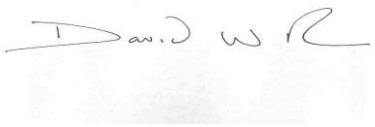
Public Document Pack

Health Policy and Performance Board

Tuesday, 19 June 2018 at 6.30 p.m.
Council Chamber, Runcorn Town Hall



Chief Executive

BOARD MEMBERSHIP

Councillor Joan Lowe (Chair)	Labour
Councillor Sandra Baker (Vice-Chair)	Labour
Councillor Marjorie Bradshaw	Conservative
Councillor Lauren Cassidy	Labour
Councillor Mark Dennett	Labour
Councillor Charlotte Gerrard	Labour
Councillor Margaret Horabin	Labour
Councillor Chris Loftus	Labour
Councillor Shaun Osborne	Labour
Councillor June Roberts	Labour
Councillor Pauline Sinnott	Labour

Please contact Ann Jones on 0151 511 8276 or e-mail ann.jones@halton.gov.uk for further information.
The next meeting of the Board is on Tuesday, 18 September 2018

ITEMS TO BE DEALT WITH
IN THE PRESENCE OF THE PRESS AND PUBLIC

Part I

In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.

HEALTH POLICY AND PERFORMANCE BOARD

At a meeting of the Health Policy and Performance Board held on Tuesday, 27 February 2018 at Council Chamber, Runcorn Town Hall

Present: Councillors J. Lowe (Chair), S. Baker, M. Bradshaw, E. Cargill, Dennett, C. Gerrard, Horabin, M. Lloyd Jones and Sinnott

Apologies for Absence: Councillors Osborne, Parker and Mr T. Baker (Co-optee)

Absence declared on Council business: None

Officers present: A. Jones, D. Nolan, L Wilson, D. Parr, P. Frost, B. Kay, and L. Taylor

Also in attendance: J. Regan – Premier Care, L. Thompson, S. McHale and A. Davies – NHS Halton Clinical Commissioning Group (CCG) and Councillors G. Stockton, Wall, Wright, N. Plumpton Walsh and C. Plumpton Walsh, P. Lloyd Jones, Gilligan, Howard, R. Hignett, C. Loftus, K. Loftus, Logan, J. Bradshaw and Rowe.

ITEMS DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HEA32 MINUTES

The Minutes of the meeting held on 28 November 2017 having been circulated were signed as a correct record.

HEA33 PUBLIC QUESTION TIME

It was confirmed that a statement had been received from a member of the public for Members' attention. A response would be sent to the sender.

The Chair declared a Disclosable Other Interest in the following item as her son's partner works for Premier Care so she did not take part in the debate following the presentation.

HEA34 DOMICILIARY CARE IN HALTON

The Board received a presentation from John Regan, the Director of *Premier Care Limited*, Halton Borough Council's lead contracted domiciliary care agency, regarding domiciliary care provision in Halton.

Members were aware that one of the main drives over the past decade both locally and nationally had been to offer support to people in their own home for as long a period as was possible. One of the most effective ways to do this had been through offering care and support to people in their own home through a domiciliary care agency.

It was noted that over the past 12 months Halton had undertaken the re-procurement of domiciliary care provision within the Borough which had led to there being one main provider, Premier Care, delivering provision where there had previously been 9 providers. Although there was one main provider, the existing contract with Premier Care, along with 3 other incumbent providers, had been extended until 31 March 2018, to allow those agencies to work together to establish a robust sub-contracting arrangement and support and strengthen local market providers.

The presentation provided Members with details of how the current system of Domiciliary Care provision worked in Halton; an overview of implementation of the new contract arrangements; challenges being faced and how Premier Care and the Council were working together to maintain the delivery of high quality services.

Following the presentation the following responses were provided to Member's queries:

- The total number of care hours delivered was approximately 1500 in Runcorn and 2000 in Widnes;
- The same carers visited the same clients on most occasions; however there could be instances where this was not always possible;
- The Premier Care office was situated in Ashley House, Widnes;
- An in-house recruitment officer was available in Ashley House and recent recruitment of staff had taken place;
- The total number of staff TUPE'd was 81 and these staff received refresher training prior to starting their jobs; and
- Training within the branch took place each week and all staff received an induction as part of the training.

RESOLVED: That the Board note the report and presentation.

HEA35 PRESENTATION FROM CHIEF EXECUTIVE ON ONE HALTON PLACE BASED CARE

The Board received a presentation from the Chief Executive, David Parr, on '*One Halton Place Based Care'.*

The Board was advised that the aim of *One Halton* was to deliver a single fully integrated place based health, wellbeing and social care system for the people of Halton, that had wellness at its heart but also addressed the health and social care needs of the local community of Halton, wherever possible from within Halton, and was easy to access, cost effective, high quality and clinically robust.

It was announced that the plan was in its development phase and would build on the health and social care expertise that already existed in Halton. The delivery and support of the plan was discussed and it was noted that the Health and Wellbeing Board would be the Governing Body of the plan, responsible for scrutinising all consultation responses.

Also included in the presentation to Members was the *Healthy New Town Wellness Centre.* This was one of 10 demonstrator sites selected by NHS England but was unique, as it was the only site with a hospital at its centre. This opportunity was highlighted, in that it would enable Halton to create a Health and Wellbeing Campus at the very heart of Halton Lea.

Finally, the Board was informed of the arrangements that had been in place within NHS Halton CCG since 4 February 2018, following the departure of NHS Halton CCG's Interim Accountable Officer.

Following the presentation the Chair invited comments from Board Members and the following points were clarified:

- There would be four multi-discipline GP 'hubs', two in Runcorn and two in Widnes. No health centres would be closed or moved;
- The staff who will work in the hubs were already there, it would be a more efficient use of resources as they would be working differently;
- Although people may want to be seen by their GP when they were unwell, in most cases (after hearing GP feedback) they could be seen by other professionals, thus freeing up GP resources;
- Patient consultation and engagement sessions had

taken place which were documented and would continue to take place through 2018 in conjunction with Members and partners within the local health economy;

- Halton Council had submitted a £40m bid to improve Halton Hospital into the 2020's;
- The development of the Healthy New Town masterplan would take into consideration shops and services already available in the area;
- Halton General Hospital would only be demolished after the state-of-the-art Cheshire and Merseyside Treatment Centre had been extended to accommodate all services currently delivered in the Hospital.

Members were invited to discuss the One Halton Place Based Care plan further with the Chief Executive and the CCG and it was agreed that the presentation be sent to all 56 Members of the Council.

RESOLVED: That the Board notes the report and receives the presentation.

HEA36 SCRUTINY REVIEW REPORT – HEALTH IMPROVEMENT TEAM

The Board received the draft Scrutiny Review report of the Health Improvement Team (HIT).

Members were advised that the report was commissioned by the Health Policy and Performance Board and was considered a suitable topic considering the HIT had transferred to Council services in 2014, so they had time to evolve and embed the service over this time. A scrutiny review working group was established and support was given by a Principal Policy Officer from the policy team and the Divisional Manager – Integrated Wellbeing Services.

The report provided details of the participation and the activity of the group undertaken between June and November 2017. It was reported that six recommendations had been identified as a result of the topic group and approval for these was now sought so that they could be forwarded to the Executive Board. The recommendations were listed on page 31 of the agenda, which was paragraph 7 of the *Health Policy and Performance Board – Scrutiny Review of The Health Improvement Team (HIT)*, as attached at Appendix 1. Members agreed to endorse these recommendations going forward to Executive Board.

As part of Member involvement in the current business planning process Members were presented with a range of topic areas identified for consideration for scrutiny for the municipal year 2018/19, as described in paragraph 3.3.1 of the report. The Chair also invited suggestions from Members that were not listed in the report.

After discussion, the Board agreed that *Care Homes – Funding and Sustainability* would be the subject of the scrutiny topic group during 2018/19.

RESOLVED: That the Board

1) endorses the Scrutiny Review of the Health Improvement Team and its recommendations going forward to the Executive Board; and

2) agrees that the scrutiny topic group for 2018/19 is Care Homes – Funding and Sustainability.

HEA37 INTRODUCTION OF THE REFERRAL FACILITATION SYSTEM (RFS): UPDATE

The Board received an update on the introduction of the referral facilitation system in Halton, in light of the national digital programme.

It was reported that in October 2016, NHS Halton Clinical Commissioning Group's (CCGs) Governing Body approved an invest-to-save approach for the implementation of a Referral Facilitation System (RFS) as part of the CCG Quality Referral Programme. The process was to facilitate the transfer of primary care referrals to secondary care via a secure electronic Integrated Care Gateway (ICG).

A patient would then be offered a choice of secondary Care Provider via use of the national e-referral system (where it was available). The administration associated with e-referral i.e. contacting the patient and booking them into an appropriate clinic electronically, was then handled by the centralised Referral Management Centre (RMC) which was currently provided by Midlands and Lancashire Commissioning Support Unit (MLCSU).

The report discussed the national programme developments, since the implementation of the referral system in Halton. Further it discussed the implications for Primary Care and the RFS locally.

In response to Member's queries regarding proof of

referral and patient notification, it was noted that the referral would be recorded with the relevant GP's records and that the patient would still receive a letter as they did now, containing details of the appointment.

RESOLVED: That the report is noted.

HEA38 OLDER PEOPLE'S MENTAL HEALTH AND DEMENTIA CARE

The Board received an update on the impact of the reconfiguration of the older people's bed base within North West Boroughs Healthcare NHS Foundation Trust (NWBFT), following the closure of Grange Ward in the Brooker Centre.

It was noted that the model of care was implemented in 2012 for Older People with Dementia and Memory loss which was a high quality community service pathway, designed to support people in their own home for as long as possible. The objective was to re-design services for people in later life in order to ensure that effective, timely and personalised services were available, to support the growing number of people who would experience memory and cognitive loss and the onset of dementia.

Members were reminded of the proposals regarding the closure of the beds at Grange Ward, as explained in paragraph 3.7 of the report. The Ward closed in December 2016 and the existing patients within Grange Ward (3 at that time) were moved to other wards within the NWBFT footprint. It was reported that mitigations were put in place to support the transport needs of families to ensure access for visitors, and patient navigators were instigated to support the families. Additionally an Admiral Nurse Service and a Care Home Liaison Service was also commissioned, as described in the report.

The Board received the in-patient data for January 2017 to March 2017, and from April 2017 to September 2017. It was noted that the latest Delayed Transfers of Care lists (as at 18 January 2018) showed that there were no Halton in-patients currently delayed.

Following the update Members requested to know the total number of psychiatrists in Halton and whether support was still available for carers etc, who were having difficulties with travel arrangements; this information would be made available to Members following the meeting as it was not known.

Members reminded Officers that it was agreed previously, at the special meeting held in December 2016 to discuss this matter, that apart from patients, carers and their families being supported with their transport requirements, that the care navigator role would remain in place for the duration of the patient's intervention to support the multi-disciplinary professionals involved in the patients care including Social Workers; so they queried if this was still in place. A response would be sought and Members informed.

Director of Adult Social Services

RESOLVED: That the report be noted.

HEA39 ALL-AGE AUTISM STRATEGY

Members received an update on the Halton *All-Age Autism Strategy*, which was appended to the report in its current draft version.

It was reported that this was developed in 2012 and since this there had been a number of national publications relating to Autism that needed to be taken into consideration. Also Halton took part in the Autism Self-Assessment Framework (SAF) which was completed at the end of 2016. Following this, a working group was established in July 2017 to move forward with planning a new All Age Autism Strategy; the work carried out by the group was discussed in the report.

Appended to the Strategy was the Delivery Plan for 2018-2019, together with the following 4 Appendices:

1. The Voice of Autism – Ashley High School;
2. Consultation with Schools;
3. Summary of Sims Cross Resource Base questionnaire to parents; and
4. Children's Services Diagnostic Pathway.

Members welcomed the strategy and discussed instances where people had gone undiagnosed up to adulthood in the past, which had caused them varying problems. In response it was noted that the development of the All-age Autism Strategy aimed to take a more joined up and holistic approach to developing opportunities and realising potential for people with Autism at every stage of their lives.

Members commented that some children could miss out on a diagnosis as the Strategy would only be implemented in the Borough's maintained schools. Further, there were no timescales with regards to referrals and

parents would want to know this type of information.

The Board asked for clarity on the position with regards to the Youth Justice Service and speech and language therapy not being available in Halton. This information would be made available to Members following the meeting as it was not known.

RESOLVED: That the Board notes the contents of the report and associated appendices and the comments made regarding this.

Director of Adult Social Services

HEA40 TOP-UP FEES

The Board was introduced to the new Policy for '*Additional Payments for Accommodation in Residential Care'* (Top-Up Fees); this was appended to the report.

The Board was advised that the Care Act now included a framework for the implementation of Care Home top-up fees. A 'top-up fee' was described as being the difference between what the local authority would usually expect to pay (depending on a person's care needs) and the extra cost of a specific care home. The additional cost was reflected in an additional service or added value. The top-up fees could apply if a person chose a care home that was more expensive than the Council agreed rate, including circumstances where a person had been paying for their own care under a private arrangement.

The report outlined the procedures relating to top-up fees and a person's right to choose between providers. It also advised of the 9 providers in the Borough who had implemented top-up fees so far.

It was noted that the Policy would be reviewed in the Summer of 2018 in light of the expected Government Green Paper on care and support for older people.

Following presentation of the paper, the following points were made in response to Member's queries:

- The amounts referred to in the table in paragraph 3.7 were weekly payments;
- The top-up payments could be made by a third party, e.g. a family member;
- There were 15 care homes for older people in Halton and 7 specialist care homes with individually agreed fees;
- The care homes could increase their fees on a yearly

basis, following consultation with the Council;

- Before a person's funding reduced to £23,500, relatives were encouraged to request a review of care of the resident; and
- Out of Borough placements were still funded by the Council as they were the responsible authority.

Members also requested to know whether the funding available affected the accommodation choices the Council made; and whether there were any interest and administration charges applied and if so, at what point were they applied. Officers would respond once this information was available.

