines Management
Mary Carr	Birmingham CrossCity CCG	Quality and Safety
Patricia Roe	Birmingham CrossCity CCG	Quality and Safety
Paul Dudley	Birmingham CrossCity CCG	GP
Sarb Gidda	Birmingham CrossCity CCG	Contracting
Rhona Woosey	Birmingham South Central CCG	Commissioning and Locality Network Support
Waris Ahmed	Birmingham South Central CCG	GP
Abrar Malik	Dudley CCG	GP
Mark Curran	Dudley CCG	Commissioning Manager (Planned Care)
Victoria Adams	Dudley CCG	Planned Care Pathway Efficiency Manager
Alison Hughes	Midlands and Lancashire CSU	Lead Nurse
Dave Rowe	Midlands and Lancashire CSU	Communications and Engagement
Denise Bell	Midlands and Lancashire CSU	IFR
Harinder Kaur	Midlands and Lancashire CSU	IFR
Preetpal Channa	Midlands and Lancashire CSU	Communications and Engagement
Shiona Aldridge	Midlands and Lancashire CSU	Evidence Analyst
Wayne Harrison	Public Health – Birmingham CC	Public Health Consultant
Allan Reid	Public Health – Solihull MBC	Public Health Specialty Registrar
Jacquie Ashdown	Public Health – Solihull MBC	Public Health Consultant
Glenda Augustine	Public Health – Wolverhampton CCG	Public Health Consultant

Name	CCG	Professional Role
Elizabeth Walker	Sandwell and West Birmingham CCG	Medicine Managements
Olivia Omartey	Sandwell and West Birmingham CCG	Operations
Geoffrey Naylor	Solihull CCG	GP
Neil Walker	Solihull CCG	Contracting, Performance and Schedule Care Pathways
Anet Baker	Walsall CCG	Planned Care Commissioning
Gary Arnold	Walsall CCG	Contracting
Wendy Godwin	Walsall CCG	Planned Care Commissioning
Sharon Sidhu	Wolverhampton CCG	Planned Care Commissioning
Kamran Ahmed	Wolverhampton CCG / Solihull CCG	GP

Key Timelines In 2016

Date	Activity
1 Feb – 14 March	Birmingham an d Solihull CCGs Engagement period (six weeks) including Public Meetings
Late March - end of June	Evaluation of survey results and report
21st March to end of June	Working Group reconvenes and considers engagement feedback. Where appropriate some policies may be revised
24 March	Discussion with Birmingham & Solihull Joint OSC
Late June	Develop Governing Body paper and recommendations
May - July	Walsall and Sandwell and West Birmingham CCGs: additional consultation and briefing of their H&OSCs and Health and Wellbeing Boards
June - October	BSOL/Walsall/SWB/Wolves - Task and finish short life implementation group to undertake: • Remaining Comms • Blueteq • Final 'You Said…' response • Joint response to RCS letter • Actions from March J HOSC • Developing patient leaflets • Updating/final proof reading of the Policy document
June - July	Present update to Solihull and Birmingham Health and Wellbeing Boards
27 July	Present update to Birmingham and Solihull Joint HOSC
July - September	Birmingham, Black Country and Solihull CCGs Governing Bodies discuss/adopt new policies • Birmingham CrossCity • Birmingham South Central • Solihull • Sandwell and West Birmingham • Walsall • Wolverhampton
July - September	Public, Primary care, and provider next stage communications including final engagement report
September - October	Contract variations to include new harmonised policy suite in each local NHS and Independent Sector Acute contract across BBCSOL patch

Why do we have Commissioning Policies?

The Kings Fund – Delivering Better Value in the NHS (June 2015) found that:

- Unwarranted variations in provider clinical practice and health outcomes across the country
- This means some invasive treatments in the NHS are not needed.
- Tackling unwarranted variations could free up NHS resources to be used more clinically effectively locally.
- Unfortunately there is no national definition on which NHS services are of 'low(er) value'; as a result, various lists of potentially low(er)-value procedures have been drawn up NHS Commissioners across England (finding of Audit Commission in 2011).
- Despite this there is reasonable consensus of what procedures form part of a local set of Commissioning Policies across English NHS Commissioners.

What does each Policy detail?

Policy will state whether procedure is:

- Not routinely commissioned: would require an Individual Funding request to demonstrate clinical exceptionality
- Restricted: only funded if particular clinical criteria / thresholds apply
- Which clinical procedure codes are covered by the policy
- Short summary explanation of what the procedure entails
- For 'Restricted' procedures what the clinical thresholds for treatment are.
- Summary of what clinical guidance commissioners have used to inform the detail of the commissioning policy, e.g. NICE, Royal Colleges or Other Clinical Associations
- Each policy is then subject to an Equality Impact Assessment review.

Principles underpinning each Commissioning Policy

Commissioning decisions by CCG Commissioners are made in accordance with the commissioning principles set out below, and in the Birmingham, Black Country and Solihull CCGs' Individual Funding Request Policy:

- CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment
- The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor.
- CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment
- CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community
- CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance
- Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered.

Individual Funding Requests (IFR) and Exceptionality

We recognise there may be exceptional circumstances where it is clinically appropriate to fund each of the procedures listed in this policy and these will be considered on a case-by-case basis. Funding for cases where either; a) the clinical threshold criteria is not met, or b) the procedure is not routinely funded, will be considered by the CCGs following application to the CCG's Individual Funding Request Panel, whereby the IFR process will be applied.

This position is supported by each CCG's Ethical Framework which can be found on the respective CCG website.

Clinician's right to seek specialist advice

In cases of diagnostic uncertainty, the scope of this policy does not exclude the Clinician's right to seek specialist advice. This advice can be accessed through a variety of different mediums and can include both face to face specialist contact, as well as different models of consultant and specialist nurse advice and guidance virtually.

How does the IFR Application System work in practice?

Commissioners, GPs, service providers and clinical staff treating registered patients of the CCGs are expected to implement this policy. When procedures are undertaken on the basis of meeting the 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.

Patients with problems or conditions that might require treatments included in this policy should be referred to a consultant or specialist only;

- After a clinical assessment is made by the GP or Consultant; AND
- The patient meets all the criteria set out in the policy.

GPs wishing to seek a specialist opinion for patients who meet the above criteria, should ensure the essential clinical information is included in the referral letter confirming the patient has been assessed in line with this policy.

GPs, Consultants in Secondary Care and provider finance departments need to be aware that the CCG will not pay for the procedures listed in this policy unless the patient meets the criteria outlined in this policy.

The CCGs recognise there will be exceptional, individual or clinical circumstances when funding for treatments designated as low priority will be appropriate.

Where a treatment is either not routinely funded, or the patient does not meet the specified clinical criteria, this means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Individual Funding Requests should only be sent to the respective 'nhs.net' accounts detailed below. Guidance regarding IFRs and an application form, can be found on the CCG's websites.

IFR contact information follows, however please refer to the CCG IFR policy for more information

Individual Funding Request Case Manager
Floor Two, Kingston House
438 High Street
West Bromwich
West Midlands
B70 9LD

Telephone: 0121 612 1408

Email addresses for Individual Funding Request teams at CCGs
(Ctrl+Click required address to send email):

- Birmingham CrossCity CCG ifr.bcccg@nhs.net
- Birmingham South Central CCG ifr.bsc@nhs.net
- Solihull CCG ifr.solihull@nhs.net
- NHS Sandwell and West Birmingham CCG ifr.swb@nhs.net
- NHS Walsall CCG ifr.walsall@nhs.net
- NHS Wolverhampton CCG ifr.wolv@nhs.net

Monitoring and Review of Commissioning Policies

Commissioning Policies are subject to continued monitoring using a mix of the following approaches:

- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits and use of authorisation software such as Blueteq.

Commissioning Policies will be kept under regular review, to ensure that it reflects developments in the evidence base regarding clinical and cost effectiveness.

Procedure/Treatment Policy Scope

New policies are highlighted in red text.

Cosmetic Surgery Procedures	Other Procedures
• Abdominoplasty / Apronectomy • Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat • Liposuction • Breast Augmentation • Breast Reduction • Breast Lift (Mastopexy) • Inverted Nipple Correction • Gynaecomastia (Male Breast Reduction) • Labiaplasty • Vaginoplasty • Pinnaplasty • Repair of Ear Lobes • Rhinoplasty • Face Lift or Brow Lift (Rhytidectomy) • Hair Depilation (Hirsutism) • Alopecia / Hair Loss • Removal of Tattoos / Surgical correction of body piercings and correction of respective problems • Removal of Lipomata • Medical and Surgical Treatment of Scars and Keloids • Botox Injection for the Ageing Face • Viral Warts • Thread / Telangiectasis / Reticular Veins • Rhinophyma • Other Cosmetic Procedures • Revision of Previous Aesthetic Surgery Procedures	• Adenoidectomy • Non Specific, Specific and Chronic Back Pain • Botulinum Toxin for Hyperhidrosis • **CATARACTS** • Cholecystectomy for Asymptomatic Gallstones • Male Circumcision • Dilation and Curettage (D&C) for Menorrhagia • Eyelid Surgery (Upper and Lower) – Blepharoplasty • Ganglion • Grommets • Haemorrhoidectomy • **HIP REPLACEMENT SURGERY** • Hysterectomy for Heavy Menstrual Bleeding • Hysteroscopy for Menorrhagia • Groin Hernia Repair • **KNEE REPLACEMENT SURGERY** • Penile Implants • Tonsillectomy • Trigger Finger • Varicose Veins

Exclusions to Scope of Policy Harmonisation

Over 50 procedure and/or treatment policy areas that are either:

(i) part of the historic (current) HEFT PLCV policy. These are still operational and will be evidence updated in 2016 and 2017, subject to project resource allocation following Birmingham and Solihull CCGs collaborative commissioning form and functions review (see **Appendix 2**) and;

(ii) new policies other local West Midlands CCGs and other CCGs nationally have developed in recent years.

These have been excluded from the policy harmonisation process. Policies in (i) not covered by the new harmonisation mean that a CCG could face the prospect of increased referral levels in the immediate term without contemporary evidence updating of supplementary policies in place to support additional referral management for these procedures of lower clinical value.

What Is The Scale of Activity Covered By The Harmonised Policies?

		All Activity No's 2015/16 to Month 10				All Activity No's 2015/16 to Month 10 - Tariff Cost	
Policy	**Category**	Bham	Solihull	Bham (%)	Solihull (%)	Bham	Solihull
All Cosmetic Procedures		**15,865**	**6,012**	**72.5%**	**27.5%**	**£ 5,242,123**	**£ 1,994,714**
Adenoidectomy	Restricted	250	25	90.9%	9.1%	£291,041	£31,058
Non Specific, Specific and Chronic Back Pain	Restricted	1,359	447	75.2%	24.8%	£884,787	£245,004
Botulinum Toxin for Hyperhidrosis	Not routinely commissioned	174	48	78.4%	21.6%	£121,144	£35,964
Cataracts	Restricted	5,246	1,928	73.1%	26.9%	£3,421,093	£1,195,211
Cholecystectomy for Asymptomatic Gallstones	Not routinely commissioned	750	188	80.0%	20.0%	£1,619,571	£363,710
Male Circumcision	Restricted	373	90	80.6%	19.4%	£331,447	£78,224
Dilation and Curettage (D&C) for Menorrhagia	Not routinely commissioned	342	189	64.4%	35.6%	£105,471	£63,277
Eyelid Surgery (Upper and Lower) - Blepharoplasty	Restricted	71	23	75.5%	24.5%	£68,024	£18,203
Ganglion	Restricted	114	24	82.6%	17.4%	£114,631	£26,131
Groin Hernia Repair	Restricted	822	234	77.8%	22.2%	£1,013,215	£297,804
Grommets	Restricted	469	86	84.5%	15.5%	£377,152	£71,374
Haemorrhoidectomy	Restricted	73	20	78.5%	21.5%	£67,731	£19,072
Hip Replacement Surgery	Restricted	998	414	70.7%	29.3%	£6,372,311	£2,622,383
Hysterectomy for Heavy Menstrual Bleeding	Restricted	128	41	75.7%	24.3%	£360,604	£115,371
Hysteroscopy for Menorrhagia	Not routinely commissioned	1,928	528	78.5%	21.5%	£1,017,580	£257,214
Knee Replacement Surgery	Restricted	1,132	397	74.0%	26.0%	£7,577,861	£2,732,721
Penile Implants	Not routinely commissioned	5	1	83.3%	16.7%	£26,386	£4,206
Tonsillectomy	Restricted	786	131	85.7%	14.3%	£892,176	£140,564
Trigger Finger	Restricted	39	14	73.6%	26.4%	£37,776	£12,360
Varicose Veins	Restricted	717	249	74.2%	25.8%	£753,048	£271,103
All Other Procure Policies		**15,776**	**5,077**	**75.7%**	**24.3%**	**£ 25,453,049**	**£ 8,600,954**
		31,641	**11,089**	**74.0%**	**26.0%**	**30,695,172**	**10,595,668**

Note: Birmingham refers to Birmingham CrossCity and Birmingham South Central CCGs.

What does this mean for patients?

By having one standardised core set of policies, all patients who may require a PLCV will have to meet the same criteria, wherever they live in Birmingham and Solihull. This ensures all patients are treated fairly.

There may be circumstances where a patient will no longer be able to receive a treatment, which they would previously been able to have. In these cases, the patient will be supported by their GP to consider the alternatives available to them, which may be of greater benefit.

The criteria for a core set of procedures will be the same, regardless of which GP the patient sees, or which hospital they attend across Birmingham or Solihull.

Appendix 1 shows how each individual Commissioning Policy was proposed to change at the start of the public engagement.

Lifestyle Factors and Surgery

Lifestyle factors can have an impact on the functional results of some elective surgery. In particular, smoking is well known to affect the outcomes of some foot and ankle procedures. In addition, many studies have shown that the rates of postoperative complications and length of stay are higher in patients who are overweight or who smoke.

Therefore, to ensure optimal outcomes, all patients who smoke or have a body mass index of 35 or greater and are being considered for referral to Secondary Care, should be able to access CCG and Local Authority Public Health commissioned smoking cessation and weight reduction management services prior to surgery.

Patient engagement with these 'preventive services' may influence the immediate outcome of surgery. While failure to quit smoking, or lose weight will not be a contraindication for surgery, GPs and Surgeons should ensure patients are fully informed of the risks associated with the procedure in the context of their lifestyle.

Psychological Factors and Surgery

Commissioners acknowledge that there is a psychological dimension for patients in seeking or considering the option of treatment and surgery. However because there are no universally accepted and objective measures of psychological distress and therefore such factors are not taken in account in any policy clinical thresholds. Nevertheless there always remains the option of an application to demonstrate clinical exceptionality through IFR process as detailed above.

Legal Duties and Public Engagement

The NHS Health and Social Care Act 2012 – S.14Z2 Section 2b sets out the duties for Clinical Commissioning Groups with regard to public participation:

1) This section applies to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements")
2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information in other ways):
    a) In the planning of the commissioning arrangements by the group.
    b) In the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
    c) In decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

Section 14Z2 places the CCG under a legal obligation to put in place proper arrangements for patient involvement in its decision making. The duty is not to involve patients directly but to have 'arrangements" in place to secure that patients will be involved in commissioning decision making. A CCG must ensure that its public involvement reaches those who "may" use the services it commissions, as well as those that do.

Whilst s14Z2 contains the obligation on a CCG to involve the public, it does not assist a CCG in determining the level of engagement that is necessary. As can be seen from the wording of the section, consultation is one means only of involving the public. It is ultimately a decision for a CCG as to whether or not it is necessary to embark on a formal public consultation.

However, s14Z2(4) empowers NHS England to publish guidance (which NHS England has done) on how a CCG should fulfil its public involvement obligations under s14Z2 and, in turn, s14Z2(5) requires CCGs to "have regard to" any such guidance. The phrase "have regard to" has a special legal meaning and in this context means that the CCG should consider the guidance and (unless it has good reason not to do so) should follow it.

Where a body has a duty to have regard to guidance and decides not to follow the guidance, it should articulate and record its reasons for taking another course.

Legal counsel was commissioned from Mills and Reeve LLP and has considered whether it would be appropriate for the CCGs to engage with the relevant HOSCs; inform them of the proposed changes; and of the nature of the public engagement exercise that is proposed.

Legal counsel has indicated that Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 requires a CCG to formally consult with Local Authorities when it "has under consideration any proposal for a substantial development of the health service…or for a substantial variation in the provision of such service." In cases where CCGs are proposing a substantial variation, the 2015 NHS England guidance confirms that the decision as to whether to conduct a formal consultation should be made in collaboration with the local OSC (pg. 8) and that "subject to feedback from the local OSC, the proposing body may decide to progress to formal public consultation" (pg. 24). 3.14 "Substantial variation" is not defined, either in the Regulations or in the NHS England guidance. Legal counsel is that the proposed PLCV harmonisation changes fall short of a substantial variation. They do not involve the large-scale reconfiguration of services, rather a change in same cases to the referral criteria for particular services.

Public Engagement maximises the chance of local authority support in the event that these proposals become highly contentious.

All local OSCs would need to be informed of the proposed changes and decide if the proposed change would result in substantial variation. Therefore, each CCG will need to consult with their relevant OSC to ascertain if they deem the proposals as a substantial variation.

Initial briefings for, and conversation with, both Birmingham Health and Oversight Scrutiny Committee and the Solihull Health and Oversight Scrutiny Committee took place in January 2016. Then in March 2016 Birmingham and Solihull CCGs and Local Authority Public Health members of the Policy Working Group met with the Birmingham and Solihull Joint Health and Oversight Scrutiny Committee (JHOSC).

The key recommendations of the JHOSC and CCGs' actions to date are detailed below.

Recommendation	CCG Response to Date
Commissioners need to strengthen engagement and communication with the public around PLCV so that there is a clearer understanding of what this means in practice and demonstrates more clearly what the implications are likely to be.	Local CCGs see the February/March 2016 meetings as the start of a wider process of Public Engagement as we start work on the second phase of harmonising local commissioning policies. This is therefore only a beginning, not the end.
GP/Primary Care need to be engaged as part development of new polices to enable the development of referral pathways.	Local CCGs ensured that GPs were actively part of the policy process but are planning more regular engagement with each CCGs' Primary Care membership meetings in 2016.
Health and Wellbeing Board need to be involved in leading and having overview of these proposals.	Local CCGs, through meeting with Birmingham and Solihull Health and Wellbeing Boards, will seek views on the level of scrutiny and oversight HWBs believe is necessary and appropriate.