RESOLVED: That the Board notes the report and appendix. — Director of Adult Social Services

HEA41 PERFORMANCE MANAGEMENT REPORTS, QUARTER 3 2017/18

The Board received the Performance Management Reports for Quarter 3 of 2017/18.

Members were advised that the report introduced, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to health in Quarter 3, which included a description of factors which were affecting the service.

The Board was requested to consider the progress and performance information and raise any questions or points for clarification and highlight any areas of interest or concern for reporting at future meetings of the Board.

It was noted that the financial information presented in the reports was Quarter 3 so was not up to date. Officers advised that the financial recovery plan was in place to ensure the budget came out on target. The Board asked for more up to date information on the budget position and year end projection.

The Chair advised that more detailed commentary under the *'key observations/milestones'* headings of the report was required in the future.

RESOLVED: That the Quarter 3 priority based reports be received. — Director of Adult Social Services

Meeting ended at 9.00 p.m.

REPORT TO: Health Policy & Performance Board

DATE: 19 June 2018

REPORTING OFFICER: Strategic Director, Community & Resources

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To consider any questions submitted by the Public in accordance with Standing Order 34(9).

1.2 Details of any questions received will be circulated at the meeting.

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

3.1 Standing Order 34(9) states that Public Questions shall be dealt with as follows:-

(i) A total of 30 minutes will be allocated for dealing with questions from members of the public who are residents of the Borough, to ask questions at meetings of the Policy and Performance Boards.

(ii) Members of the public can ask questions on any matter relating to the agenda.

(iii) Members of the public can ask questions. Written notice of questions must be given by 4.00 pm on the working day prior to the date of the meeting to the Committee Services Manager. At any one meeting no person/organisation may submit more than one question.

(iv) One supplementary question (relating to the original question) may be asked by the questioner, which may or may not be answered at the meeting.

(v) The Chair or proper officer may reject a question if it:-

- Is not about a matter for which the local authority has a responsibility or which affects the Borough;
- Is defamatory, frivolous, offensive, abusive or racist;
- Is substantially the same as a question which has been put at a meeting of the Council in the past six months; or
- Requires the disclosure of confidential or exempt information.

(vi) In the interests of natural justice, public questions cannot relate to a planning or licensing application or to any matter which is not dealt with in the public part of a meeting.

(vii) The Chairperson will ask for people to indicate that they wish to ask a question.

(viii) **PLEASE NOTE** that the maximum amount of time each questioner will be allowed is 3 minutes.

(ix) If you do not receive a response at the meeting, a Council Officer will ask for your name and address and make sure that you receive a written response.

Please bear in mind that public question time lasts for a maximum of 30 minutes. To help in making the most of this opportunity to speak:-

- Please keep your questions as concise as possible.
- Please do not repeat or make statements on earlier questions as this reduces the time available for other issues to be raised.
- Please note public question time is not intended for debate – issues raised will be responded to either at the meeting or in writing at a later date.

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton** - none.

6.2 **Employment, Learning and Skills in Halton** - none.

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

6.5 **Halton's Urban Renewal** – none.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background papers under the meaning of the Act.

REPORT TO: Health Policy and Performance Board

DATE: 19 June 2018

REPORTING OFFICER: Chief Executive

SUBJECT: Health and Wellbeing minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Wellbeing Board from its meeting on 17 January 2018 are attached for information.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

5.2 **Employment, Learning and Skills in Halton**

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background papers under the meaning of the Act.

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 17 January 2018 at The Halton Suite - Select Security Stadium, Widnes

Present: Councillors Polhill (Chair), T. McInerney, Woolfall and Wright and N. Atkin, C. Carlin, P. Cook, S. Ellis, A. Fairclough, G. Ferguson, T. Hemming, T. Hill, A. McGee, E. O'Meara, I. Onyia, D. Parr, M. Pearson, C. Samosa, R. Strachan, D. Sweeney, l. Thompson, S Wallace-Bonner and S Yeoman.

Apologies for Absence: M. Larking, D. Parr, H. Patel

Absence declared on Council business: None

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB19 MINUTES OF LAST MEETING

The Minutes of the meeting held on 4th October 2017 having been circulated were signed as a correct record.

HWB20 WELL NORTH UPDATE - CHRIS CARLIN

The Board received a presentation from Chris Carlin, a representative of Halton CCG, who provided an outline of the work as part of the Well North funding programme. Well North was a partnership between Public Health England (PHE), The University of Manchester and Manchester Academic Health Science Centre; local authorities, NHS organisations, business (both big and small), community, voluntary and enterprise organisations.

The Well North principles were to:

- Address inequalities by improving the health of the poorest, fastest;
- Increase resilience at individual, household and community levels; and
- Reduce levels of worklessness.

The Board was advised that Well Halton was one of

ten regional “pathfinder” sites across the North and a place based approach had been adopted that built upon the unique nature of the Borough and capitalised on Halton’s many assets. Details of the unique projects which were being developed in various neighbourhoods, each being co-produced with the community, VCSE providers, agencies and private sector partners, were outlined in the report.

During the first year of the Well North Halton programme, the following five strategic goals had been set:-

- To create a Community Hub at Windmill Hill;
- Harness the reach of the Widnes Vikings Generate Positive Change;
- Identify and develop worldwide initiates;
- Unit Halton Brook’s assets in a campus approach; and
- Create a social business hub in Runcorn Shopping City.

It was noted that as part of the second year of the funding programme it was agreed to continue with the five strategic goals and to expand the stem/science partnerships with Sci-Tech Daresbury and Catalyst Museum. The presentation also provided Members with an outline of how the budget had been allocated during the first year of funding.

Members were also invited to contact Chris Carlin in order to visit any of the sites which were included in the presentation.

RESOLVED: That the contents of the presentation and the review of the draft plan be noted.

HWB21 UPDATE ON DEVELOPMENTS IN HALTON ADULT MENTAL HEALTH SERVICES

The Board considered a report of the Director of Adult Social Services, which provided an update on some of the changes to service delivery that had been taking place in Halton in the past two years with regard to Halton Adult Mental Services. In 2015 a whole-scale review of the way in which mental health services were delivered across the footprint of the 5Boroughs Partnership NHS Trust was commissioned by the combined Clinical Commissioning Groups (CCG’s) covering Halton, St. Helens, Knowsley, Warrington and Wigan.

The Board was advised that the review produced a

set of recommendations covering five key areas and these themes and recommendations that came from them were largely accepted by the CCGs and their partner agencies. Consequently, work streams were set up to put the recommendations into place. In Halton it was reported that the following developments had taken place in mental health services during the past two years:-

- work had taken place locally to implement recommendations of the report in a way which created positive change for the people of Halton. The NHS Halton CCG, supported strongly by the Council, had led Task and Finish Groups with all key partners to establish clear, care pathways through the mental health system;

- within the North West Boroughs NHS Trust, there had been considerable local redesign;

- there had been some changes to the delivery of Social Care Services for people with mental health problems in the Borough; and

- the use of the Mental Health Resource Centre in Vine Street, Widnes had been redesigned;

- the Mental Health Outreach Team had been redesigned and positive results were being reported.

RESOLVED: That the report be noted.

HWB22 CQC LOCAL SYSTEM REVIEW OF HEALTH AND SOCIAL CARE IN HALTON

The Board considered a report of the Director of Adult Social Services, which provided an update on the Care and Quality Commission (CQC), Local System Review (LSR) of Health and Social Care in Halton. The review took place in August 2017 and examined how people moved between health and social care, including delayed transfers of care, with a particular focus on people of 65 years old in Halton. The review included an assessment of commissioning across the interface of health and social care and of the governance systems and processes in place in respect of management resources. Although the review did not include mental health services or specialist commissioning specifically, they did look at the experiences of people living with dementia.

Members noted that the final report from the CQC

was published on 12th October following a Quality Summit which took place at the Stadium on the 11th October, which was attended by representatives from across partner agencies. The summary of the findings of the CGC review were set out in the report, together with the areas identified by CQC where they felt improvements could be made. As a system, Halton was required to submit a system-wide action plan to CQC by 9th November. Consequently, working collaboratively across our statutory partners and with support from Social Care Institute for Excellence, an associated Action Plan was developed in response to the issues highlighted within the report.

It was reported that progress against the actions outlined in the Action Plan would be monitored over the next few months by the Health and Wellbeing Board and Halton Borough Council's Management Team.

RESOLVED: That the report and associated appendices be noted.

HWB23 CARE QUALITY COMMISSION- LOCAL SYSTEM REVIEW ACTION PLAN (HEALTH AND WELLBEING BOARD ACTIONS)

The Board considered a report of the Director of Public Health, which provided an update on progress against actions from the CQC Action Plan relating to the Health and Wellbeing Board. During the summer 2017, CQC were commissioned by the Secretaries of State for Health and Communities and Local Government, to undertake a programme of target system reviews in 12 local authority areas; Halton was selected as the first area for one of these reviews. Following the publication of the review on 12th October 2017, an action plan, with a number of themes, was developed in response to issues highlighted in the report. Under the theme of Strategic Vision and Governance the following action was developed for the Health and Wellbeing Board:

Review role of Halton's Health and Wellbeing Board to ensure that there was enhanced challenge across the Health and Social Care system.

In order to respond to this action, a number of areas for development were identified to be presented to the Board. These were as follows:

- revised Membership (to include GP Federations). A copy of the revised membership list was included in

the report;

- review Terms of Reference;
- format of Future Meetings to include Board development;
- performance Dashboard which would focus on the local system performance (to include Delayed Transfers of Care and the performance against the national standard for A and E) and highlight system risks.

RESOLVED: That

(1) the contents of the report and associated documents be noted;

(2) the proposed approach and revised Terms of Reference be agreed; and

(3) update reports be brought to future meetings of the Board. — Director of Public Health

HWB24 PHARMACEUTICAL NEEDS ASSESSMENT

The Board considered a report of the Director of Public Health, which provided Members with the final version of the Pharmaceutical Needs Assessment (PNA) and a briefing on the results of the statutory 60-day consultation. Following the period of consultation, the Steering Group met on the 17th October 2017 and agreed that the PNA should be submitted to the Health and Wellbeing Board as the final version. The following next steps were proposed:-

- the PNA must be published no later than 1st April 2018;
- the attached version of the PNA was approved as the publication version;
- the PNA should be uploaded onto the Council's website;
- key stakeholders and the public would be advised accordingly; and
- the Steering Group would meet periodically to produce supplementary statements during the lifetime of the PNA.

RESOLVED: That

(1) the PNA be approved for publication; — Director of Public Health

(2) the Steering Group be delegated to deal with a

production of supplementary statements needed throughout the lifetime of the PNA;

(3) the continuation of Healthy Living Pharmacies be supported;

(4) the use of New Medicine Reviews and Medicine Management Reviews by pharmacists in Halton be supported; and

(5) Pharmacists in their stewardship role on prescribing of antibiotics be supported.

HWB25 SAFEGUARDING ADULTS BOARD ANNUAL REPORT

The Board considered a report by the Independent Chair of the Halton Safeguarding Adults Board (SAB), which outlined the Annual Report 2016/17. The focus of work activity addressed SAB's priorities as identified from the 2015-2016 Annual Report, Performance Framework and Strategic Plan (2016-2018). In addition to acknowledging local and national safeguarding adults emerging issues/trends/policies throughout the year.

The report provided a summary analysis of the data gathered from both CCG and the Council Safeguarding Adults Collection and highlighted how this information informed the work priorities for 2017 – 2018. It was noted that the Halton Safeguarding Adults Board had agreed the three priority areas of work for the forthcoming year:-

- creating a safer place to live for all adults living in Halton (Safeguarding Prevention);
- providing the skills and knowledge to enable genuine care and understanding for adults at risk of harm (awareness raising and training);
- gaining a greater understanding of how mental health can impact adults at risk being protected and cared for in the best possible way (mental health).

These priorities would help shape the activity of SAB and SAB sub groups and key partners for 2017/2018 to enable the Board to continue to meet its strategic aims.

RESOLVED: That the report and associated Appendix be noted.

HWB26 ONE HALTON AND THE DEVELOPMENT OF AN ACCOUNTABLE CARE SYSTEM

The Board considered a report of the Chief Executive, which provided an update on One Halton and the Development of an Accountable Care System (ACS).

The Board was advised that an ACS was one in which several social and health care organisations provided all health and social care for a given population. There were three core elements to the system and significantly, the ACS would centre on the involvement of general practitioners in the network of providers delivering care along with local authorities and providers and commissioners of services.

In 2014/15 the Council committed to the development of an integrated model of health and social care, and agreed a shared vision – One Halton. The development of an ACS fits the original One Halton concept, delivering across the Halton Local Authority footprint. The revised Halton Accountable Care Strategic Vision, attached at Appendix 1, built on an initial commitment of partners to improve the delivery of health and social care provision. It was reported that to achieve the ACS, partners had established the One Halton Accountable Care system, with a memorandum of understanding and terms of reference, both of which were attached at Appendix 2 and 3 respectively. These documents underpinned the commitment to move towards the more integrated community based system, which reduced the demand on acute services and provided care closer to home.

At its meeting on 14th December 2017, the Executive Board endorsed the revised One Halton strategic vision and governance structure as described and approved the recommendations as highlighted in the report.

RESOLVED: That

(1) the One Halton (ACS) Vision, be endorsed;

(2) the memorandum of understanding for the One Halton Accountable Care System Board be agreed; and

(3) the Terms of Reference for the One Halton Accountable Care System Board be agreed.

HWB27 DATES OF FUTURE MEETINGS

The following dates of future Health and Wellbeing Board Minutes were circulated to the Board:

The Board was provided with dates of future Board Meetings to 31st March 2019. All meetings were at 2pm in the Halton Stadium, Widnes.

RESOLVED: That the dates of future meetings be noted.

Meeting ended at 3.20 p.m.

REPORT TO:	Health Policy & Performance Board
DATE:	19th June 2018
REPORTING OFFICER:	Strategic Director – People
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Health Policy and Performance Board Annual Report : 2017/18
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Health Policy and Performance Board's Annual Report for April 2017 - March 2018.

2.0 **RECOMMENDATION: That the Board:-**

i) note the contents of the report and associated Annual Report (Appendix 1).

3.0 **SUPPORTING INFORMATION**

3.1 During 2017/18, the Health Policy and Performance Board has examined in detail many of Halton's Health and Social Care priorities. Details of the work undertaken by the Board are outlined in the appended Annual Report.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications arising directly from the Annual Report. Any policy implications arising from issues included within the Annual Report will have been identified and addressed throughout the year via the relevant reporting process.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 As with the policy implications, there are no other implications arising directly from the report. Any finance implications arising from issues included within it would have been identified and addressed throughout the year via the relevant reporting process.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**
There are no specific implications as a direct result of this report however the health needs of children and young people are an integral part of the Health priority.

6.2 **Employment, Learning & Skills in Halton**
None identified.

6.3 **A Healthy Halton**
The remit of the Health Policy and Performance Board is directly linked to this priority.

6.4 **A Safer Halton**
None identified.

6.5 **Halton's Urban Renewal**
None identified.

7.0 **RISK ANALYSIS**

7.1 None associated with this report.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None associated with this report.

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

9.1 None under the meaning of the Act.

Health Policy and Performance Board

Annual Report

April 2017 - March 2018

In last year's annual report, I referenced the fact that I was looking forward to 2017/18 and the continued challenge of ensuring that the quality of health and social care services within Halton continues to be of the highest standard; this has certainly been the case!

During the course of the year, the Board have continued to be actively involved and consulted on a range of issues including a number of proposed changes to services. This has included changes to Stroke Services available to Halton residents and the work undertaken to align General Practice to Care Homes in Halton.

The Board have also had the opportunity to comment on a number of proposals and developments including the work being undertaken to develop One Halton Place Based Care and we will continue to follow developments associated with this very closely.

Visits to Learning Disability Services took place during April 2017 – I would personally like to pass on the Board's thanks to everyone working in Learning Disability Services for all their hard work, commitment and dedication to delivering high quality services.

I would also like to take this opportunity to acknowledge the help and assistance the Board receives from our Lead Officer, Sue Wallace Bonner and recognise the work of Council Officers and those in Partner organisations, who provide the Board with reports and information throughout the year in support of the Board scrutiny role.

Finally I would like to thank all Members of the Board for their valued contribution and support to the Board's work over the last 12 months, particularly in respect to this year's Board scrutiny review in relation to the Health Improvement Team Service.

It has certainly been a very busy year! However you can be assured that during 2018/19, we will continue to work across the health and social care economy to foster a culture of quality and continuous improvement for the residents of Halton.

Cllr Joan Lowe, Chair

Health Policy and Performance Board Membership and Responsibility

The Board:

Councillor Joan Lowe (Chairman)
Councillor Shaun Osborne (Vice-Chairman)
Councillor Sandra Baker
Councillor Mark Dennett
Councillor Margaret Horabin
Councillor Charlotte Gerrard
Councillor Stan Parker
Councillor Martha Lloyd Jones
Councillor Ellen Cargill
Councillor Pauline Sinnott
Councillor Marjorie Bradshaw

During 2017/18, Tom Baker was Halton Healthwatch's co-opted representation on the Board and we would like to thank Tom for his valuable contribution.

The Lead Officer for the Board is Sue Wallace-Bonner, Director of Adult Social Services.

Responsibility:

The primary responsibility of the Board is to focus on the work of the Council and its Partners, in seeking to improve health in the Borough. This is achieved by scrutinising progress against the aims and objectives outlined in the Council's Corporate Plan in relation to the Health priority.

The Board have met four times in 2017/18. Minutes of the meetings can be found on the Halton Borough Council website. It should also be noted that the Board, at each of their meetings, receive and scrutinise the minutes from Halton's Health and Wellbeing Board and monitors work/progress within this area.

This report summarises some of the key pieces of work the Board have been involved in during 2017/18.

GOVERNMENT POLICY- NHS AND SOCIAL CARE REFORM

Physician Associates

The Board received an interesting presentation from Warrington and Halton Hospitals NHS Foundation Trust regarding the background to the development and use of Physician Associates within the Health Service. Physician Associates (PAs) are typically life sciences graduates (with a pre-medical degree) who move on and do a two year postgraduate clinical diploma course.

The Board were keen to get assurances that the PAs are not taking the place of doctors. PAs are working alongside doctors and when on duty work under the direct supervision of doctors and they are actively contributing to the skill mix of professionals within the Health Service.

SERVICES

Homelessness Service

In June 2017, the Board received an update on the work of the Council's Housing Solutions Team which focused on recent developments within the homelessness service and details of recent/anticipated legislative changes and the impact this would have in Halton, particularly in respect of the Homelessness Reduction Bill, which is to be introduced from April 2018.

The Team continue to proactively work with individuals and families in assisting and preventing people from becoming homeless in the Borough.

Councillor Ron Hignett was in attendance for the update to the Board and he conveyed his thanks to the Homelessness Housing Solutions Team for their hard work and dedication to the service; this was echoed by members of the Health PPB.

NorthWest Ambulance Service (NWAS) NHS Trust

The Board received a presentation from NWAS, updating them on the key issues arising from the Care Quality Commission's (CQC) inspection report published in January 2017, together with specific issues in respect of Halton.

The Board were keen to hear about the progress being made to address the recommendations within the CQC report, especially in respect of the recruitment of additional paramedics, and how work is continuing on improving performance in relation to responses times to calls within Halton.

Halton Urgent Care Centres (UCCs)

The Board was pleased to receive an update report on the activity being undertaken at Halton's UCCs since they opened in 2015. Information was provided which

outlined an increase in the utilisation of the UCCs by local people since their opening.

Both UCCs are well within the A&E 4 hour wait targets, with in excess of 99% of patients receiving treatment within 4 hours.

Each of the UCCs obtain feedback from Service Users via the completion of patient satisfaction questionnaires. These questionnaires are then used to generate a Friends and Family score for each Centre. The Board was pleased to hear how the score for both UCCs has been consistently above 90% since their opening, as well as the fact that over the last two years A&E attendances to Whiston and Warrington A&E Departments have fallen by 5.8%.

General Practice Alignment to Care Homes

In 2016/17, the Board received details of the work proposed on aligning care homes within the Borough with identified General Practices. As outlined in last year's annual report the consensus of the Board was that this was a good idea, however wanted to see the results of the public consultation.

A report was presented back to Board in June 2017 which outlined that overall there had been overwhelming support for the proposals following the extensive consultation exercise. A number of individuals responded that they didn't agree with the proposals due to patient choice around registered GP. However, the proposal maintained that patient choice is paramount. Residents in Care Homes will not have to change registered GP, if they do not wish to do so. The Board gave their formal support to the proposal.

Windmill Hill General Medical Services

The Board welcomed a report from NHS Halton Clinical Commissioning Group (CCG) in June 2017 which outlined the outcome of the work undertaken to support the transfer of patients to alternative practices as a result of the GP practice at Windmill Hill having to close at the end of March 2017.

The Board were pleased to hear that the transfer of patients was a success with no problems being reported and as such NHS Halton CCG conveyed their thanks to the residents of Windmill Hill and others affected, as they had completely embraced the changes, which contributed to the success of the process; this thanks was echoed by the Board.

Stroke Services

Members received an update on the Stroke Reconfiguration that was taking place in Mid-Mersey.

The Board were informed about the extensive Patient and Public engagement sessions that had been held across, Warrington, Halton and St Helens localities regarding the changes and were provided with details regarding the main themes of the concerns raised by people; these included concerns over the loss of local services and ability to travel.

The Board acknowledged that the changes had been made without undertaking formal consultation because of a risk to the safety and welfare of patients in respect of the current service delivery model.

However, the Board will continue to monitor developments in this area to ensure that our residents receive high quality services in relation to Stroke Services.

Halton Older People's Empowerment Network (OPEN)

The Board received a presentation from representatives of Halton OPEN regarding the valuable work that they do in the Borough. Halton OPEN was established in 2001 and has become the collective voice of people aged 50 plus who live and work in Halton. Presently the membership is over 1,100 members. Their aim is to influence and encourage the development of services which can help to improve the quality of life and wellbeing of all older people in Halton. Halton OPEN work with other agencies in the Borough including Age UK Mid Mersey, NHS Halton CCG and Halton Partners in Prevention. The Board heard about and discussed the main issues affecting older people in Halton such as access to public transport; financial issues such as pensions, fuel bills and benefits, isolation/loneliness and health and wellbeing.

Halton Safeguarding Adults Board (HSAB) Annual Report 2016/2017

The Board received information, from the Chair of the HSAB, regarding activities during 2016/17 and the work priorities for 2017/8 as follows:-

1. Creating a safer place to live for all adults living in Halton;
2. Providing the skills and knowledge to enable genuine care and understanding for adults at risk of harm; and
3. Gaining a greater understanding of how mental health can impact adults at risk being protected and cared for in the best way possible.

One Halton Place Based Care

David Parr, Chief Executive of Halton Borough Council attended the Board to outline plans in relation to One Halton Place Based Care.

The Board was advised that the aim of One Halton was to deliver a single fully integrated place based health, wellbeing and social care system for the people of Halton, that had wellness at its heart but also addressed the health and social care

needs of the local community of Halton, wherever possible from within Halton, and was easy to access, cost effective, high quality and clinically robust.

The plan is in its development phase and would build on the health and social care expertise that already existed in Halton. As part of David's presentation the Board also heard about the development of the Healthy New Town Wellness Centre. This is one on 10 demonstrator sites selected by NHS England but was unique, as it was the only site with a hospital at its centre. This opportunity was highlighted, in that it would enable Halton to create a Health and Wellbeing Campus at the very heart of Halton Lea.

The Board will be closely following developments in this area.

Domiciliary Care in Halton

In February 2018, the Board welcomed John Regan, the Director of Premier Care Limited, who following an extensive re-procurement exercise of domiciliary care provision within the Borough, had since October 2017 became the lead contracted domiciliary care agency for domiciliary care provision in Halton.

The presentation given by John provided the Board with details of how the current system of Domiciliary Care provision worked in Halton, an overview of implementation of the new contract arrangements, challenges being faced and how Premier Care and the Council were working together to maintain the delivery of high quality services.

Older People's Mental Health & Dementia Care

Following two reports presented to the Board in 2016 regarding the changes to the Northwest Boroughs Partnership NHS Foundation Trust inpatient services for older people and adults in Halton, the Board were keen to understand the impact that these changes have had, as the new arrangements had now been in for approximately 12 months.

The Board were pleased to receive information to say that the changes were proving to be successful and that the mitigations planned to support the transport needs of families to ensure access for visitors had been successful and were still in place, along with the addition of the Admiral Nurse Service and a Care Home Liaison Service.

POLICY

Referral Facilitation System

During 2017/18 the Board received updates from NHS Halton CCG regarding the introduction of a Referral Facilitation System (RFS).

RFS is a process where primary care referrals are made to secondary care via a secure electronic Integrated Care Gateway. The patient is then offered a choice of

secondary care provision via use of the national e-referral system. As part of RFS's implementation a clinical triage process was also to be introduced.

The Board were pleased to hear how the new process will ensure that all referrals are securely communicated to secondary care with all the correct information provided thus avoiding delays. The new process will also provide much more assurance for patients that they will be booked into the appropriate clinic, as this is specified as part of the referral process, thus reducing the occurrence of inappropriate appointments and the potential for multiple clinic visits prior to getting the treatment needed.

Medication Policy
The Board was very pleased to receive details of the new overarching Medication Policy for the Borough Council. The Medicines Management Team of NHS Halton CCG led the development of the policy due to the technical knowledge required to appropriately advise services of safe and effective practice.

Blue Bade Policy
The Board received details of the review that had taken of the Blue Badge Policy.

Details were provided to the Board on the changes that had been made to the Policy as a result of the review and how it had been amended to take into account two key issues that had arisen during the review process, as follows;-

- Enforcing the correct use and tackling abuse of the scheme; and
- The eligibility requirements for organisational badges

Procedures of Lower Clinical Priority
The Board received details of the work taking place across a number of CCGs in parts of Cheshire and Merseyside regarding the development of a core set of Procedures of Lower Clinical Priority (PLCP). At the moment, the criteria for these procedures vary between areas, which can cause differences in availability for patients. Nationally, the NHS believes that by having a more standardised set of policies, which are more consistent across the region, a more equal service for patients can be delivered.

PLCPs are routine procedures that have some clinical value, but only in certain circumstances, and so might not offer the best medical outcomes to patients - they are known to have medical benefit only in very specific situations or for a small group of people.

As a result, some of the criteria has/will be reviewed and may mean that fewer patients have access to these services, as their clinical circumstances will no longer meet with the evidence base for revised clinical eligibility for treatment.

There are more than a hundred policies being reviewed and the Board will keep this review under close scrutiny and be requesting that NHS Halton CCG report back to the Board in 2018/19 regarding progress in this area.

Halton Gypsy Travellers Pitch Allocations Policy

The Board noted that the Policy is reviewed annually to ensure it is current and fully compliant with legislation. In addition to the Allocations Policy, the Board were provided with an update with regards to the current accommodation sites within Halton that were owned and managed by the Borough Council in addition to privately owned sites. In addition to the Allocations Policy, the Board were provided with an update with respect to the illegal encampment procedure which had been jointly devised between the Borough Council and the Police.

Halton Suicide Prevention Strategy

The Director of Public Health attended the Board to provide members with an update in respect to Halton's Strategy, its vision, areas for action, outcomes and key achievements.

The Board acknowledges that suicide is a major public health issue and each suicide in Halton is an individual tragedy and a terrible loss to our local families and communities. Although it is reported that the numbers of people who take their own life in Halton each year are low, those ending their own life should be viewed as the tip of the iceberg, and as such the Board appreciate that locally levels of distress and suicide attempts would be much higher and as such there is still a need for continuing vigilance and action around suicide prevention.