Recommendation	CCG Response to Date
That case study information and information in 'Plain English' is more widely disseminated to the public about PLCV.	Once we have the final draft of each policy with the help of patient panel reps we will start to work on 'Plain English' leaflets of each policy.
That the Scrutiny Committee receives a final copy of the Consultation report.	A final draft is being prepared and will be share asap along with a 'You Said; We Did' document.
That the Scrutiny Committee consider proposals for implementing PLCV at a future meeting (suggested date June 2016) with a focus on implications for service users.	We are awaiting confirmation from the JHOSC, of a date to update them.

Approach to Engagement

A full draft of the Birmingham and Solihull CCGs Engagement report and Commissioner proposed changes to January 2016 draft policies is provided in **Appendix 3**.

A full draft of Birmingham, Black Country and Solihull CCGs suite of harmonised Commissioning Policies upon which we have engaged, including Commissioner proposed changes to January 2016 draft policies, is provided as both a 'delta (change)' version and a 'clean' version in **Appendix 4**.

Phase 1: Pre-Engagement

Pre-engagement took place in several phases during 2015. Over the summer of 2015, initial responses were sought and received from local NHS Acute Trusts. Between November to December 2015, CCGs discussed the work of harmonising local commissioning policies with Patient Panel groups in Birmingham and Solihull.

Two meetings were held in Solihull (November 2015) and Birmingham (December 2015) to help the CCGs to shape and inform the second, more detailed phase of engagement.

Solihull Patient Voice Panel Meeting

Solihull CCG held a meeting with members of its Patient Panel on 17 November 2015. This was attended by nine people, including representatives from Solihull Advocacy, Patient Panel, Patient Participation Group (PPG) Network and CCG Lay Members.

The panel were informed that public engagement was about to take place regarding Procedures of Lower Clinical Value. The panel discussed potential survey questions which they felt would help the public contribute fully towards the consultation. The survey would be aimed at the public and highlight the different policies under review.

The panel felt it was important that the survey did not just use closed questions (i.e. quantitative data), which could only be answered with a 'yes' or 'no'. Having open questions (i.e. qualitative data) would allow respondents to give their views more fully. The panel also felt there should be context provided before the questions, with respondents being asked about which policy or policies they had looked at, whether it was clear, easy to access, useful and informative.

The panel were informed that members of the public will be able to access the policies via the CCG website. There was concern from the panel that some members of the public may not have access to the internet or feel comfortable looking online. Solihull CCG agreed to promote the policies in GP practices and that hard copies of the policies would be available on request for those who needed them. The Patient Participation Group (PPG) network was suggested as a good way to share information in addition to the third sector, GP Practices and care services that could also signpost patients.

The panel were then asked to focus on particular policies: cataract surgery, knee and hip replacement. The decision to focus on these particular policies resulted from the Equality Impact Assessment (EIA) which had highlighted that these policies were the most relevant as they potentially had the greatest impact. As a result it was felt to appropriate to offer wider discussion on these policies.

The Panel worked in small groups to think about what was or was not reasonable – for instance, should Body Mass Index (BMI) be taken into account when thinking about knee or hip surgery.

The Panel was broadly supportive of all the new policies; however, they felt that the policies should be clear and easy-to-read, using plain English, with minimal jargon. It was suggested a user-friendly patient leaflet for each policy should be produced which could be printed off for patients.

For the policies on knee and hip replacement, where BMI is a consideration, it was felt it would be useful to signpost patients towards local weight loss services commissioned by the CCG and Solihull Council. However, it was felt in the main that using BMI as part of the threshold criteria was suitable and appropriate.
The panel felt that both disability and lifestyle are aspects that should be looked at in connection with the policy for cataracts.

Patient Engagement Meeting – Birmingham

Birmingham South Central CCG and Birmingham CrossCity CCG held a joint Public Engagement Meeting on 11 December 2015. The meeting was attended by seven people.

Dr Waris Ahmad and representatives from both CCGs discussed three policies in detail with the attendees; a draft survey questionnaire and timelines for the patient engagement were also shared.

Attendees were asked to comment on three of the draft policies; cataracts surgery, and hip and knee replacement and make suggestions for how these could be communicated more widely to local people. As noted above, the decision to focus on these particular policies resulted from the EIA which had highlighted that these policies were felt to be the most relevant as they potentially had the greatest impact.
Views were also sought on a draft survey which was to be used as the main channel for feedback on the policies.

Key feedback from pre-engagement events:

- The need for a more simplified patient questionnaire;
- Production of a glossary of terms, to help people understand clinical terminology used in the policies;
- Ensure terms and definitions are used consistently, i.e. Botox or Botulism toxin;
- Production and availability of a document detailing the changes to the criteria for each policy for each CCG; and
- The need for information to be clear and easy to read, using plain English, with minimal jargon. It was suggested a user-friendly patient leaflet for each Policy should be produced which could be printed off for patients.

These documents were made available during the Phase 2 engagement process.

Phase 2: Engagement

The CCGs were conscious of the requirements under the NHS Duty to Involve in Section 12 of the NHS Act 2012 and Regulation 23 of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. These require a CCG to formally consult with Local Authorities when it is proposing a substantial variation or development in a health service for which it has responsibity.

Having taken legal counsel, the CCGs concluded that the harmonisation of policies did not amount to a substantial variation in services; nevertheless, it was appropriate to consult both the Birmingham and Solihull Health and Social Care Overview and Scrutiny Committees (HSCOSC). The CCGs suggested that they would consult with the public for a period of six weeks and the HSCOSC approved the CCGs suggestion for a six week period of engagement

It was subsequently agreed to meet with the Solihull and Birmingham Joint Health Overview and Scrutiny Committee (JHSCOSC) on 24 March 2016. Although the meeting was held after the engagement period had closed, the CCGs have assured the JHSCOSC that its recommendations would be fully taken into account in determining next steps.

Draft recommendations from the JHSCOSC are included in the consolidated table of responses in **Appendix 4** and summarised below.

DRAFT recommendations from the Solihull and Birmingham Joint Health and Social Care Overview and Scrutiny Committee:

- Commissioners need to strengthen engagement and communication with the public around PLCV, so that there is a clearer understanding of what this means in practice and demonstrates more clearly what the implications are likely to be;
- Primary Care staff (including GPs) need to be engaged as part development of new polices to enable the development of referral pathways;
- Health and Wellbeing Board need to be involved in leading and having overview of these proposals;
- That case study information and information in Plain English is more widely disseminated to the public about PLCV;
- That the Scrutiny Committee receives a final copy of the consultation report; and
- That the Scrutiny Committee consider proposals for implementing PLCV at a future meeting (suggested date June 2016) with a focus on considering implications for service users.

Public Sector Equality Duty (PSED)

The PSED requires NHS organisations to fully understand the likely impact of any proposed changes to local NHS services on any group that has a protected characteristic under the Equality Act 2010; for example disabled people, the elderly and people from Black and Minority Ethnic (BAME) background.

An Equality Impact Assessment (EIA) was undertaken on each policy prior to the engagement period to identify the impact on particular groups and support targeting of engagement activities. The EIAs were made available to the public on the CCG's dedicated PLCV web pages.

Information was available on request in other languages and in other formats. One request was received, from the Royal National Institute for Blind people (RNIB), to provide the survey in large print format. Material was also produced in large print format, for an attendee at the Birmingham engagement event.

Communication and Engagement

The approach to public engagement focused on "*robust information dissemination by the CCGs to ensure that their public involvement reached those who "may" use the services it commissions, as well as those that do, with the opportunity for patients and public to feed back their views"*. Utilising a variety of communication channels and types of engagement activity, CCGs aimed to:

- explain PLCVs and the rationale supporting harmonisation;
- raise awareness of the proposed changes to harmonise the 21 PLCV policies;
- to provide information on each of the PLCV policies, including supporting information such as Equality Impact Assessments; and
- sign-post and encourage feedback via the online survey and participation in two events.

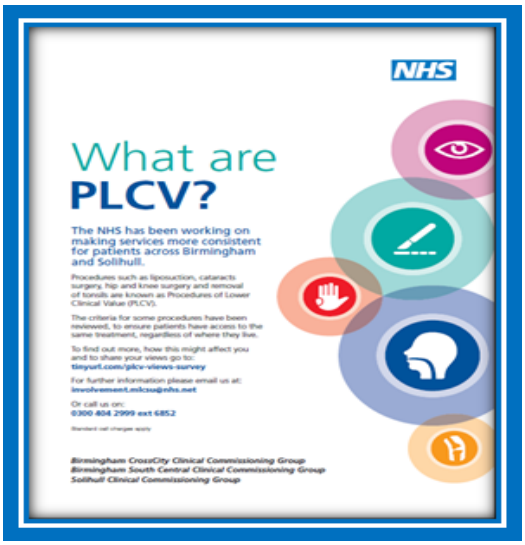
Key messages, explaining the rationale behind the harmonisation of the policies, were consistently communicated throughout all channels and at all public events.

Key Messages:

- A core set of consistent policies across Birmingham, Solihull and the Black Country would be fairer for patients
- The review of policies took account of the latest clinical evidence base
- The harmonisation of policies is about investing funds more efficiently by focussing on treatments and procedures that offer the most clinical benefit
- No treatments were being decommissioned, but there may be circumstances where patients were no longer able to access a treatment
- Your views are important, please take the survey and take part in the events

Information and communications material

A brand was created for the engagement and was used consistently across all the channels used and communications materials. The strapline *"Talk to us about PLCV"* was used to promote the online survey and events.



Patient leaflet and other material

A total of 7,000 leaflets summarising the details and scope of the PLCV project were distributed to GP practices, pharmacies and other stakeholder organisations across the three CCGs.