Telecare Charging Policy

The Board were provided with details on the updated Telecare Charging Policy and Procedure. The Halton Telecare Service (formally Lifeline) has now been established for over 27 years. During this time, the Telecare service has grown from a static onsite warden service to a fully operational, assessment, installation and response service. Telecare has the potential to benefit people who may need care and support by increasing their confidence and helping them to remain in their own homes. The service is for people who feel at risk or vulnerable in their own homes and people chose to use the service for a variety of reasons as discussed in the report.

All Age Autism Strategy

The Board welcomed an update on the Halton All-Age Autism Strategy.

The original Autism Strategy was developed back in 2012 and since this there had been a number of national publications relating to Autism that needed to be taken into consideration. Members were pleased to see how the new All-Age Autism

Strategy in Halton aims to take a more joined-up and holistic approach to developing opportunities and realising potential for people with Autism at every stage in their lives.

Top Up Fees

In February, the Board received details of the new Policy for 'Additional Payments for Accommodation in Residential Care' (Top-Up Fees).

A 'top-up fee' is basically the difference between what a local authority would usually expect to pay (depending on a person's care needs) and the extra cost of a specific care home. The additional cost is reflected in an additional service or added value.

Members of the Board were advised that the Care Act now included a framework for the implementation of Care Home top-up fees. The top-up fees could apply if a person chose a care home that was more expensive than the Council agreed rate, including circumstances where a person had been paying for their own care under a private arrangement.

The Board were advised that 9 Care Home providers in the Borough have implemented 'top-up fees' so far.

SCRUTINY REVIEWS

Health Improvement Team Service

The Health Improvement Team service scrutiny topic examined the work of the division, its contribution to health and wellbeing outcomes, how priorities are determined, what performance measures were made and how success is celebrated.

As a result of the scrutiny review, the Board concluded that the Health Improvement Team was a well-run, effectively structured and widely respected service.

Recommendations made by the Board revolved around minimal service improvement opportunities, but identified a clear need for wider strategic focus on maintaining services into the future. These recommendations will now go forward to the Council's Executive Board.

PERFORMANCE

The Health Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. Therefore, in line with the Council's performance framework, during the year the Board has been provided with thematic reports which have included information on progress against key performance indicators, milestones and targets relating to Health.

INFORMATION BRIEFING

During 2017/18 the Board continued to receive an Information Briefing Bulletin in advance of each of the Board meetings.

The Information Briefing is a way of trying to manage the size of the agendas of the Board meetings better. Including information on topics which were previously presented to Board as reports only for the Board's information now into the Information Briefing bulletin allows the Board to focus more on areas where decisions etc. are needed.

Example of areas that have been included in the Information Briefing over the last 12 months have included:-

- Local Account 2016/17
- Community Pharmacy Update
- Quality Accounts Event: April 2017
- Adult Social Care Charging Policy
- Tobacco Control Plan for Halton
- Deprivation of Liberty Safeguards (DOLS)

WORK TOPICS FOR 2018/19:

At the Board's meeting in February 2018, a number of topics were considered for scrutiny.

However, due to developments and challenges faced by the Care Home sector, the Board agreed that during 2018/19 they would examine the funding and sustainability of Care Homes in Halton.

Report prepared by Louise Wilson, Development Manager – Urgent and Integrated Care, People Directorate
Email: louise.wilson@halton.gov.uk Tel: 0151 511 8861

REPORT TO:	Health Policy & Performance Board
DATE:	19th June 2018
REPORTING OFFICER:	Strategic Director, People
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Bridgewater Community Healthcare NHS Foundation Trust.
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To receive a presentation from Dr Andrew Davies, Clinical Chief Officer, NHS Halton Clinical Commissioning Group (CCG) on Bridgewater Community Healthcare NHS Foundation Trust.

2.0 **RECOMMENDATION: That the Board:**

i) note the contents of the report and associated presentation.

3.0 **SUPPORTING INFORMATION**

3.1 During 2017/18 NHS Halton CCG had in place a contract with Bridgewater Community Foundation Trust and during that period a number of clinical quality concerns had been raised with the trust, specifically around leadership, workforce and sustainability.

3.2 The CCG has been working with other commissioners in a collaborative commissioning forum to agree arrangements that will reinforce and continue to build upon the services provided by Bridgewater by addressing the issues associated with the health and well-being of the residents of Halton.

4.0 **POLICY IMPLICATIONS**

4.1 None identified.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None identified.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**
None identified.

6.2 **Employment, Learning & Skills in Halton**
None identified.

6.3 **A Healthy Halton**
The presentation provided to the Board will directly link to this priority.

6.4 **A Safer Halton**
None identified.

6.5 **Halton's Urban Renewal**
None identified.

7.0 **RISK ANALYSIS**

7.1 None associated with this report.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified.

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

9.1 None under the meaning of the Act.

REPORT TO: Health Policy and Performance Board

DATE: 19th June 2018

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Children, Education and Social Care
Health & Wellbeing

SUBJECT: Everyone Early Help Strategy 2018-2021

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the new Everyone Early Help Strategy that combines children, adults and public health.

2.0 **RECOMMENDATION: That**

i) The content of the strategy is discussed and comments invited.

3.0 **SUPPORTING INFORMATION**

3.1 Services to support children, families and vulnerable adults are facing unprecedented challenges. It is obvious that Early Help and Prevention services should make up the cornerstone of any delivery model. If low-level needs can be prevented (or delayed) from developing into more serious or acute needs then this is win-win. Effective, early help and prevention can not only increase independence, improve outcomes and the quality of life for individuals, but also provide a financial return to the Local Authority in the form of cost avoidance and a reduction in the use of more expensive, acute resources.

3.2 This transformation in thinking is about undertaking a whole system review of the approach to Early Help and Prevention, with a focus on increasing the resilience of communities and their potential to help themselves, supported by a planned prioritisation of resources, integration, collaboration, and understanding the benefits that Early Help can have on a wide range of longer term outcomes for everyone involved.

Halton's Approach

3.3 There is a long standing and strong commitment to early help and prevention across all agencies and strategic partners in Halton.

Within Halton during 2016/2017 the council restructured to combine the adult and children directorate to create a People's directorate. Both of the existing directorates had in place a prevention/ early intervention strategies but it was agreed to the creation of a new joint Early Help strategy that would sit across the new People Directorate.

3.4 In response to the range of national and local policy developments, this new strategy for Early Help represents a refresh of our approach and reflects our desire for an integrated approach to Early Help across children,' adults and older people's services and public health as part of a whole Council approach.

3.5 Halton's definition of "early help and prevention" across children's and adults' services and public health can be described as:

"Supporting communities to prevent and reduce need at the earliest stage whilst taking targeted action as soon as possible to tackle emerging situations, where there is a risk of a person developing problems. Early intervention may occur at any point in a person's life".

3.6 Within the strategy there are five key aims

1) More children and young people will lead healthy, safe lives and will be given the opportunity to access education and develop the skills, confidence and opportunities they need to achieve their full potential;
2) More adults will have the support they need to live their lives as healthily, successfully, independently and safely as possible, with good timely access to health, mental health and social care services;
3) Everyone will be given the opportunity to voice their opinions and experiences to ensure that services meet their individual needs;
4) The best possible services will be provided within the resources we have, giving excellent value for the public.
5) Our workforce will continue to thrive and work effectively to support each other and the community they serve, ensuring that we have a confident, competent, happy workforce.

3.7 Contained within the strategy there are 3 priorities that we are wanting all agencies to work towards to help further embedded early help principles.

1) The right early help, in the right place at the right time.
2) Ensuring a whole system approach to early help with strong partnership working
3) Empowering local people and communities to build capacity and resilience, to enable people and communities to do more for themselves.

3.8 This strategy is ensuring that we are all responsible for Early Help. The idea is to build upon people's strengths at an early stage, so they are enabled with the support of family and friends to recognise when help is required. By tackling the root causes of a problem as early as possible, people are able to maintain their independence and general wellbeing longer and where necessary can self-refer to an appropriate person or service.

3.9 We will expect to see that more individuals and families are empowered and enabled to take control of their lives, and they are supported in their local communities avoiding the need for services intervention. When there is service intervention we will expect to see the positive impact in a timely way with families reporting sustained improvement in their circumstances.

3.10 Going forward we will focus on some key elements to assist with our early help offer these will be around improving information management and use of information technology, enhancing co-ordination and timing of service delivery, enhancing approaches to whole household and/or family support and building resilience and community capacity.

3.11 The development of a robust early help offer for children, young people, adults and families in Halton will prevent problems escalating and becoming entrenched and more complex. It will also lead to a reduction in the need for more costly, specialist and statutory services while preventing unnecessary trauma and emotional upheaval for families.

4.0 POLICY IMPLICATIONS

4.1 There are no policy implications identified.

5.0 FINANCIAL IMPLICATIONS

5.1 None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Early help strategy directly relates to improving the safety and wellbeing of children and young people The document also support key elements within Halton's Safeguarding and Children and Young People's Plans.

6.2 Employment, Learning & Skills in Halton

There are no implications for Employment, Learning & Skills arising from this Report.

6.3 **A Healthy Halton**

Early Help Strategy supports the Council's strategic priority of Improving Health.

6.4 **A Safer Halton**

There are no implications for Safer Halton arising from this Report.

6.5 **Halton's Urban Renewal**

There are no implications for Urban Renewal arising from this Report.

7.0 **RISK ANALYSIS**

7.1 None identified

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

9.1 None under the meaning of the Act.

Strengthening our Communities

Everyone Early Help Strategy 2018 - 2021

Early Help For Everyone In Halton – Children, Young People, Adults, Families

Version Number	Date	Author	Review Date
V9	May 2018	Clare Hunt	September 2019

Foreword

FOREWORD

Councillor Tom McInerney
Lead Member Children, Young People and Families Chair, Halton Children's Trust Board

I am pleased to introduce Halton's Early Help Strategy. Effective Early Help is essential to improve the life chances of Halton's children, young people and their families. Although Halton, along with many other Local Authorities and our partner agencies, faces unprecedented financial pressures, we believe that a focus on support, prevention and early intervention will not only mean that we can overcome the current and future financial challenges but also, and more importantly, give people of all ages, the opportunity to take full advantage of everything that Halton and life has to offer. Our vision is to empower our children, young people, adults and families to become more resilient and less reliant to cope with the demands of life in the 21st century. Early Help is fundamental to achieving this vision.

Milorad Vasic
Strategic Director
People, Halton
Borough Council

This Early Help Strategy is an enabling approach for all ages in Halton and it stresses the importance of different areas of social care, health and mental health working together with other agencies to improve the wellbeing of every individual. The Care Act (2014) highlighting the individual's right to choice and independence combined with The Children & Family Act 2014 which has a focus on greater integration across health, social care and education underpin much of what we do already and is articulated in this Strategy through examples, of how individuals, families and communities can benefit from different teams pooling their ideas and resources to develop local priorities and deliver early help that can make a significant difference in people's lives. Our approach will provide children, young people, families and older people with a straightforward route to the services they need from their first contact with us and strike the right balance between specialist support, targeted work to prevent issues getting worse and access to universal services that are open to all in our communities.

This balance of provision is becoming ever more difficult to maintain as the challenging financial position of the public and voluntary sector continues. This strategy is, therefore, an important document that will shape and guide the development of services by both the Council and its partners over the coming years and how we will work with you, as we all seek to ensure that Halton's families are supported in providing their children with the best start in life and maximise the chances for their children to achieve in their schools and into adulthood and for older people to live independently

1. INTRODUCTION

There is a long standing and strong commitment to early help and prevention across all agencies and strategic partners in Halton. The majority of people, irrespective of their individual circumstances want to live a fulfilling and where possible active life. They also want to stay healthy for as long as possible while remaining a valued part of the community and able to play a part. Halton fully supports this view. It recognises that by addressing needs and the root causes of a problem at an early stage, individuals and families can be supported to cope better and achieve their own future potential.

In response to a range of national and local policy developments, this new strategy for **Early Help** represents a refresh of our approach and reflects our desire for an integrated approach to Early Help across children,' adults and older people's services and public health as part of a whole Council approach.

This strategy aims to build upon the good practice and existing strategies from early help and prevention which already exists in Halton. We will use these foundations to establish a new **'Everyone' Early Help Strategy** that is firmly embedded within the main relevant legislative acts for children and adults. Throughout this document the term 'Adult' is defined within the meaning of the Care Act (a person aged 18 or over and which also includes 'older people' - aged 55+).

Whilst the Early Help services in the People's Directorate of the Council has a key role in the provision of early help services by taking a lead in the delivery and commissioning of services; it also has a role as a partner working collaboratively and co-operatively within a system of services from the statutory, voluntary and community sector. In addition, as a facilitator it helps to build capacity and confidence among young people, adults and families within Halton as well as the wider partnership.

The main benefits of early help approaches include identifying and promoting protective factors at an early stage and as a result prevent negative outcomes developing. The overall aim is to support people to maximise their potential, and as a consequence, enjoy a better quality of life. Early help approaches are often 'enabling': equipping individuals and communities with the tools to succeed, rather than interventions being imposed upon them. Asset based approaches, being introduced in communities in Halton will foster self-reliance and resilience rather than dependency.

2. PURPOSE AND AIMS OF STRATEGY

In Halton we see a focus on early help as fundamental in tackling the root causes of problems as soon as they arise; this is critical to improving people's quality of life throughout each life stage. We want to break down intergenerational cycles of deprivation and poor outcomes, prevent problems from escalating and reduce the need for the involvement of statutory services. Early Help is an overarching philosophy that that should influence all strategies in Halton. The aim of the strategy is to achieve much better outcomes for local people of all ages and their families.

In doing so, we will be promoting better outcomes for the people of Halton and the communities which are an integral part of their identity. We want to help to ensure that we reduce avoidable spending on acute services where early help would have prevented, decreased or delayed the need for them, and hence provide better value for public money.

The strategy outlines our intentions and approach to ensure early help is understood, accessible and firmly embedded within the working practices of all agencies, promoting lifetime and whole-family planning to deliver effective early help in Halton.

We want to empower our children, young people, adults and families to become more resilient and less reliant.