The leaflet provided details about the different PLCVs, gave examples of the treatments covered by the policies, explained why they were being harmonised and how patients could get involved and also provide feedback through the online survey. Posters were also provided and distributed for display in GP practices and pharmacies. Digital images for display on GP practice TV screens were also produced, where available. A copy of the patient leaflet is included in Appendix 7 of the Engagement report.

PLCV Webpages

Individual CCG websites established a dedicated webpage to help provide a single point of access for information about individual PLCV policies and the engagement process. Details made available on these webpages included the following information:

- the full PLCV policy document and the 21 individual policies;
- the Equality Impact Assessments (EIAs) for each policy;
- a 'contrast mapping document' which described the changes for each policy;
- the patient leaflet; and
- a link to the online survey.

Copies of the webpages can be found in **Appendix 8** of the full Engagement Report.

Stakeholder Communications

CCGs used all available communications resources to ensure stakeholders were aware of, and had the opportunity to be involved with, the consultation. This included the use of social media (see below), external and membership newsletters and existing patient and stakeholder groups.

Each CCG used its existing stakeholder database to ensure information, including briefing documents and leaflets, were pro-actively disseminated. This included:

- 79 local third sector voluntary and community organisations, including Birmingham and Solihull Healthwatch, Birmingham Voluntary Service Council (BVSC) and Birmingham LGBT;
- 136 local councillors and 12 Members of Parliament (MPs);
- Letters, meetings and briefing for both Birmingham and Solihull Health and Social Care Overview and Scrutiny Committees (HOSCs); and
- A range of patients, support groups, CCG public and patient panels and networks.

The CCGs also took the opportunity to ensure that bespoke, targeted, engagement took place to ensure that key groups of stakeholders had the opportunity to be involved in aspects of the PLCV consultation which were specific to them. For example the Royal National Institute for Blind People (RNIB) were contacted directly regarding proposed changes to cataract procedures. BID Services (a charity which provides services to deaf and hard of hearing people in the West Midlands) were also contacted by email and telephone to highlight the consultation to their community. Birmingham CrossCity CCG also offered to help support patients with a hearing impairment to attend the PLCV public events.

Furthermore, emails were sent to the West Midlands Academic Health Science Network (WMAHSN), Age UK, RNIB, the Birmingham Voluntary Services Council (BVSC) and Healthwatch Birmingham to publicise the consultation via their own newsletters, e-bulletins, social media and respective websites.

The voluntary organisations contacted were asked to cascade information to their own networks, via their newsletters, bulletins and websites. This significantly increased the reach of the publicity.

Briefings were also included in Local Authority Member bulletins and sent to MPs, who were asked to raise awareness by including details on their websites and in regular constituency newsletters.
Details of the engagement were also included on *Birmingham Be Heard*, Birmingham City Council's consultation database for the public.
Details of all the stakeholders communicated with are highlighted in **Appendix 6** of the full Engagement Report.

Media

A pro-active approach to the media was adopted, including identifying and training a clinical spokesperson to act on behalf of all CCGs. Press releases were issued on 19 January, 2 February and 3 March 2016, prior to and at the launch of the consultation, and to promote the public engagement events. There was, however, no media interest during the engagement period. Examples of the press releases can be found in **Appendix 8**.

Following the close of the formal, public, consultation, there was national and local media interest following a press release (in the form of an open letter) issued by the Royal College of Surgeons (RCS) to the national media, with articles appearing in the Telegraph, Daily Mail, Birmingham Mail, and on a number of online news websites.

The RCS open letter was treated as feedback by the project team and was incorporated into the feedback gained through the public consultation.

Social Media

Social media formed an important part of our overall communications and engagement strategy. Social media allows commissioning organisations to reach far wider audience that might be gained from more traditional print media.

Collectively, the CCGs have approximately 1300 Facebook 'Likes' and over 18,000 Twitter followers. Throughout the engagement period tweets and Facebook posts were issued by the individual CCG accounts, using both pre-agreed and organic content.

CCGs were also expected to release social media content at specific points of the consultation; launch, mid-way through the consultation and with a week to go prior to the public consultation closing. Social media was also utilised to promote the engagement events taking place in Birmingham and Solihull.

Opportunities were also taken to, 'like', 'retweet' or to 'tweet' in response to feedback received. Stakeholders were also encouraged to retweet to their followers.

Examples of social media can be found in Appendix 8 of the Engagement Report.

Providers and Clinical Engagement

Each CCG providing a briefing to its GP members through their established channels, for example membership newsletters, network meetings, GP training events and intranet 'members' areas'. The details of individual policies were shared with Primary Care Clinicians and examples of the policies were shared with local branches of Birmingham LMC.

Those providers involved in the provision of the treatments impacted by the proposed changes to policies were directly contacted by their co-ordinating commissioner CCG during spring 2015, and asked for feedback on the proposed changes. Clinical Responses were received from:

- University Hospitals Birmingham NHS FT
- Heart of England NHS FT
- Birmingham Children's Hospital NHS FT
- Royal Orthopaedic Hospital NHS FT
- Birmingham Women's Hospital NHS FT
- Birmingham Community Healthcare NHS FT
- Royal National Institute for the Blind
- NHS England West Midlands Local Eye Network

In April 2016, after the end of the public engagement timetable, we also received feedback from:

- Royal College of Surgeons
- Chartered Society of Physiotherapists

Online Survey

The core channel for feedback was an online survey. This was chosen as the preferred method, as it enabled feedback to be received in a consistent manner against a standard set of questions for each policy. Ultimately, this assisted the analysis of comments as part of reviewing each policy. The link to the survey was extensively promoted through all the channels used for communications.

It was appreciated that not all respondents would necessarily have access to the internet, or that they may wish to receive the document in another format. This was communicated to stakeholder organisations and potential respondents would be offered the opportunity to receive the survey in an alternative format, or to attend one of the public meetings if they preferred.

The survey questions were formulated to allow respondents to give a full range of information when responding to the survey.

The survey was a mixture of closed format and multi-option questions (both to gather quantitative data), with additional open questions to gather qualitative data and allow respondents to make any additional comments in support of their responses.

The first question covered the objectives underpinning the review and respondents were asked the extent to which they agreed or disagreed with each of the six objectives, on a scale ranging from 'strongly agree' to 'strongly disagree'.

Respondents were subsequently asked to select the policies they wanted to comment on and were asked the same set of questions for each policy they selected. These questions were:

- Have you had this treatment / procedure?
- To what extent do you agree with the proposed criteria of the policy?[1]

Each individual policy question included a link to the policy. In addition, respondents were invited to provide any additional comments in a comment box.

Equality monitoring information was collected as part of the survey to inform the CCGs about the demographics of respondents to the survey. Respondents were also asked if they wanted to be involved in future work relating to PLCVs in 2016.

The full survey report is available in **Appendix 3** of the Engagement report.

Events

Two events to provide an opportunity for the public to ask questions and discuss the policies in more depth were held in Birmingham and Solihull. These events were supported by commissioning and clinical representatives from the CCGs and provided an opportunity for members of the public to ask more detailed questions about the policies.

These events were held on:

- Wednesday 9 March 2016, 4.30-7pm; The Bond, Digbeth, Birmingham; and
- Thursday 10 March 2016, The Renewal Centre, Solihull, 6-8.30pm.

[1] Respondents were asked to assess on a scale running from 'Strongly agree' to 'Agree' to 'Neither nor disagree' to 'Disagree' and finally to 'Strongly disagree'.

As noted previously, extensive advertising was utilised to promote both events; this included the use of social media, information being posted in CCG publications and websites as well as publication on fellow stakeholders websites and media, for example BVSC, the WMAHSN and Healthwatch.

In spite of the relatively low attendance, feedback from those attending was positive. 17 people completed an evaluation form from the Solihull event, of these 15 scored the presentation and speakers as 4 or 5 (excellent) and 12 scored the workshops as a 4 or 5 (excellent). 7 people completed an evaluation form for the Birmingham event; all rated the event as 4 or 5 (excellent).

A summary of the themes from the meetings is given in **Appendix 5** of the main Engagement report.

Feedback

Feedback was received from the following:

- 75 responses to the online survey (individuals and some representing organisations)
- Birmingham Children's Hospital NHS Foundation Trust
- Birmingham Community Health Care NHS Foundation Trust
- Birmingham Local Medical Committee
- Birmingham and Solihull Joint Health Overview and Scrutiny Committee
- Birmingham Women's Hospital NHS Foundation Trust
- Heart of England NHS Foundation Trust
- Chartered Society for Physiotherapists
- NHS England West Midlands Local Eye Network
- Royal College of Surgeons
- Royal National Institute for the Blind (RNIB)
- The Royal Orthopaedic Hospital NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust

Summary Comments Feedback from the Engagement (You Said)

Many respondents have experience of the treatments and talk positively about the impact and feel the blanket application of criteria is inappropriate; it is for the Clinician and the individual to decide on whether a treatment should go ahead;

> "*Criteria must not be the only means to determine if treatment goes ahead – Clinicians and patients must decide ultimately on an individual basis*"

At the events, there was a lot of support for ensuring that the latest clinical evidence was used to determine criteria and some individuals talked about their own experience and how they had noticed changes in clinical practice. For example, tonsils were removed less frequently now. Female participants mentioned that Hysterectomy for heavy menstruation was no longer the accepted treatment.