2.1 Aims

These aims set out our aspirations in broad terms. Further detail will be in the action plans that are currently being developed. By 2021 in Halton:

1. More children and young people will lead healthy, safe lives and will be given the opportunity to access education and develop the skills, confidence and opportunities they need to achieve their full potential;
2. More adults will have the support they need to live their lives as healthily, successfully, independently and safely as possible, with good timely access to health, mental health and social care services;
3. Everyone will be given the opportunity to voice their opinions and experiences to ensure that services meet their individual needs;
4. The best possible services will be provided within the resources we have, giving excellent value for the public.
5. Our workforce will continue to thrive and work effectively to support each other and the community they serve, ensuring that we have a confident, competent, happy workforce.

3. LEGISLATIVE FRAMEWORK

The recent changes in legislation have reinforced the need to consider the needs of all individuals regardless of age and their families.

The Children & Family Act 2014 sets out a range of new responsibilities including the promotion of greater integration across education, health and social care. This focus on joint approaches to deliver integrated and personalised care provides a fresh impetus on achieving together the outcomes that matter to children, young people and their families. The act requires particular attention to be given to:

- Prevention
- Early identification
- Access
- Transition across life stages, and
- Preparation for adult life.

Also important to Early Intervention and Prevention work for children are the Children Act 1989 and 2004; the Ofsted single inspection framework; the thematic Ofsted framework; the Ofsted Children's Centre inspection framework; and the new Ofsted SEND inspection framework.

The Care Act 2014 highlights the requirement of effective person-centred planning to help intervene at the earliest possible stage. It states "*It is critical to the ethos of the Care Act that the care and support system works to actively promote wellbeing and independence, and does not just wait to respond when people reach a crisis point.*" To meet the challenges of the future, it will be vital that the care and support system intervenes early to support individuals, helps people retain or regain their skills and confidence, prevents need or delays and deterioration wherever possible".

According to the Care Act 2014 the most important part of adult care and support is to help people achieve those outcomes that are important and matter most to them in their life. This means that Halton, when carrying out its care and support functions for any person, must always promote that person's wellbeing. This idea of wellbeing covers many areas but can be summarised as follows:

- remain mentally and physically healthy
- maintain dignity stay safe and be in control
- enjoy, achieve and remain socially connected
- have a suitable home
- avoid financial and domestic troubles

4. WHAT DO WE MEAN BY EARLY HELP?

Early help aims to give people who are experiencing difficulty at any point in their lives the help they need as early as possible. It also supports individuals, families and communities to do more for themselves. People are no-longer considered passive recipients of care. Instead, they are actively involved and encouraged to adopt a 'can do' approach in tackling many of their own problems. This reduces dependency, but stresses independence and self-referral as means of accessing early support when needed.

In Halton, all agencies working with children or adults recognise that **prevention and earlier intervention** are more successful and cost effective than later or more formal interventions. We are all engaged to a greater or lesser extent in work that seeks to prevent the escalation of difficulties or the deterioration of circumstances which could adversely affect people at any age.

Halton's definition of "early help and prevention" across children's and adults' services and public health can be described as:

"Supporting communities to prevent and reduce need at the earliest stage whilst taking targeted action as soon as possible to tackle emerging situations, where there is a risk of a person developing problems. Early intervention may occur at any point in a person's life".

By **early help** we mean **the targeted action** that we take to prevent the development or escalation of problems. This definition importantly includes both help provided **early in life** (with young children, including pre-birth interventions) as well as the help delivered **early in the development of a problem** (with any person, regardless of age).

Who is responsible?

Everyone is responsible. The idea is to build upon people's strengths at an early stage, so they are enabled with the support of family and friends to recognise when help is required. By tackling the root causes of a problem as early as possible, people are able to maintain their independence and general wellbeing longer and where necessary can self-refer to an appropriate person or service.

For this to work effectively, a number of different groups involving public, private, voluntary and community have to work together to ensure the appropriate support is made available at the right time and in the right place.

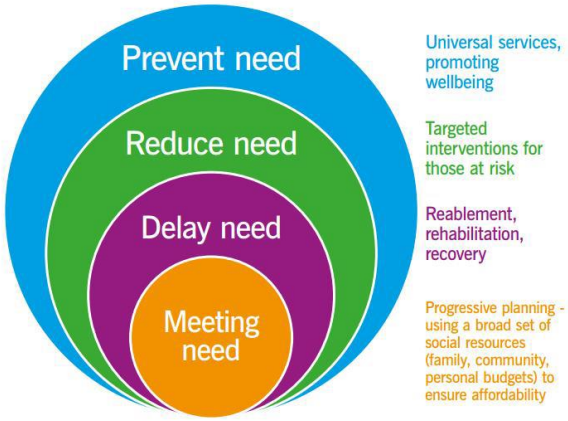
Specifically in relation to children's services, Munro (2011) outlines three levels of prevention: primary, secondary and tertiary. Focussed more on adults, the Care Act 2014 provides a similar categorisation using the language of prevent, reduce and delay.

This definition highlights the importance of early intervention in improving outcomes for people. The dual aspects of better life chances and improved value for money are

fundamental. In addition to this overarching definition, the Partnership recognises a continuum of prevention, ranging from:

- 'primary' or 'upstream' approaches (including whole population approaches and/or services and interventions for people with lower level needs)
- through 'secondary' approaches – typically those directed at people with emerging needs, in an attempt to stop these getting worse; and finally
- 'tertiary' or 'downstream' approaches to prevention, usually targeted at people with a range of complex needs and/or more pronounced ill-health, focused on maintaining stability and preventing deterioration for as long as possible.

The diagram shows how both the principles of "Prevent, Reduce, Delay" interrelates with Primary, Secondary and Tertiary Prevention, so that whether we are talking of children's or adults' services, we have a clear framework to describe early help in Halton.



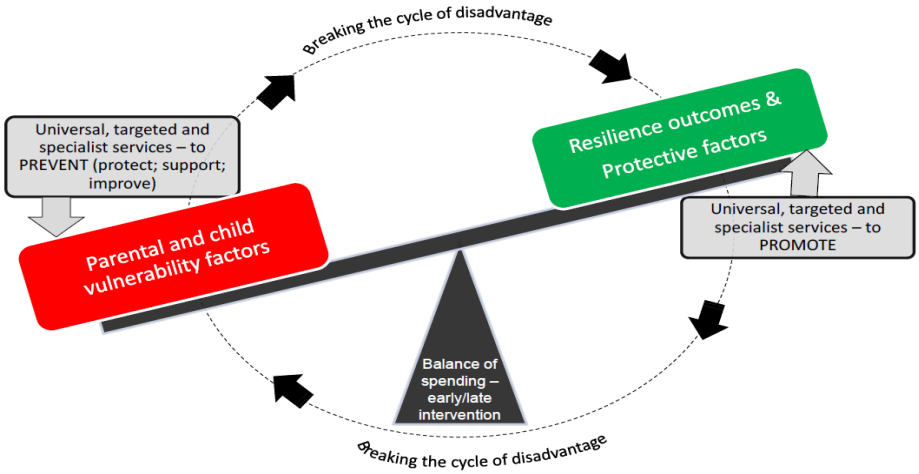
The table below summarises the different levels of prevention to help agencies to describe their contribution across three levels.

Primary Prevention: Prevent	Secondary Prevention: Reduce	Tertiary Prevention: Delay
Preventing the occurrence of problems	**Preventing problem escalation**	**Reducing the severity of problems**
Early Help is taken at the level of the whole population in order to prevent the development of risk factors. At this universal level agencies build resilience across the population. Informal and formal education, awareness raising, helps to strengthen the support communities provide for local people.	At this level agencies will intervene early with individuals who have existing risk factors, vulnerabilities or acknowledged additional needs to ensure that problems are halted and do not become either more significant or entrenched.	At this level agencies work with individuals to tackle more complex problems to reduce the severity of those problems that have already emerged and reduce or delay the need for the involvement of more specialist services. This includes individuals, children, young people and families in crisis and on the edge of family breakdown.

HALTON'S LEVELS OF NEED FOR CHILDREN

It is important that there is a clear understanding of where early help fits into the 'threshold of need' for children and that it is used appropriately by all partners. The diagram below illustrates this relationship it provides a continuum of needs of all children and their families in Halton.

What we do with children and young people now will have an impact and future savings for the adult population and the community. For example, social and emotional foundations in the early years, capable and confident parenting amongst vulnerable families, healthy lifestyles and good education experiences set during the primary and secondary school years can determine positive outcomes throughout the life course. It can also tackle the costly consequences of issues such as school exclusions and unemployment in later years.



EARLY HELP IN HALTON

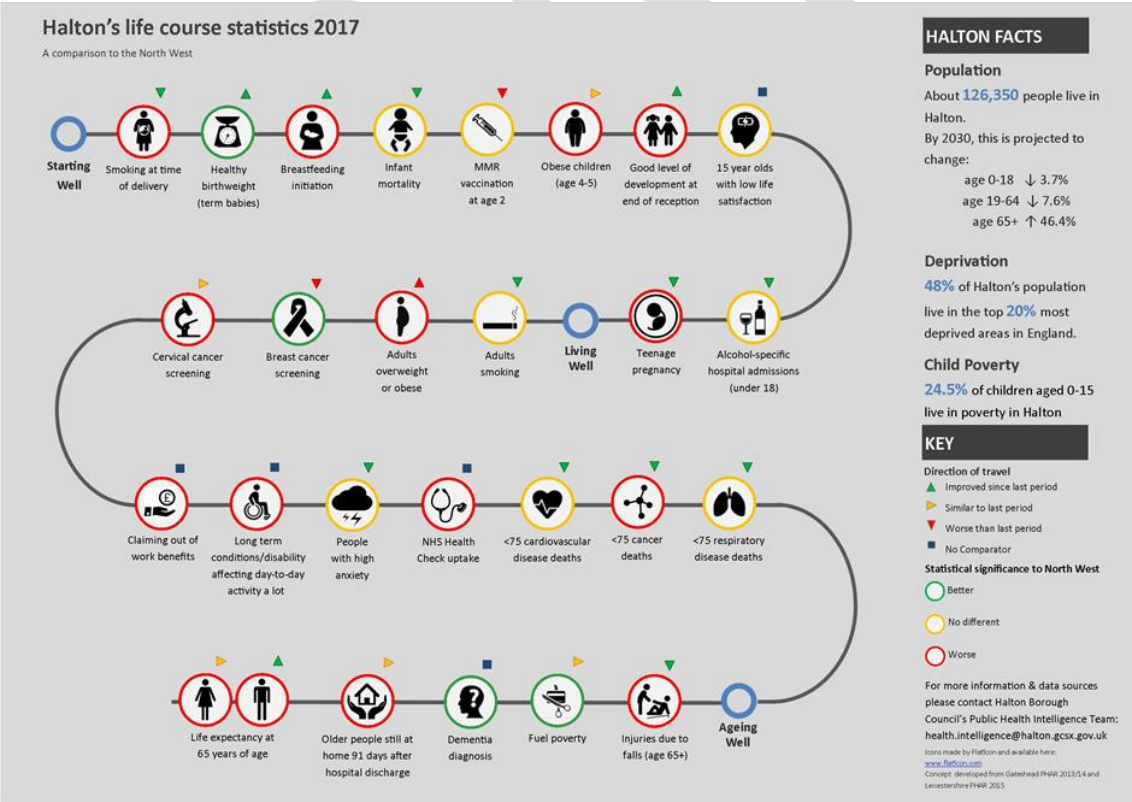
Halton's strategy is made up of three elements:

- a set of **shared early help priorities** to support the shift to early help,
- a set of **early help principles** to inform the borough partners' work on early help
- a selection **of early help 'stories',** that help to illustrate some of the real benefits of effective early help to individuals, families and communities.

5.1 SETTING OUR PRIORITIES FOR 2018–2021

The Joint Strategic Needs Assessment uses all available data and information to assess the current and future health and wellbeing needs of our local residents and communities. Such information is used to inform how resources are allocated across the borough in accordance with identified needs, ensuring the best possible health and wellbeing outcomes are achieved whilst also reducing health inequalities.

The following diagram provides an overview of the key findings from the most recent Joint Strategic Needs Assessment and other intelligence sources. The diagram reflects some common risk factors associated with the need for early help.



Priority 1

The right early help, in the right place at the right time.

Outcome

Individual's families and communities are self-aware, able to identify when they need support, and engage appropriate services to maintain their independence and overall wellbeing.

We will:

- Ensure whole system early help pathways are developed which are clearly understood and embedded in practice.
- Work with all agencies to put in place a workforce development plan to provide a whole system workforce response to our early help offer.
- Embed an outcome-focussed approach, ensuring that we can demonstrate the impact and difference made to, and in partnership with, our communities through the delivery of a whole system early help offer.

What difference will it make?

- People in Halton will know what advice and support is available to them and their families. This will help them respond to problems or needs arising due to changing circumstances.
- They will know where and who to go to for support, and what to expect.
- People will be able to deal with issues or problems before they become more severe or complicated. They will be independent and resilient enough to support themselves in the longer term, appropriate to their particular needs.

Priority 2

Ensuring a whole system approach to early help with strong partnership working

Outcome

Mature and adaptive partnerships which have shared ownership and accountability for the delivery of an effective early help offer.

We will:

- Embed a shared understanding and commitment of the 'everyone early help' offer.
- Ensure that all learning across the early help spectrum is shared to celebrate successes, but also learn from areas of improvement.
- Ensure that Early Help is not seen as something at the periphery of service design and delivery, but is embedded as mainstream.

What difference will it make?

- Service Providers will work together to minimise duplication, share knowledge about services available, and ensure that vulnerable people don't fall through gaps in processes.

Priority 3

Empowering local people and communities to build capacity and resilience, to enable people and communities to do more for themselves.

Outcome

Strong, connected communities supporting themselves and each other to lead happy and fulfilling lives, thereby reducing the demand on statutory services.

We will:

- Ensure that the premise of early help is underpinned by an asset-based approach to community development and resilience.
- Enable individuals, families and communities to self-help, and access services independently through maximising the use of technology, ensuring everyone is well informed about the service and support available.
- Promote independence by encouraging and enabling individuals to maintain a good quality of life accessing provision in their communities (helping them to help themselves).
- Recognise the need for strong connectivity with universal services to ensure people who need help are identified early, and effective step-up and step-down practices are in place.
- Ensure that the voice of the individual is at the centre of the early help offer, and individuals, families and communities are empowered to take control of their lives.

What difference will it make?

- People will have the knowledge and confidence to get involved or take a lead on community-based activities and projects, tailored to the skills and needs of their local areas.
- People will feel enabled to be independent, but aware of how to seek support services when needed.

Early Help Enablers

To assist with the 3 highlighted priorities we recognise that we need to more in the following areas:

- Improve **Information Management and Use of Information Technology**
- Enhance **Co-ordination and Timing of Service Delivery**
- Enhance approaches to **Whole Household and/or Family Support**
- **Building Resilience** and **Community Capacity**

We want to support individuals to make choices in their lives that enable them to achieve their full potential. Recognising that carers, staff and volunteers are an important part of delivering our vision, and must be valued and supported.

Our purpose is to improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill-health, promoting self-care and independence, arranging local, community-based support whenever possible and ensuring high-quality hospital services for those who need them.

We will work with local people and with partner organisations including healthcare providers and the voluntary sector. This will ensure that the people of Halton experience smooth, co-ordinated, integrated and high-quality services to improve their health and wellbeing.

The Council is working hard to maintain services with fewer resources and with further cuts expected, this will continue over the coming years. Our focus will be on prevention and independence and through making the most of universal and community based services to help young people, families and adults build, retain and recover skills.

5.2 Early Help Principles

Our vision is underpinned by a number of early help principles;

- Adopting strength based approaches using the strengths of individuals, families and communities;
- Supporting independence at all stages, with different levels of intervention offered;
- Working together as a strong partnership to deliver an effective local offer of support;
- Early help will be addressed across the life course, from developmental support in early years, to maximising wellbeing in later years.
- Ensuring we have an engaged, knowledgeable and committed workforce, that fully understand the importance of their role in early help;
- Identifying the children, young people, adults and families who need extra help and support at the earliest opportunity.
- Commitment to a 'Think Child', 'Think Parent', 'Think Family' and 'Think Community' approach to the assessment of needs which will have a positive impact upon all individuals within the whole family.
- Listening to children, young people, adults and families, and ensuring that the voice of children, young people, adults and families is evident throughout our involvement.
- Make every contact count – through effective assessment processes and by empowering professionals to address recognised needs of children, young people, adults and their families at the first opportunity.
- Share information – in a timely way, avoiding the need for continuous or repetitive assessment and 'starting again' syndrome. Understanding the whole family's needs, regardless of which individual service or setting they come to.
- Continuously improve – learning as we go along by monitoring, reviewing and evaluating the way that we work, gaining a better understanding of what helps families most, eliminating wasteful systems and bureaucracy and focusing our resources on making a positive difference.

By 2021 we will have:

Introduced targeted prevention, so that more people can live independently for longer in their communities, needing less; preventing and delaying the need for traditional public health or social care services.

Implemented and embedded requirements of the new Care Act.

Become more efficient in the way we work, making more use of digital technology to produce better results for people.

Supported new and existing providers of public health and social care to increase the range and quality of services.

Developed a confident, skilled and knowledgeable workforce that works flexibly with a range of partners to provide services.

5.3 Early Help Stories

The early help stories help to illustrate some of the real benefits of effective early help to individuals, families and communities.

David developed skills and confidence to live more independently

David has a diagnosis of Autism. He moved out of his family home to live in supported accommodation. His informal family carers were getting older and keen to see him settled in his own home.

At an early stage David was supported by his social worker and learning disability nurses to ensure all of his health needs were being met. Halton Housing was able to find suitable supported housing accommodation that David felt comfortable with. With assistance from his support agency he has been able to increase his independence gradually and improve his daily living skills such as maintaining his personal care and completing domestic tasks.

David now feels comfortable and safe in his new environment. Halton's Community Bridge Builders have enabled him to locate a local range of meaningful activities to take part in. These include volunteering with the local museum at Norton Priory to taking part in wider community activities such as walking groups. David and his family agree that the move has overall been a great success. He will be reviewed regularly by the social work team to ensure there is a continual emphasis on outcomes that match what David wants now and in the future.

Halton offers support to people at all levels of need and at every level will actively explore how people can be safeguarded and protected from harm. We offer timely intervention from our 'Home Support,' 'Rapid Access' and 'Reablement' teams. All of our actions are targeted to promote independence like David's story above.

Doris was reassured and felt enabled to access support

Doris's Story:

I felt horribly alone when my partner died 4 years ago, especially as my remaining family live in London. Apart from shopping once a week I don't go out due to diabetes affecting my feet. I used to enjoy playing whist, but lack of transport made the journey impossible. When I had trouble with my answerphone and Lifeline I realised something had to be done.

I was referred to the Volunteer Service who arranged a whole raft of other services for me. These included door-to-door transport, enabling me to play whist gain. My answerphone and Lifeline problems were quickly solved and I had my feet checked at the Podiatary Clinic.

Social isolation and the twin problems of loneliness and depression are common among people who are over 55 and living alone. The Volunteer Service that Doris found so helpful is part of Halton's SureStart to Later Life information service. This offers information about a range of activities available in the local community (benefits and pensions, transport, education, social activities, health and fitness and much more. The idea is to enable older people to counter loneliness and take an active part in their community.

Betty was supported to develop the right skills helping her to move forward to independence

Betty's Story:

Betty has Down syndrome and a diagnosis of Autism. She recently moved from her family home to live in her own flat in Runcorn. She receives some support each day to help her to maintain her tenancy, cook her meals and maintain her personal care. Before moving, she worked with her social worker and the Community Bridge Building team to set up social, education and work-based activities in her week. Structure and routine are very important for her and plans were put in place before she moved to avoid unnecessary disruption to her.

Betty is now attending college each week thank to the intervention of Halton's Bridge Building team and her social worker. She does voluntary work at a cafe and a salon both of which are run by Halton Day Services. She has a much more active social life and attends events in her local area with her friends. For big decisions that she may have to take about her life, she has help from advocacy services and also support from the Bridges Health Team to put plans in place and increase her independence. Currently, she is working with her social worker in order to gradually reduce the support that she needs from staff.

Community Connectors is a recent example of a local project that will provide practical person centred assistance to anyone in specific localities in the borough. The service is about empowering people to have the skill set to solve their own problems before they reach the crisis stage.

Individuals will be enabled to clarify their own goals, strengths and needs and develop a plan to pursue their aspirations, build resilience and improve their possibilities for a more fulfilled life.

Robinson Family were fully supported, reassured and motivated to regaining the confidence to move forward with family life

The Robinson family, are two parents under 25 years of age with a 2 year old and new born baby. A Health visitor referred the family for early help with a number of support needs including parenting, budgeting and mums isolation and low mood.

The family worked with a Family Support Worker for four months to holistically address their individual needs as adults, developing the families parenting skills as well as ensuring that the individual needs of the children were met.

The Family Support Worker supported the family through a range of suitable approaches to meet their needs; expanding their skills in areas such as child development, money management and parenting, as well as supporting Mum to access mental health support.

As a result of this early help, the family developed the necessary skills to grow their confidence to move forward with their lives independently. They have built strong connections in their community, helping to reduce social isolation, maintain their independence and improve their quality of life.

Halton offers a variety of support to parents and families. This family found support through their health visitor interactions, support via the G.P and with their local children's centre. These interactions got mum to talk about their mental health issues and get support, it identified a 2 year funded place, plus access to local groups to widen their support networks and improving their parenting confidence.

6 WORKING TOGETHER

6.1 The vital role of partnerships

We need to build on the work of the partnership to date to ensure we draw on the full range of resources, expertise and insight of all partners so we can better understand the needs of our children, young people, adults and families. We need to better identify and engage with those families who will benefit most from services, and provide co-ordinated services that effectively address needs early, to ensure the very best outcomes for our children, young people, adults and families.

The strategy is set in the context of a very challenging economic climate which has seen unprecedented levels of central government cuts to local authority funding. Central Government funding for Halton Borough Council has already fallen by £45m. The next four-year period looks equally challenging. One example is within the North West. Alder Advice were commissioned to report on the future of Adult Social Care

in the region. Their report indicated a number of key risks and challenges some of which involved moving from expensive residential care to community provision and greater use of digital technology to lower the cost of long-term care. This highlighted major financial challenges for Halton. By 2022 a further £4.8m will be needed to fund services. If demographic changes are included this figure increases to £12.8m. Halton's challenge working with others, is to deliver on our agreed priorities while maintaining front-line services within limited resources and at a difficult time for the national economy. To achieve this, particularly with vulnerable adults, Halton has introduced a new model of care. This emphasises the need to work with adults as early as possible. It aims to make the most of the person's own strengths and skills, enabling them to live independently as long as possible. The focus of assessment is for the individual leading a life (as fulfilling as possible) rather than having a service.

Partnerships are the key to being able to maintain effective services and continue to improve outcomes for everyone in Halton. There are key partnerships between the council and health services in supporting early help. The partnership between the third sector, the council and other partners is also crucial to achieving better outcomes for children, young people, adults and families. Third sector partners, including community groups and volunteers, perform an important role in reaching local communities and supporting individuals and families and it is important there is further collaboration across the partnership which maximises the third sector's contribution, and its ability to lever in additional resource.

Partnerships need to build on our achievements to date and encourage both the alignment of resources and more formal joint commissioning arrangements. Grants for 11 voluntary sector organisations, totalling £214,000 have been recommended for the current financial year (2018-19). These will contribute to the council's priorities involving: Children and young people; employment learning and skills; healthy Halton and Safer Halton. These grants will have a significant impact on volunteering, training and development opportunities as a means of reducing reliance on statutory services.

6.1 Commissioning

Bringing agencies to work together to meet the needs of children, adults and families is at the heart of early help. This is requires whole system change, driven by energetic and visionary leadership which is already in place across the Council. Integrated commissioning is the key. It will support the delivery of the whole system change that is needed. It will also provide a robust, credible and objective way of making decisions about sparse resources, so that they have maximum positive impact on the lives of children, adults and families.

Key commissioning principles

We will:

- adopt an outcomes based approach to commissioning;
- understand the needs and priorities of our community, now and in the future and clearly specify our requirements;
- ensure that value for money and achieving sustainable efficiencies are the foundation of our commissioning solutions;
- undertake co-production and involve customers and service users in the planning, design, monitoring and evaluation of services;
- ensure commissioning takes place at the most appropriate level (services will be personalised wherever possible);
- be honest about the financial and legislative frameworks in which services are to be provided;
- support market developments to ensure there is a mixed economy of commissioned services enabling partners and individuals to deliver services where they can enhance outcomes and efficiency;
- build the capacity of our local third sector and small businesses to ensure they have equal opportunity to participate in commissioning;
- promote investment in the local community through all stages of the commissioning process; and
- work jointly with other relevant local and regional commissioners to best secure positive outcomes and value for money for our residents.

Halton will use commissioning and co-production approaches to develop and imbed a different widespread culture and practice. This will supports and allow innovation and collaboration, as well as greater capacity and relevant freedom at local level to develop and implement new approaches.

An example of our joint commissioning is around Mental Health Services. Following a redesign of the services provided by the council for people with mental health needs, the Mental Health Outreach Team is now working collaboratively with NHS Halton Clinical Commissioning Group to provide targeted and time-limited support for people with the full range of mental health conditions in Halton, including people with

complex needs supported by the North West Boroughs NHS Trust and those people with more common, but often equally difficult to manage, mental health conditions who are supported only by primary care services.

When people are referred to the outreach team, they are interviewed about what changes in their lives they want to make, in order to have a better quality of life and to be able to participate in their own communities. An individual plan is then developed with them, targeted at their wishes and needs, and a member of the team supports them over an agreed time period to achieve these aims. This approach is having a considerable level of success and is reducing the need for people to be referred for more complex and expensive levels of support.

In addition, the mental health social work service has redesigned and is able to focus more fully on people whose needs are only being managed through primary care services. Both approaches are achieving positive outcomes for local residents with mental health problems.

6.2 Community Capacity Building – Working Towards a Community Asset Based Approach

Halton Borough Council has always helped communities to "help themselves", including helping people to understand their needs and develop their own solutions to these needs. There are three key areas that we can continue with to develop this further:

1. Unlock the capacity of communities to support themselves and vulnerable individuals and families – reducing the demand on public service.
2. Support communities to work in partnership with the Council to design and deliver services, including those currently delivered by the Council
3. Develop voluntary and community sector (VCS) organisations in Halton as effective providers in a diverse market which supports delivery of the Council's priorities.

By 2021 we will have:

Strengthened arrangements for existing public health services so that more people get the right support to manage lifestyle issues such as substance misuse, smoking or being overweight.

Put in place actions to support communities and individuals to reduce loneliness and social isolation.

Improved preventative services for children and young people through the Healthy Child Programme.

Invested in local community projects within Halton that support people to live longer, healthier and more independent lives.

7 THE CASE FOR CHANGE - NATIONAL RESEARCH AND EVIDENCE

Nationally there are varying degrees of commitment to early help. Many services across health and social care are responding to escalating levels of demand through increased crisis management. However there is a growing body of evidence to support early help, which has been highlighted in key national documents and research.

Many local authorities are operating within a climate of unprecedented challenge for the public and voluntary sector, as demand for specialist services rapidly increases against a backdrop of dramatically reducing resources. For some families (estimated at 30 per cent of the population), difficulties arise which, if addressed early enough, can be prevented from escalating into costly statutory service intervention.

The Marmot Review into health inequalities in England published in February 2010 acted as a timely reminder of the continuing social and economic cost of health inequalities and provided further pointers towards early intervention help and support. In doing so, it presents a robust and well-evidenced business case for national and local action to address health inequalities through concerted action.

Work undertaken by the Early Intervention Foundation, the Washington State Institute for Public Policy, the Dartington Social Research Unit, MP Frank Field's review on the Foundation Years, MP Graham Allen's review of Early Intervention, and the work of the WAVE Trust among many others provide enough evidence that Early Help can reduce demand on more reactive and expensive services.