Some respondents questioned the clinical evidence used to support the criteria. In particular the use of Body Mass Index (BMI) thresholds for hip and knee surgery was questioned by the Royal College of Surgeons (RCS):

> *"Referring patients to hip and knee surgery only if their BMI is below 35 could affect a number of people, and the average prevalence of severe knee osteoarthritis is 6.8% across the population covered by the six CCGs.*
>
> *The British Orthopaedic Association (BOA) challenges the decision of the CCGs to include hip and knee replacements in a list of procedures of lower clinical value, considering the low QALY cost of the procedures;*
>
> *There is evidence that prolonging the wait for total hip replacement in patients with severe pain and reduced mobility results in poorer outcomes from surgery, and this is outlined in NICE guidance for osteoarthritis; and*
>
> *According to the BOA, there is no consistent evidence that patients with a high BMI who undergo hip replacement surgery, for example, do better or worse than other patient groups".*

The RCS also questioned the clinical evidence to support the provision of Grommets for the treatment of Glue Ear:

> *"Rationale for a policy to document five or more episodes of glue ear in a child before being referred for grommets treatment is not evidenced in RCS/SSA or NICE guidance"*

The RCS also raised concerns that its guidelines have been misrepresented:

> *"The document makes extensive reference to guidance published by the RCS and surgical specialty associations (SSAs) in setting out new commissioning policies on thresholds to referral to surgical procedures. Policies for some procedures reference RCS and SSA guidance which is subsequently ignored or cited out of context, thereby presenting the policies as if they are supported by clinically-evidenced guidance, but that in places contravene it".*
> *Likewise, the criteria for treatment of adenoids was also questioned, in particular the approach of only undertaking an adenoidectomy at the same time as a tonsillectomy:*
>
> *"The RCS does not agree with a policy of only referring patients for the procedure if undertaken at the same time as grommets or tonsillectomy. It seems particularly unusual to insist on performing a tonsillectomy at the same time if a patient requires an adenoidectomy, as this may increase surgical risk for the patient who may only need an adenoidectomy to treat sleep-disordered breathing".*

Birmingham Local Medical Committee (LMC) commented on the process, specifically the need to ensure GPs have access to seek a specialist opinion:

> *"GPs must retain full clinical freedom to refer for a specialist assessment/opinion whenever they believe it is appropriate; this will include instances where the referral is made because the patient is insistent on a specialist opinion".*

The full survey report is available in **Appendix 3** of the Engagement Report.

Full details of all comments and feedback received through the online survey, events and direct correspondence and Commissioners responses and proposed changes are set out in **Appendix 4** of the Engagement report.

Summary of Key Principles Questions Asked in the Engagement ('You Said')

The purpose of this consultation was to take the opportunity to ask members of the public, service users, stakeholders and staff their views on the proposed harmonisation of policies listed as procedures of lower clinical value.

The first question in the survey covered the objectives underpinning the review. Respondents were asked the extent to which they agreed or disagreed with each of the six objectives, on a scale ranging from 'strongly agree' to 'strongly disagree'.

The result of this was that the overwhelming majority of respondents indicated their support for the 6 objectives underpinning the review of the 21 PLCV policies (see Table 1 below). This was particular true of objective 1 where over 90% of respondents supported this objective.

Although there was no significant levels of disagreement for any of the objectives, a significant minority of respondents stated that they neither agreed nor disagreed with objectives 3 (8%), 4 (9.3%), 5 (10.7%) and 6 (12%).

Table 1: Assessment of the level of support for the stated objectives of the PLCV consultation:

	Question	Response	Support for Objective
1	'To ensure that procedures and treatments are offered consistently and fairly to patients'.	Most respondents agreed (61.3%) or strongly agreed (29.3%) with the question.	Yes
2	To end the 'postcode lottery; which currently exists, by having the same eligibility criteria for treatments'.	Most respondents agreed (65.3%) or strongly agreed (21.3%) with the question.	Yes
3	'To ensure that policies meet the latest national clinical guidance and are supported by robust clinical evidence'.	Most respondents agreed (52%) or strongly agreed (33.3%) with the question.	Yes
4	'To stop using treatments that do not have any benefits for patients, or have a very limited evidence base'.	Most respondents agreed (37.3%) or strongly agreed (42.8%) with the question.	Yes
5	'To prioritise treatments which provide the greatest benefits to patients'.	Most respondents agreed (46.7%) or strongly agreed (32%) with the question.	Yes
6	'To stop offering cosmetic treatments e.g. Botox injections, liposuction, face lift, repairs of ear lobes and thigh lift'.	Most respondents agreed (52%) or strongly agreed (22.7%) with the question.	Yes

As for the individual policies themselves, there was mixed support from the public survey. Of the 21 policies produced for consideration, over half produced inconclusive results from the survey, with no significant levels of support or disagreement.

For seven policies; Non Specific, Specific and Chronic Back Pain, Ganglion, Hip Replacement Surgery, Hysterectomy for Heavy Menstrual Bleeding and Menorrhagia, Knee Replacement Surgery, and Penile Implants, the largest proportion of survey respondents disagreed or strongly disagreed with the proposed policies.

Table 2: Survey results:

Policy	Agree (%)	Disagree (%)	Neither Agree / Disagree (%)	Total Respondents	Support for Policy
Adenoidectomy	33.3	33.3	33.3	3	Inconclusive
Cosmetic Surgery	44.4	44.4	11.11	9	Inconclusive
Back Pain	37.5	50	12.5	8	No
Botox	60	0	40	5	Yes
Cataracts	18.75	39.5	43.75	16	Inconclusive
Cholecystectomy	66.66	33.3	0	3	Yes
Male Circumcision	16.67	33.34	50	6	Inconclusive
D&C for Menorrhagia	40	40	20	5	Inconclusive
Blepharoplasty	25	25	50	4	Inconclusive
Ganglion	22.22	55.55	22.22	9	No
Grommets	40	40	20	5	Inconclusive
Haemorrhoidectomy	40	20	40	5	Yes
Hip Replacement	25	56.25	18.75	16	No
Hysterectomy for HMB	33.34	50	16.67	6	No
Hysterectomy for Menorrhagia	20	60	20	5	No
Groin hernia repair	33	33	33	3	Inconclusive
Knee Replacement	18.18	63.64	18.18	11	No
Penile implant	25	50	25	4	No
Tonsillectomy	50	37.5	12.5	8	Yes
Trigger Finger	40	0	60	5	Inconclusive
Varicose Veins	33.3	33.3	33.3	6	Inconclusive

Only three policies; Male Circumcision, Eyelid Surgery (Upper and Lower) Blepharoplasty and Trigger finger, saw significant support from survey respondents.

Proposed Changes to Draft Commissioning Policies ('You Said; We Did')

Feedback from our stakeholders and service users was at the heart of our consultation and we value all of the feedback we have received. For full details of the CCG Clinical Working Group responses to comments received during the consultation, please refer to **Appendix 4** of the full Engagement report.

Some of these comments were particularly important, and we have presented these as a series of actions – 'You Said, We Did':

General Comments

1. Birmingham LMC said: GPs must retain full clinical freedom to refer patients for a specialist assessment/opinion whenever they believe it is appropriate.

   We responded: We do not seek to restrict outpatient referrals for specialist opinion. In Solihull and Birmingham specialist advice and support can also be received via e-referral and through 'Consultant

Connect' in a range of clinical specialties which might ultimately mean that a GP referral is no longer required.

2. Birmingham LMC said: Changes to policies should not put any additional un-resourced workload on general practice.

   We responded: We do not seek to restrict outpatient referrals for specialist opinion. In Solihull and Birmingham specialist advice and support can be received via e-referral and through 'Consultant Connect' in a range of clinical specialties.

3. The Royal College of Surgeons said: Patients' access to treatment must be based on clinical assessment and evidence-based practice.

   We responded: Local CCGs would like to reassure that no absolute referral or treatment block exists because of the shared Individual Funding Request process across Birmingham, Black Country and Solihull since 2013.

4. Birmingham Children's Hospital said: Concern that there appears to be no differentiation between adults and children in the policies. Birmingham Children's Hospital believes that there are fundamental differences between the implementation and effects of certain policies for both adults and children.

   We responded: Further discussions have taken place with Birmingham Children's Hospital to identify specific areas of concern and, where possible, the draft policies have been amended (see individual policy and treatment lines within Appendix 4).

5. Members of the public said: The cosmetic surgery policy does not seem to take into account additional issues arising from conditions treated by cosmetic surgery such as poor mental health.

   We responded: No local commissioning policy includes mental health criteria; this is because there are no objective measures of psychological distress that can be used. However, CCGs allow for clinical 'safety net' of the Individual Funding request (IFR) process to be used where, in exceptional circumstances, an application can be submitted by a suitably qualified Clinician such as a Psychiatrist or Psychologist.

6. Respondents said: They had concerns that the non-specific, specific and chronic back pain policy had been considered as a procedure of lower clinic value due to wider spread a debilitating effect this condition has.

   We responded: We can confirm that the policy is based on current Map of Medicine and the British Pain Society (BPS) guidance; this guidance recognised the need to develop easy-to-use, succinct pathways for Clinicians. Additionally, NICE are currently consulting on revised guidance for Non-Specific Bank Pain and Sciatica and expect to publish updated clinical guidelines in September 2016. At that point this policy will be updated to align with that revised NICE guidance.

7. The Royal College of Surgeons said: They had concerns that the varicose veins policy proposes to only surgically treat more advanced cases of varicose veins. The Royal College of Surgeons noted that varicose veins that are not treated at an earlier stage are likely to deteriorate and require later surgery.

   We responded: We have reflected on the feedback provided by the Royal College of Surgeons and members of the public and have further reviewed NICE guidance relating to varicose veins. As a result the draft policy has been amended to take on board this feedback.