They all independently reached the same conclusion that it is important to provide help early in order to improve outcomes. Nationally, interest is growing in an evidence base for early help and in particular a need to demonstrate effectiveness to produce cost savings in more specialist and acute services. It is important to recognise that early help is not a one-off fix, but a highly targeted process and approach – a way of working with specific outcomes.

The emphasis on the economic value of early help has been developed further by the Social Research Unit at Darlington University. The American 'Blueprint' model is being translated into a UK context for a number of evidence-based interventions. The work currently in progress is specifically on child protection, however work on Early Years and Young Offending has already been published.

It is estimated nationally that if the number of offences by children and young people were reduced by 1%, it would generate £45 million in savings to households and individuals per year. The cost of educational underachievement has been projected at £18 billion per year by the London School of Economics for the Prince's Trust. Statistics highlight intergenerational cycles; daughters of teenage parents are three times more likely to become teenage mothers, and 65% of sons with a convicted father go on to offend themselves, with significant costs to society. Inequality also

impacts; a child living in poverty is more likely to have poorer health, lower attainment and less earning potential.

As people age they become more likely to have reduced contacts with family and friends .They are also more likely to be less mobile and have reduced income. These factors and others such as increased likelihood of hearing and sight deterioration can cause older people to be vulnerable to loneliness. Loneliness and isolation pose severe risks to health and can lead to early death. The effect of loneliness on life expectancy exceeds the impact of factors such as physical inactivity and obesity, and has a similar effect to that of cigarette smoking and alcohol consumption. Older people who are lonely have a greatly increased risk of developing Alzheimer's disease and have an increased use of health and social care services.

Well targeted loneliness interventions can substantially decrease spending on health and social care services. SCIE give case studies of befriending schemes saving £300 per person per year and Community Bridge Builder / Sure Start to Later Life type services saved even more. Research highlights that for every £1 spent on preventing loneliness there is a potential to save £3.

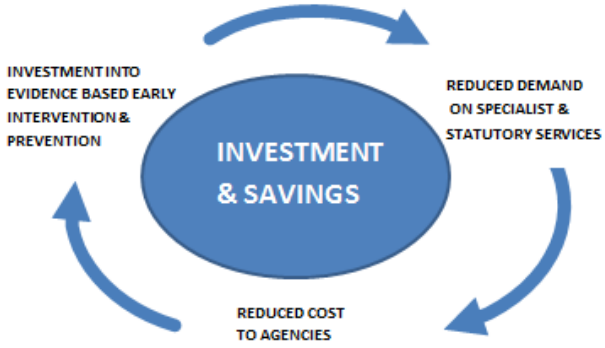
8 HALTON'S APPROACH

A key priority of this strategy is to develop a more cost effective, integrated and sustainable service model for people's services which identifies emerging problems as early as possible and prevents them from escalating.

In achieving this, a new financial model needs to be developed, which will include a focus on:

- Protecting the existing early help spend, focusing this on evidence-based interventions;
- Acknowledging that there is no new money to invest in interventions, exploring opportunities for attracting investment to pump prime early help initiatives;
- As early help is systematically rolled out and evidence of changes of demand becomes apparent, a commitment to re-prioritise some high cost expenditure on acute and crisis management services into cost effective early help provision.

This approach aims to create a cycle where a proportion of savings from reduced demand are reinvested into early help and prevention activity which in turn leads to a further reduction in demand on specialist and statutory services. This feedback approach is outlined in the diagram below:



By 2021 we will have:

Designed, developed and delivered services with people who use them, in ways that make good use of volunteers' time and are an efficient use of public money.

Routinely asked people who are experts by experience and where relevant Carers, to help us assess the quality of care and health providers.

Improved the ways in which we show that people and staff's involvement makes a difference – so that they can see and understand that we listen to what they tell us and that it influences what we do.

Kept more vulnerable people safe. We will do so by raising awareness and understanding in the social care workforce and the public about what to do if they are worried about someone who is vulnerable.

9 HOW WE WILL MEASURE SUCCESS

We will constantly review how we work to make sure that we are delivering better care and results for people. We know it is important to listen to people, if we have a good understanding of what people think, want or need, we are more likely to deliver the right result for them. We will not know if we are successful in making a difference to people's lives unless we can measure the results, and we will measure how well we are doing in a number of ways:

The Adult Social Care Outcomes Framework - tells us how well care services are meeting people's needs, as we would expect for ourselves, our friends and relatives. This includes whether people feel they are treated with dignity and respect, feel safe

and are independent, for example, being still able to live at home after a stay in hospital.

Public Health Outcomes Framework - tells us how well public health services in Halton are working, for example not only how long people live, but how healthy they are. Other indicators of success include reducing the number of people who have falls, or who feel they are lonely.

NHS Outcomes Framework - as we work more closely with partners, sometimes our performance will be jointly measured. For example, with our NHS colleagues how successful are we at reducing avoidable emergency admissions to hospital.

9.1 How will we know if Early Help in Halton is working?

We will expect to see that more individuals and families are empowered and enabled to take control of their lives, and they are supported in their local communities avoiding the need for services intervention. When there is service intervention we will expect to see the positive impact in a timely way with families reporting sustained improvement in their circumstances.

The success of the strategy will be reported through agreed key performance indicators. The indicators we are developing will provide a benchmark of whether early help for children, young people, adults and families in Halton is making a difference to our community. All our partnership activity – whether strategic or operational – over the next three years will be expected to make a contribution to these outcomes.

This strategy follows an outcome-based accountability model. The indicators below tell us whether early help is working locally. Outcome measures are used at service level to tell us whether early help is working for individuals and families. It follows that if early help services are delivering positive outcomes to individuals and families, then we should see that reflected at community level.

9.2 Governance

The Early Help Strategy covers the period 2018–2021 and will be reviewed annually to ensure the plan remains agile and focused on the emerging needs of local people and communities. The reviews will also enable an assessment to be made on progress to the previous year and provide means to harness commitment to deliver the future year's aspirations.

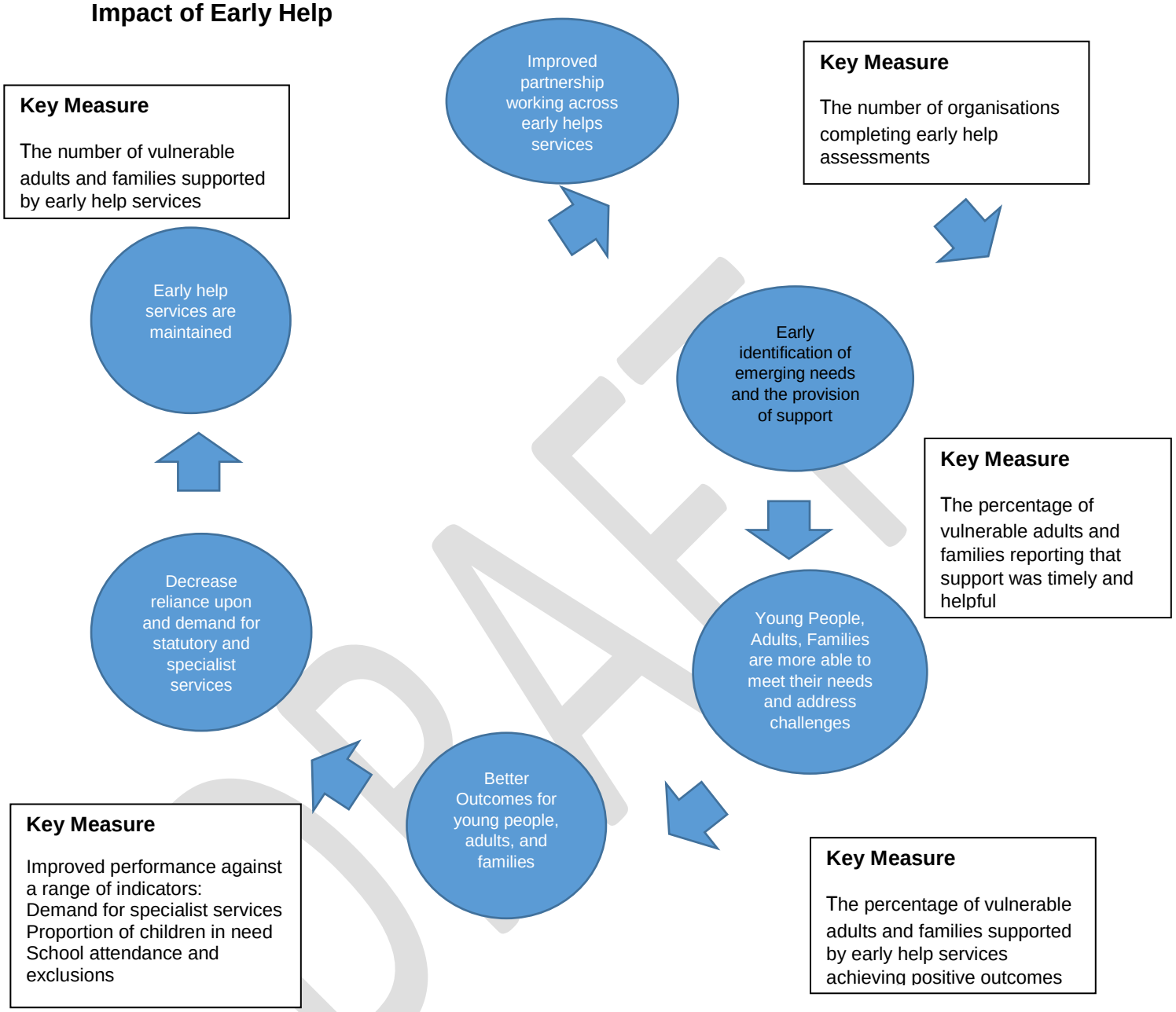
Responsibility for the monitoring of the implementation of the Strategy lies with the Children's Trust and Health and Well Being Board.

The Early Help Strategy is fully joined up with existing plans and priorities relating to:

- One Halton Health and Wellbeing Strategy 2017-2022
- Sustainable Community Strategy 2016- 2026
- Children and Young People's Plan 2018 – 2021
- Adult Social Care Business Plan 2017 – 2020
- The Care Act 2014

A governance structure and early help priority groups will oversee the development and delivery of these priorities. Each group will use a life course approach and ensure each action plan includes action to maximise prevention and early help.

Impact of Early Help



10 CONCLUSION

The success of our approach to Early Help is dependent upon collaborative and integrated working and will only be achieved by making Early Help an integral ‘golden thread’, which is woven into all our borough’s strategic plans and comes with a clear commitment across the partnership.

The development of a robust early help offer for children, young people, adults and families in Halton will prevent problems escalating and becoming entrenched and more complex. It will also lead to a reduction in the need for more costly, specialist and statutory services while preventing unnecessary trauma and emotional upheaval for families.

Halton has the opportunity to provide an early help offer which is more coordinated, one which avoids duplication and makes the most of the resources available in an efficient and effective way. To deliver the early help offer requires a significant transformation of some current models of service delivery. This practice and culture change can take time and requires commitment into the medium and longer term future.

Appendix 1 - Cost Benefit Analysis

There is a growing body of evidence which indicates that early intervention is cost effective when delivered in a targeted and timely fashion. It can create savings across a number of public sector services further down the line by taking demand out the system.

Since social and economic policy decisions are made under resource constraints, the value of public investment must be judged, at least in part, through economic efficiency, in terms of value for money. In deciding how funds should be allocated, public agencies need to know not only what is effective, but also which choice brings the greatest benefits for a given set of resources.

In the case of early year's interventions, the long-term economic impact is determined by comparing the benefits to society to the costs accrued. Benefits to society include the benefits to the programme recipient and family.

Costs to society include the benefits foregone from not using the resources for some other use. Due to the large differences in the methodologies adopted by studies aiming to evaluate the economic impact of early year's interventions, it is difficult to compare results across interventions. Nevertheless, a number of studies do provide indications regarding whether early years or other interventions generate benefits in the long term that outweigh the costs.