8. Solihull and Birmingham Joint Health Overview and Scrutiny Committee recommended that case study information and information in Plain English is more widely disseminated to the public about PLCV.

We responded: Once we have the final draft of each policy with the help of patient panel reps we will start to work on 'Plain English' leaflets for each policy. This work is commencing in June 2016 and will take some time due to the number of policies being harmonised and making sure that patient panel input is carefully considered and reflected in the final product.

Policy Specific Comments

In regard to specific treatment policy feedback changes to the draft commissioning policies which we engaged on we detail below a number of proposed changes:

1. **Adenoidectomy.** The following additional treatment eligibility criteria to be added:

   Children or adults with sleep disordered breathing/apnoea confirmed with sleep studies undergo procedure in line with recognised management of these conditions.

   Based on RCS Commissioning Guidance we propose that the linkage with tonsillectomy is removed and replaced with the following text:

   'As nationally there is a more than 5 fold variation in procedure rates for sinus surgery per 100,000 population by CCG across England secondary and Primary Care Clinicians should ensure they undertake maximum medical therapy following the RCS High Value Care Pathway for Rhinosinusitis, with surgery reserved for recalcitrant cases, with a diagnosis confirmed by radiology, after an appropriate trial of treatment.'

2. **Cosmetic Surgery**

   The following procedures within the Cosmetic Surgery policy received no feedback and will remain unaltered:

   - Abdominoplasty / Apronectomy
   - Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat
   - Liposuction
   - Breast Reduction
   - Breast Lift (Mastopexy)
   - Vaginoplasty
   - Face Lift or Brow Lift (Rhytidectomy)
   - Alopecia (Hair Loss)
   - Removal of Tattoos / Surgical correction of body piercings and correction of respective problems
   - Removal of Lipomata
   - Botulinum Toxin Injection for the Ageing Face
   - Thread / Telangiectasis / Reticular Veins
   - Resurfacing Procedures: Dermabrasion, Chemical Peels and Laser Treatment
   - Other Cosmetic Procedures
   - Revision of Previous Cosmetic Surgery Procedures

Gynaecomastia
Clarification that the option remained for a Children's acute provider to make an IFR application in 'exceptional' cases e.g. unilateral gynaecomastia if the treating Clinician deemed surgery necessary.

Ear Reconstruction
(Bone Anchored Hearing Implants). Regarding BCH's comments on BAHIs these are commissioned by NHS England Specialised Services (assessment, implantation and rehabilitation). NHSE has not specified whether any incidental ear reconstruction would be funded by them England. Therefore pending further clarification from NHS England Specialised Service that any such additional surgery could be applied for through the IFR process.

Pinnaplasty (Children)
Clarification that the option remains to make an IFR application in 'exceptional' cases.
Repair of Ear Lobes. Regarding 2-5 year olds and 12-17 year olds we believe the examples cited could be covered with an amplification of the policy treatment to say:

'Repair of split ear lobes are not routinely commissioned except for the following traumatic injury examples:

- *Young children typically under 5 whose parents have their child's ear pierced and the child subsequently pulls it off splitting the earlobe.*
- *Older children typically 12-17 years who have earrings who sustain a traumatic injury with the earring splitting the earlobe.*

Breast Augmentation/Breast Reduction/Breast Lift/Inverted Nipple Correction
The commissioning policy for cosmetic surgery allows for Breast reconstructive surgery of the cancer affected breast following full or partial mastectomy. NICE CG80 - Early and locally advanced breast cancer: diagnosis and treatment (2009) and NICE Quality Standard 12 – Breast Cancer (2011) recommend that women should have the choice of whether to have reconstructive surgery at the same time as a mastectomy or at a later date. However NICE does not deal with the issue of contralateral surgery on the other breast not affected by cancer whether symmetrising surgery including: Breast Augmentation/Breast Reduction/Breast Lift/Inverted Nipple Correction.

Both HEFT and UHB Clinicians have commented on the psychological factors but no Birmingham, Solihull and Black Country commissioning policy includes psychological factors in their clinical access thresholds. This is because there is no objective clinical measurement/standard that commissioners can apply. It is important that commissioners do not discriminate against non-cancer affected women who would like to have NHS funded Breast augmentation, breast reduction, breast lift (mastopexy) or breast reduction (or nipple inversion) surgery which are in most circumstances considered to be Cosmetic Surgery.

The WG on 29th June proposed that for breast cancer patients facing reconstructive surgery on the cancer affected breast should have the option at the same time reconstructive surgery is being undertaken of contra-lateral surgery on the non-cancer affected breast to include Breast Augmentation, or Breast Reduction, or Breast Lift or Inverted Nipple Correction surgery. Separate later/subsequent applications for such contra-lateral surgery would not however be routinely commissioned.

Labiaplasty
Clarification that in cases of congenital deformity (a very low volume procedure) that Children's providers can make an IFR application in 'exceptional' cases.

3. Non Specific, Specific and Chronic Back Pain

Clarification that draft policy is based on current Map of Medicine and the British Pain Society (BPS) guidance which recognised the need to develop easy-to-use, succinct pathways for Clinicians.
We have reflected that regarding non-pharmacological or non-invasive first line treatment for 'non-specific back pain', that the policy needed to emphasise more strongly the following pre-surgical options:

- Structured individual or group exercise programmes
- A course of manual therapy, including spinal manipulation, comprising up to a maximum of nine sessions over a period of up to 12 weeks performed by chiropractors and osteopaths, as well as by doctors and physiotherapists who have undergone specialist postgraduate training in manipulation
- A course of acupuncture needling comprising up to a maximum of 10 sessions over a period of up to 12 weeks. But not offering injections of therapeutic substances into the back for non-specific low back pain.

We propose adding the following statement*, 'NICE are currently consulting on revised guidance for Non-Specific Bank Pain and Sciatica' and expect to publish updated clinical guidelines in September 2016. At that point this policy will be updated to align with that revised NICE guidance.'*

We have noted that the draft NICE Clinical Guidance no longer recommends acupuncture for the management of non-specific low back pain (and sciatica). Upon final publication of the updated NICE clinical guidance we propose at that point this policy will be updated to align with that revised NICE guidance.

Regarding RCS comments regarding 'single injection' we propose that the Specific Pain section of the policy should be re-drafted as follows:

'Lumbar facet joint injections should not be routinely considered for patients with low back pain of up to 12 months duration or moderate to severe depression.
Few patients will need referral to Secondary Care, where this is necessary the CCG will fund this treatment if the high value part of the RCS Low Back Pain pathway can be evidenced as regards to:

- Assessment
- Injections
- Pain Management
- Surgery (where other recommended treatments have been exhausted).'

Clarification that:

- Functional Restoration Programme was one of an number of nationally recommended options at an Intermediate level of care (this could be delivered in both acute and non-acute settings).
- The policy should/will reflect the clinical management journey: Primary / Intermediate / Secondary care rather than between non-specific/specific/chronic back pain.
- Epidurals and nerve root injections for radicular pain are a recognised treatment (per http://bja.oxfordjournals.org/content/111/1/112.short). This policy currently is restricted to the Back Pain rather than Radicular Back Pain pathway. During 2016/17 this policy will be cross-referenced and updated where appropriate to the current Birmingham and Solihull Scheduled Care SRG pathfinder project on Spinal Surgery and Back Pain. At that stage Radicular (nerve pressure) Back Pain will be incorporated into this policy.
- Commissioners have confirmed that:
  - FRP has been formally commissioned by Birmingham CrossCity as co-ordinating commissioner for ROH.
  - Birmingham CCGs have commissioned the option of up to 100 hours of combined physical and psychological therapy.

We propose that the policy should cross reference to current live Birmingham and Solihull Scheduled Care Strategic Resilience Group pathfinder project on Spinal Surgery/Back Pain which ROH and UHB are partners in. The current draft policy follows the Back Pain element of the national Pathfinder Pathway but not the Radicular (nerve pressure – including sciatica) Back Pain element of the national Pathfinder Pathway.

4. Cataract Surgery

Several textual changes proposed by UHB were agreed, namely:

- Final bullet point should read: *'Patients with glaucoma who require cataract surgery to contract control intraocular pressure.'* The Working Group meeting on 14th April agreed that policy text should be amended.
- The advice that '…but the Ophthalmologist should explain the possibility of total blindness if severe complications occur' is not relevant to a discussion of when cataract surgery should be commissioned and that this text should be deleted.
- There is no statement in the Royal College Cataract Surgery guidance to suggest 'the possibility of total blindness if severe complications occur.' We agree that the above sentence was not consistent with the Royal College guidance and should be removed.

The WG meeting of 29th June 2016 further reflected on the fact that visual acuity is the most common measurement of visual function as it can be quickly and easily measured. However, the sole use of visual acuity can underestimate visual disability because it does not take account of symptoms such as glare or reduced contrast sensitivity.

Significant improvements in visual symptoms and visual function may occur following cataract surgery even where the preoperative visual acuity is 6/6 or better. However, it is important to note that the risk of worse visual acuity after surgery also increases where the preoperative visual acuity is very good, so surgery should be considered at this level of visual acuity only where the patient is experiencing significant symptoms attributable to cataract.

The Royal College of Ophthalmologists' National Ophthalmology Database shows that, for the period 2006-2010, 3%, 5% and 36% of eyes undergoing cataract surgery have
preoperative visual acuities of better than or equal to 6/6, 6/9 and 6/12 Snellen indicating that before restrictions on access to cataract surgery based on visual acuity were commonplace, eyes with visual acuities of 6/9 or better accounted for less than 10% of cataract surgery.

Although visual acuity remains a useful component of the assessment of visual disability from cataract, cataract surgery should be considered in the first eye or second eye of a patient who has disabling visual symptoms attributable to cataract. For instance, a patient who experiences disabling glare due to cataract when driving may still achieve a visual acuity of better than 6/9 under ideal conditions of illumination. This recommendation is consistent with advice from the Royal College of Ophthalmologists, and where implemented in local Commissioning guidance has been found to be practical and equitable.

We also noted that in patients with learning disability or cognitive impairment for other reasons, it may not be possible to measure visual acuity accurately and in these cases, Clinicians will need to base the clinical decision to offer cataract surgery on clinical examination findings and information provided by carers.

Therefore the WG has decided to propose removing the linkage between a visual acuity of 9/6 or worse and other disabling visual symptoms linked cataracts.

It should be noted that NICE publish their guideline for the diagnosis and management of cataracts in April 2018 (https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0741).

5. Eyelid Surgery (Upper and Lower) – Blepharoplasty.

Clarification for Children with Chalazion (meibomian cyst) that unless acutely infected, it is harmless and nearly all resolve if given enough time. If conservative therapy fails, chalazia can be treated by surgical incision into the tarsal gland followed by curettage of the retained secretions and inflammatory material under local anaesthetic.

The policy document will be amended to reflect this clarification.
Confirmation that the existing draft policy allowed for surgical treatment of congenital ptosis(drooping eyelid) occurring from birth.

6. Ganglion.

We agree with the comment that it is rare for Ganglions to cause neurology and therefore questioned the merit of a Nerve Conduction Study. We proposed therefore that the existing criteria in operation should be retained, namely:

- Surgery for ganglia will be funded where painful lump causing disabling pain on activities of daily living and/or work;
- Surgery for mucous cysts will be funded when causing distortion of nail growth and discharge predisposing to septic arthritis.

This change is subject to the ROH being able to indicate how disabling pain could be objectively and consistently measured for policy operation purposes.

7. Groin Hernia Repair.

We accept that a key sentence which had been part of line of an earlier draft had been omitted in error and that it should re-include the following criteria:

> 'all patients with an overt or suspected inguinal hernia to a surgical provider except for patients with minimally symptomatic inguinal hernias who have significant comorbidity (ASA grade 3 or 4) AND do not want to have surgical repair (after appropriate information provided).'

8. Grommets.

We agree that the policy title needs to explicitly state this is for patients >3 years and <12 years and therefore clarify that this policy would not impede grommets for under 3s prior to Cochlear Implantation or children aged 12+ with speech development problems.
We have re-reviewed NICE CG60 - Otitis media with effusion in under 12s: and agree that surgery does not include a requirement for '5 or more episodes of glue ear in a child before referral.' This requirement should be removed from the draft policy. It was included in the older SIGN – Clinical Guidance 66: Diagnosis and management of childhood otitis media in Primary Care.

9. Haemorrhoidectomy

We are satisfied that the draft policy is consistent with national commissioning guidance on the treatment of rectal bleeding. However we did feel that it was necessary in the policy to make clearer the eligibility as follows:

- #Minor text changes to confirm that pre-Haemorrhoidectomy recommended treatments such as Rubber Band Ligation and Injection of a Grade 1 or Grade 2 Haemorrhoid can still be undertaken in a clinic setting.
- For Grade 3 or Grade 4 cases replace the term 'surgical treatment 'with 'Haemorrhoidectomy' and replace Roman numerals (III/IV) with standard number.

Note:

- Grade One: No prolapse
- Grade Two: Prolapse that goes back in on its own
- Grade Three: Prolapse that must be pushed back in by the patient
- Grade Four: Prolapse that cannot be pushed back in by the patient (often very painful).

10. Hip or Knee Replacement Surgery

We have considered at length the BMI (Body Mass Index) criteria set in these policies, and have concluded that there is not sufficient or unequivocal evidence either to support/ include or to not include a particular BMI for Hip replacement. We are therefore proposing to amend the criteria and have no set BMI, while more strongly emphasising the need for surgeons/anaesthetists to carefully assess the clinical risk of surgery for higher BMI patients where the ASA (American Society of Anesthesiologists) score exceeds 2. We also believe that it is necessary to insert new text into main policy suite introduction to emphasise the importance of engaging with local Lifestyle Management services.

11. Male Circumcision

While we believe the current Medical Circumcision policy contains appropriate clinical criteria, we have agreed that individual CCGs are free to operate a supplementary local policy on Religious Circumcision if their Governing Body elects to do so.

12. Penile Implants

We have noted that NHS England in January 2016 started a consultation on an evidence review of penile prosthesis surgery. Its initial conclusion is that 'evidence to support the use of penile prosthesis implantation in men with erectile is predominantly of low level evidence.' And that to date no review of cost effectiveness of the treatment has been undertaken. NICE has not published clinical guidance on Erectile Dysfunction (ED) in terms of clinical effectiveness, safety and tolerability and cost effectiveness. If NICE do evaluate treatments of ED, specifically penile prosthesis surgery, Commissioners will review and update this policy.

13. Tonsillectomy

We propose to add a note to the policy confirming that Walk in Centre or Out of Hours documented episodes that had been communicated in writing to GP Practices are included in the episode count.

14. Trigger Finger

We reflected on the feedback given regarding diabetic patients and noted that The British Society for Surgery of the Hand (BSSH) in its 2011 guidance comments: people with insulin-dependent diabetes are especially prone to triggering, but most trigger digits occur in people without diabetes.
GP members of the working group commented that most diabetic or non-diabetic patients with Trigger Finger are in fact treated by steroidal injection rather than surgery and that there was no need in the draft policy to separately identify insulin dependent patients as the clinical protocol for pre-surgical treatment and surgical treatment apply to diabetic and non-diabetic patients.

15. Varicose Veins

We have re-reviewed NICE CG168 and propose to revise the policy to:

- Remove reference to compression hosiery pre-surgical treatment as this is not part of NICE CG 168.
- Make more explicit NICE recommended pre-surgical options.
- Emphasise that for patients who have 'varicose veins that have bled and are at risk of bleeding again' then they should be referred to Secondary Care immediately.

Appendix 1

Procedure Level Policy Change/Impact Assessment

Changes in policy category are highlighted in red text.

No	Policy	Treatment	Existing Category	Proposed Category	Main Changes To Policy and/or Areas of Risk
1	Adenoidectomy		Restricted	Restricted	No major difference in the set criteria. Adenoidectomy links in with the Tonsillectomy and/or Grommets policy
2	Cosmetic Surgery	Abdominoplasty / Apronectomy	Not routinely commissioned	Not routinely commissioned	No difference
3	Cosmetic Surgery	Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat	Not routinely commissioned	Not routinely commissioned	No difference
4	Cosmetic Surgery	Liposuction	Restricted	Not routinely commissioned	New policy states that funding is not routinely commissioned and funding will only be considered via the IFR process. Existing policy: Liposuction may be used as a technique in the management of true lipid dystrophies or as an adjunct to other surgical procedures (e.g. modification of flaps for re-constructional repair.) • It will not be commissioned simply to correct the distribution of fat.
5	Cosmetic Surgery	Breast Augmentation	Not routinely commissioned	Not routinely commissioned	The new policy will only fund for breast augmentation for cancer patients with set criteria. Funding will only be considered for other circumstances through the IFR process.
6	Cosmetic Surgery	Breast Reduction	Restricted	Restricted	The new policy criteria states the age must be 21 years or over (RCS Commissioning Guidance does not include an age threshold), previously the criteria was 18+ The new policy states the patient must have a cup size of F +, previously the criteria was E+ The BMI now states less than 27, previously the BMI was between 20 and 27
7	Cosmetic Surgery	Breast Lift (Mastopexy)	Not routinely commissioned	Not routinely commissioned	No major difference - the new policy clarifies criteria for breast cancer patients, for other circumstances funding would only be considered via the IFR process.
8	Cosmetic Surgery	Inverted Nipple Correction	Restricted	Not routinely commissioned	Funding will only be considered via an IFR, previously the procedure was considered for post-pubertal women with permanently inverted nipples that cannot be passively everted and caused functional problems.

No	Policy	Treatment	Existing Category	Proposed Category	Main Changes To Policy and/or Areas of Risk
9	Cosmetic Surgery	Gynaecomastia (Male Breast Reduction)	Restricted	Not routinely commissioned	The criteria previously set a BMI, a screening consultation to exclude endocrinological and gross asymmetry/ reduction in breast size. The criteria now states funding will only be considered via the IFR process, Gynaecomastia is not routinely commissioned.
10	Cosmetic Surgery	Labiaplasty	Restricted	Restricted	No difference
11	Cosmetic Surgery	Vaginoplasty	Restricted	Restricted	No difference
12	Cosmetic Surgery	Pinnaplasty	Restricted	Not routinely commissioned	Pinnaplasty was previously available for patients that met the set criteria which included; under 19 years, assessment by consultant which showed concern. A referral for pinnaplasty would be considered for patients under 5 years that were seen by child psychologist. The new criteria states the treatment is not routinely commissioned and will only be considered for funding via the IFR process. The previous restrictions were consistent with RCS 2014 Commissioning Guidance.
13	Cosmetic Surgery	Repair of Ear Lobes	Restricted	Not routinely commissioned	The procedure is no longer routinely commissioned including for direct trauma including the result of total split ear lobe. Funding is only considered via the IFR process.
14	Cosmetic Surgery	Rhinoplasty	Restricted	Restricted	Rhinoplasty is now available when there is documented nasal obstruction or complex congenital conditions. No major difference
15	Cosmetic Surgery	Face Lift or Brow Lift (Rhytidectomy)	Restricted	Restricted	No major difference
16	Cosmetic Surgery	Hair Depilation (Hirsutism)	Restricted	Restricted	Treatment is no longer available for severe facial hair. Patient must meet the eligible criteria or funding can be considered via the IFR process.
17	Cosmetic Surgery	Alopecia / Hair Loss	Restricted	Restricted	Treatment was previously available in a result of previous surgery, cancer or trauma. The treatment is no longer routinely commissioned and can only be considered for funding via the IFR process.
18	Cosmetic Surgery	Removal of Tattoos / Surgical correction of body piercings and correction of respective problems	Not routinely commissioned	Not routinely commissioned	No difference

No	Policy	Treatment	Existing Category	Proposed Category	Main Changes To Policy and/or Areas of Risk
19	Cosmetic Surgery	Removal of Benign (non-cancerous) or Congenital Skin Lesions	Restricted	Restricted	Previously treatment was routinely commissioned for the diagnosis of isolated spider naevi on face and neck in children or risk of malignancy. Funding is now only available when there is suspected malignancy or lesion causing function impairment or causing obstruction of orifice or vision.
20	Cosmetic Surgery	Removal of Lipomata	Restricted	Restricted	No major difference
21	Cosmetic Surgery	Medical and Surgical Treatment of Scars and Keloids	Not routinely commissioned	Not routinely commissioned	No major difference
22	Cosmetic Surgery	Botox Injection for the Ageing Face	Not routinely commissioned	Not routinely commissioned	No major difference
23	Cosmetic Surgery	Viral Warts	Restricted	Restricted	Funding is now only available for ano-genital warts . Previously Secondary Care treatment was available when Primary Care was not available and patient had symptoms which caused everyday living disruption and/or pain.
24	Cosmetic Surgery	Thread / Telangiectasis / Reticular Veins	Restricted	Not routinely commissioned	Treatment is no longer routinely commissioned and will only be considered for funding via the IFR process.
25	Cosmetic Surgery	Rhinophyma	Restricted	Not routinely commissioned	Previously funding would be considered for severe cases that did not respond to conservative treatment, now funding will only be considered via the IFR process. No major difference
26	Cosmetic Surgery	Resurfacing Procedures: Dermabrasion, Chemical Peels and Laser Treatment	Restricted	Not routinely commissioned	Funding will only be considered via the IFR process. Previously treatment was considered for post traumatic scarring and severe acne.
27	Cosmetic Surgery	Other Cosmetic Procedures	Not routinely commissioned	Not routinely commissioned	No difference
28	Cosmetic Surgery	Revision of Previous Aesthetic Surgery Procedures	Not routinely commissioned	Not routinely commissioned	No difference
29	Non Specific, Specific and Chronic Back		Restricted	Restricted	Back pain criteria has been set for each separate diagnosis for • Non-specific Back Pain • Specific Back Pain

No	Policy	Treatment	Existing Category	Proposed Category	Main Changes To Policy and/or Areas of Risk
	Pain				• Chronic Back Pain and • Spinal Cord Stimulation for Chronic Back Pain In the new policy when there is no specific back pain diagnosis, treatment is not routinely commissioned this is in line with NICE guidance). Specific Back Pain: • Facet Joint Injection is only given for specific back pain - clarity given when more than one injection would be considered. • Clarity given to and/or criteria to be met when an injection will be given • Clarity provided for treatments / interventions that are to be tried prior to an injection. There is no major difference in the eligible criteria for treatment. Chronic Back Pain : There was no previous criteria for funding Spinal cord stimulation, the criteria is set in line with NICE TA159, recommended as a possible treatment for adults with chronic pain of neuropathic origin if they: • continue to experience chronic pain (measuring at least 50 mm on a 0–100 mm visual analogue scale) for at least 6 months despite standard treatments, and • have had a successful trial of spinal cord stimulation as part of an assessment by a specialist team. • Treatment with spinal cord stimulation should only be given after the person has been assessed by a specialist team experienced in assessing and managing people receiving treatment with spinal cord stimulation.
30	Botulinum Toxin for Hyperhidrosis		Not routinely commissioned	Not routinely commissioned	Botulinium Toxin was funded for • Frey's syndrome • Blepharospasm • Cerebral palsy • Overactive bladder (as per NICE clinical guideline 40) • Severe axillary hyperhidrosis, where first-line topical therapy and/or iontophoresis have failed or are contraindicated It is no longer routinely commissioned for hyperhidrosis - funding will only be considered as an IFR. Other indications continue to be funded.

No	Policy	Treatment	Existing Category	Proposed Category	Main Changes To Policy and/or Areas of Risk
31	Cataracts		N/A – New Policy	Restricted	• The visual symptoms has now changed from 6/12 to 6/9 • The criteria sets visual acuity must be 6/9 AND impact on lifestyle or difficulty in everyday tasks or driving difficulty or live independently • Previously the criteria listed exceptions when treatment was available when the Visual acuity was not met. • The criteria now expects for a report/referral form to be presented.
32	Cholecystectomy for Asymptomatic Gallstones		Not routinely commissioned	Not routinely commissioned	No difference in criteria
33	Male Circumcision		Restricted	Restricted	No difference in criteria - more clarity in the new policy for diagnosis.
34	Dilation and Curettage (D&C) for Menorrhagia		Restricted	Not routinely commissioned	D&C is no longer routinely commissioned; previously it was funded when there was suspicious of underlying pathology. There are alternatives to D&C including ultrasound as a diagnostic tool and other therapeutic treatments.
35	Eyelid Surgery (Upper and Lower) - Blepharoplasty		Restricted	Restricted	Surgery on the upper eyelid (Upper lid blepharoplasty): The criteria set a visual field that should be met to have treatment. Previously the treatment was available when a lesion was produced from a secondary eye condition. Surgery on the Lower eyelid (Lower lid blepharoplasty): There is no difference in the criteria set
35	Ganglion		Restricted	Restricted	The criteria defines that treatment is only available when Neurovascular symptoms are confirmed, previously the criteria was based on a lump causing disabling pain
37	Groin Hernia Repair		Restricted	Restricted	The new policy defines and demonstrates when treatment is available. Clarity is given for children <18 and hernia in women and when a patient should be referred as an emergency.
38	Grommets		Restricted	Restricted	The criteria defines when grommets surgical intervention is available including dBHL and episodes of acute OME.
39	Haemorrhoidectomy		Restricted	Restricted	The existing and proposed polices are similar- the new policy clarifies haemorrhoidectomy is not commissioned for grade 1 or 2 Haemorrhoids and will only be considered for funding via IFR process
40	Hip Replacement Surgery		New - N/A	Restricted	BMI has changed from below 40 to less than or equal to 35. New policy criteria clarifies when treatment is available
41	Hysterectomy for Heavy Menstrual Bleeding		Restricted	Restricted	Similar policies - no major difference

No	Policy	Treatment	Existing Category	Proposed Category	Main Changes To Policy and/or Areas of Risk
42	Hysteroscopy for Menorrhagia		Not routinely commissioned	Not routinely commissioned	New policy criteria is that the procedure is not routinely commissioned, funding will only be considered via IFR process.
43	Knee Replacement Surgery		New - N/A	Restricted	No material change in criteria, BMI remains at/below 35.
44	Penile Implants		Restricted	Not routinely commissioned	The well-defined pre-surgery steps and criteria set in the current policy are being replaced by a position of 'not routinely commissioned' and will only be considered if an application is approved as an IFR
45	Tonsillectomy		Restricted	Restricted	The new policy requires for all tonsillitis episodes to be documented No major difference in policies.
46	Trigger Finger		Restricted	Restricted	The new policy defines that at least 2 steroid injections have been tried and failed
47	Varicose Veins		Restricted	Restricted	The criteria now includes varicose ulceration No major difference in criteria.
-	Dupretren Disease		Restricted	Removed - Pending Xiapex trial results [ROH]	

Residual Procedures Operational in Historic HEFT PLCV Policy

Policy
Port Wine Stain
Rosacea – Laser Treatment
Planned Caesarean section
Laser treatment for myopia
Diagnostic Arthroscopy of the knee
Dupuytren Disease - Palmer Fasciectomy
Carpal Tunnel Syndrome
Reversal of male and female sterilisation
Complementary and alternative therapies
Any treatment purporting to treat allergy as a cause of chronic (post-viral) fatigue syndrome
Treatment of myalgic encephalomyelitis
Treatment of anal tags
Any treatment of candida hypersensitivity syndrome
Radiotherapy for age-related macular degeneration of the eye
Bionucleoplasty for disc degeneration
Laser disc surgery and ligament procedures for low back pain
Arthroscopic washout
Reversal of vasectomy
Use of dilators or microwaves for benign prostatic hyperplasia
Use of lithiotripsy to treat small asymptomatic renal calculi
Treatment for hyperhidrosis
Excision of sebaceous cysts (removal of benign skin lesions)
Congenital vascular abnormalities
Photodynamic therapy
Surgical removal of mucoid cysts at DIP joint
NIV and CPAP Machine
Hyperbaric Oxygen Therapy
Bone-anchored hearing aids
Removal of ear wax
Investigation of painless rectal bleeding
Allergy Testing
Acupunture
Carotid artery surgery for asymptomatic patients with carotid artery disease
EVAR-Endovascular stent [NHSE commissioned]
Cryotherapy to remove lesion of eyelid
Botulinum toxin for facial ageing