A number of studies have been conducted which demonstrate these cost benefits and include:

Policy Area	Illustrative Example
Mental Health	According to the Mental Health Foundation – Fundamental Facts about Mental Health (2015), In England, early intervention for first-episode psychosis has been calculated to result in savings of £2,087 per person over 3 years as a result of improved employment and education outcomes. • A study by the LSE estimated savings of £8 for every pound spent on parenting programmes to prevent conduct disorder over the course of a child's lifetime. The report also stated that "the economic returns from school-based programmes to deal with bullying and other behavioural problems are even larger. • The same study estimates a saving of £18 is for every pound spent on early intervention psychosis teams that work with young people in their first episode of schizophrenia or bipolar disorder • Investment in suicide training for GPs saves £44 for every pound invested, while bridge safety barriers save £54. Screening and brief intervention in primary care for alcohol misuse saves nearly £12 for every pound invested • Workplace mental health promotion programmes save almost £10 for every pound invested.
Parenting	The Incredible Years Parenting Programme, which deals with

	children diagnosed with disruptive behaviour, costs around £1,344 to deliver a six month intervention to improve behaviour. It is estimated that without intervention, the continued conduct disorder of an individual costs an additional £60,000 to public services by the age of 28.
Early Years (Dartington Report)	It is estimated nationally that if the number of offences by children and young people were reduced by 1%, it would generate £45 million in savings to households and individuals per year. The cost of educational underachievement has been projected at £18 billion per year by the London School of Economics for the Prince's Trust. Statistics highlight intergenerational cycles; daughters of teenage parents are three times more likely to become teenage mothers, and 65% of sons with a convicted father go on to offend themselves, with significant costs to society. Inequality also impacts; a child living in poverty is more likely to have poorer health, lower attainment and less earning potential.
Early Years	A UK-based study, contrasted estimated £70,000 per head direct costs to the public of children with severe conduct disorder, with a £600 per child cost of parent training programmes. Although such figures do not demonstrate cost-effectiveness, they highlight the very low costs of early years' intervention compared to later expenditures once the problem is not addressed.
Literacy	Poor literacy skills are estimated to cost between £5,000 and £64,000 for each individual over a lifetime with the vast majority of these costs being due to lower tax revenues and higher benefit payments. The cost of a specific intervention with school pupils, in this case the Reading Recovery Programme, costs £2,609 per pupil and has shown that 79% of participants have been lifted out of literacy failure.
Economic Development & Skills	It has been argued that early year's interventions should also be portrayed as economic development initiatives and one way of considering this issue is with regards to skills formation. Research suggests that early skills and behavioural disturbances, or antisocial behaviour – during childhood and adolescence found average costs to UK society ranging from £13,000 to £65,000 annually per child. These costs are disproportionally higher than the cost of early prevention/intervention. A failure to obtain skills and qualifications the first time around cannot be made up entirely in adulthood, even with significant investment. The costs of such remedial programmes per person can be more than double the cost per child spent on pre-school or compulsory school education and are not likely to be as effective.
Pause	Every local authority within the UK has women with complex and challenging needs to whom multiple children are born and subsequently removed into the care system under child protection proceedings. A Lancaster University study estimates the scale and pattern of recurrent care proceedings over a seven

	year period (Broadhurst et al 2014). The numbers are significant, showing a total of 46,094 birth mothers appearing before the courts of which 15.5% (7,143) were linked to recurrent care applications. As each woman may be linked to more than one child, the total number of care applications associated with this group is as high as 29% of all care applications (22,790). If we estimate that 100 women, with a similar profile to those currently on Pause, were spread over 5 sites over a 5 year period with no intervention, they could potentially have 264* children removed into care at a cost of almost £20million. These are primarily the costs of taking those 264* children into care and do not account for other associated costs.
Older People	It is widely acknowledged that falls and fall-related injuries result in major costs to health and care systems: • Around one in three people over 65 and one in two people over 80 fall at least once each year. • Falls account for around 40% of all ambulance call-outs to the homes of people over 65 and are a leading cause of older people's use of hospital beds. • Each year there are around twice as many fractures resulting from falls as there are strokes in the over 65s. • Falls are a common precipitant for people moving into long-term care, or needing more help at home. A Cochrane review looking at the effectiveness of various interventions in the prevention of falls among older people living in the community, concluded that home safety assessment and modification interventions were effective at reducing the rate and risk of falls. The most common serious injury arising from a fall is a hip fracture. Around 70,000-75,000 hip fractures occur in the UK each year. The annual cost for all hip fractures in the UK, including medical and social care, is about £2 billion (c £26,000 per hip fracture) Applying the New Zealand finding of a 26% reduction in falls achieved by very modest adaptations would indicate a potential reduction of 18,000 falls with resulting savings of half a billion pounds (£500 million) each year
Young Adults Positive Behaviour Support Service (PBSS)	In terms of cost reduction over a 6 -7 year period, a single young woman with PBSS and Halton Supported Housing Network (HSHN) staff to support her has saved Halton £578,000 on packages of care. This was able to happen due to an early intervention plan and reward system which ensured Lucy (not her real name) remained engaged and was able to address her issues through training.
Telehealthcare	The principal social care and financial arguments supporting the use of Telehealthcare stem from the Department of Health 'Whole System Demonstrator Programme and other controlled studies since such as: Medvivo (2014) which found that the

	following gains were possible in a large group GP practice for patients with COPD: • 45% reduction in patient deaths (mostly among those over 65) • 52% reduction in hospital admissions • 36% reduction in visits to A & E • 35% reduction in GP visits In an attempt to estimate overall cost savings they found the following savings per person per year: • £1,250 in reduced unplanned hospital admissions • £110 in reduced visits to the GP • £480 reduced visits by the community matron • £30 in reduced attendance at A & E This represents a total annual saving per individual with COPD of £1,870 (this figure doesn't include the cost of equipment and training). By 2020 the estimated number of COPD patients in Halton (aged 16+) will be approximately 4,400. This represents a potential saving for COPD overall using Telehealthcare of around £8.25m.

REPORT TO: Health Policy & Performance Board

DATE: 19th June 2018

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health & Wellbeing

SUBJECT: Procedures of Lower Clinical Priority

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide the Board with an update following the public consultation and NHS Halton Clinical Commissioning Group's (CCG's) Governing Board decision on the Merseyside review of the Cheshire and Merseyside Procedures of Lower Clinical Priority

2.0 **RECOMMENDATION: That the Board:**

i) Note that NHS Halton CCG's Governing Body approved the review of the revisions to the policies in January 2018, following a presentation of the policy review to the Halton PPB which became operationally live on the 16th April 2018; and

ii) Note that the policies have adopted the current relevant national guidelines for care and comply with the general equity duties set within the national regulations.

3.0 **SUPPORTING INFORMATION**

3.1 In September 2017 the Board was informed of the Merseyside wide review of the existing Procedures of Lower Clinical Priority and the process being undertaken for the stakeholder and public engagement. The 12 week formal public consultation was undertaken in the autumn of 2017 with the summarisation of the comments and feedback being collated in November.

3.2 The policy development steering group reviewed the consultation feedback and made any final amendments where it was appropriate. The final set of policies were prepared and presented to each of the CCGs Governing Bodies in January 2018, with the exception of Knowsley CCG which reviewed the policies in March.

3.3 All of the CCGs Governing Bodies approved the review and the proposed policies, and have adopted them from the beginning of April 2018.

3.4 For hospital contractual terms the policies are live from the 16th April 2018, following the notice period required with in the NHS Standard Contract.

4.0 **POLICY IMPLICATIONS**

4.1 The CCG's policies have been revised in accordance with the decision made by the Governing Body

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The approved policies are in line with the most effective use of resources principles for the care and treatment of patients

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**
The policies provide equitable treatment for all ages.

6.2 **Employment, Learning & Skills in Halton**
None identified

6.3 **A Healthy Halton**
The policies are in line with the current national guidance

6.4 **A Safer Halton**
None identified

6.5 **Halton's Urban Renewal**
None identified

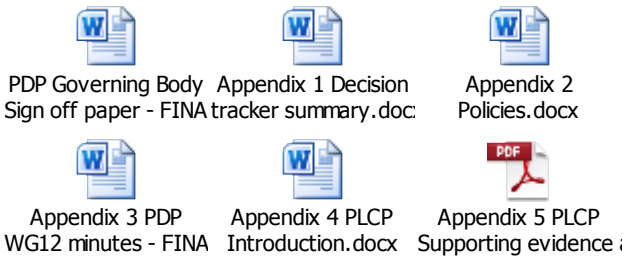
7.0 **RISK ANALYSIS**

7.1 The review has updated to the policies to conform to current national clinical guidelines and regulations for equity and diversity, which reduces any potential challenge.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 An Equity Impact and Risk Assessment has been undertaken as part of the review process to ensure the final policies comply with the regulations.

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**



CBCT PUBLIC DOC
2018-19 FINAL Policy

Midlands and Lancashire Commissioning Support Unit

NHS Halton Clinical Commissioning Group
NHS Knowsley Clinical Commissioning Group
NHS Liverpool Clinical Commissioning Group
NHS St Helens Clinical Commissioning Group
NHS South Sefton Clinical Commissioning Group
NHS Southport and Formby Clinical Commissioning Group
NHS Warrington Clinical Commissioning Group

Collaborative Policy Development Project: Governing Body paper seeking sign off of all policies reviewed to date, ahead of implementation with Providers

Authors: Midlands and Lancashire CSU Clinical Directorate

Harinder Kaur, Senior IFR Development Lead and
Michael O'Brien, Policy Development Project Manager
Jo Navin, Communications and Engagement Senior Manager
Jenny Mulloy, Equality and Inclusion Business Partner

Date: Friday 8th December 2017

Contents

Executive Summary

The purpose of this paper is to support Clinical Commissioning Group (CCG) Governing Bodies with their processes to agree and sign off the policies in the current *Cheshire and Merseyside Procedures of Lower Clinical Priority (PLCP) and Fertility policy 2014/15* that have been through a process to review and update the procedures and treatments listed within the policy, which is being project managed by Midlands and Lancashire Commissioning Support Unit (MLCSU).

The project is being managed on behalf of 7 CCGs and following just over a year of work, CCGs are now in a position to implement 42 reviewed and updated policies with providers. This paper outlines the background to the project and the process that has been followed in order to review and engage on the proposed changes with both clinicians and the public. The paper also demonstrates the decisions that have been taken by the Project Working Group throughout the journey for each policy and the key decisions that were taken in November 2017 following extensive work from an equality and engagement perspective to understand how certain changes may impact on clinicians, patients and the public.

CCG Governing Bodies are asked to agree and sign off the policies that have been developed so that formal notification can be sent to providers, allowing all reviewed policies to be issued in February 2018.

Background to the Project

Since September 2016 MLCSU and seven Merseyside and Warrington Clinical Commissioning Groups have been working collaboratively to review the procedures and treatments listed in the current *Cheshire and Merseyside Procedures of Lower Clinical Priority (PLCP) and Fertility policy 2014/15* and develop new policies as directed by the CCGs. The review has been undertaken as part of policy harmonisation for the CCGs involved.

For clarity, the current suite of policies available requires updating. This project is part of a regular review of policies that was due to take place in 2015; however this was delayed due to organisational change within Commissioning Support Units. There are over 100 policies that require review and possible update.

MLCSU has implemented a Policy Development team to review and update clinical policies with the aim of minimising postcode variations to commissioning across CCGs involved by having a single local clinical policy. This service specification is more cost effective because it is delivered at scale for all 7 CCGs.

CCGs engaged in the Project

CCGs engaged in the Policy Development Project are:

- Halton CCG
- Knowsley CCG
- Liverpool CCG
- St Helens CCG
- South Sefton CCG
- Southport and Formby CCG
- Warrington CCG

The process

The process for reviewing each policy has been as follows:

1. At the start of each phase in the project the views of the Working Group were sought, to determine which policies they wish to see progressed within that stage. Decision making here has been supported by analysis of activity and costs via SUS and Aristotle to determine high cost and activity procedures to focus on in the early stages of the project.

2. Policies for review have been shared with the MLCSU IFR Panel for their initial clinical input and this has included input from Public Health and Medicines Management experts.

3. Any suggested amendments made by the IFR panel are then circulated to the Virtual Clinical Forum (VCF) which is made up of representative GPs from the participating CCGs. The Forum has provided comments and suggestions in light of the feedback received from the IFR panel. At this stage an initial draft for each policy has been created by the Project Team.

4. Initial drafts have been taken to the PDP Working Group for review. The Working Group has also identified where specialist input may be required and if this is the case it is sourced by the Project Team, for example, the cataracts policy and the suite of back pain policies.

5. Once the Working Group were content with the revised draft proposals they were then shared by CCG Commissioning Leads with their CCG GP leads and Secondary Care Providers. This was not a form of public communications and engagement, as it was carried out separately. Following GP and secondary care feedback, was discussed with the Working Group and any necessary further amendments were made.

6. Once the Working Group was content with the revised draft proposals they were then shared with the public for communications and engagement work to take place. This engagement was determined by the level of change to the criteria between the original and proposed new draft of each policy, where three levels of engagement were identified and the appropriate level applied to each policy. Each policy was RAG rated, with Red rated policies containing elements of change that will affect patient access to that treatment. Green rated policies have not required any form of engagement.

7. The Governing Bodies for each CCG have previously been sighted on all policies and the proposed change and RAG rating.

8. Equality Impact and Risk Assessments (EIRA) have been completed on every policy and these have been progressed alongside the policies as they were being developed by the Project Team.

9. Legal advice has not been required against any of the policies in suites 1 and 2 and this has been determined via discussion with the PDP Working Group and input from the CCGs Communications Leads who have also been involved in the project.

10. Please be aware, a slightly different process was followed for the back pain policies as described at points 2 and 3 above. These policies were developed by working jointly with colleagues at the Walton Centre to align our proposed policies with the National Back Pain pathway that is being implemented in the region. Once the proposals were drafted, they were shared with the IFR Panel, the VCF and the Working Group for feedback before re-entering the process described at point 5 above.

How has each policy in suites 1 and 2 been developed?

Each policy has developed via the process described at page 2 above. Appendix 1 demonstrates the decisions taken against each policy and where, by whom and on what date the decision was taken to propose the change. This also includes the rationale for the decision. Given the extensive discussions held for each policy and the robust nature of the process we have followed, we have summarised all outcomes in the appendices. The minutes of each meeting and agreements made have been recorded and can be made available.

Suites 1 and 2 followed two distinct timescales. All policies in suite 1 were developed between September 2016 and January 2017. Given the low number of red rated policies in this suite, and the anticipated period of purdah that was due to take place from 27th March, the Working Group took the decision to move forward with the review of the policies in suite 2. It was anticipated that there would be a larger number of red rated policies in this suite because the focus for this suite was on cosmetic procedures. What was not anticipated was the snap general election that was called and extended the purdah period. We worked on the suite 2 policies between late January and mid-April.

At this point, to maintain momentum whilst we awaited the end of the purdah period, the project team also began a rapid review of 16 further back pain policies (not originally included in suites 1 or 2) working collaboratively with the Walton Centre due to their involvement with the National Back Pain Pathway. This work was completed during May 2017, in time for the beginning of the engagement period on the suites 1 and 2 red policies which started on 26th June and closed on the 18th September 2017.

The report of findings was then produced throughout October 2017 and issues coming out of the Communications and Engagement work and EIRA work were brought to the Working Group in November for discussion and decision. This is explained in more detail on pages 11 to 13.

Which Policies require CCG GB sign off?

All policies from suites 1 and 2 of the project now require final CCG Governing Body sign off. The following table summarises which policies went to engagement (Red) and those where this was not required (green) and provides a brief summary of changes for each red policy. Further detail can be found in Appendix 2:

Policy name	Suite	What has changed?
Policy Introduction	n/a	The introduction to the policy has been shortened to make it more succinct and more straightforward. The key issue to note here is the removal of the line saying the children under 16 can be eligible for certain cosmetic treatments for psychological reasons. This is explored in detail at page 11.
1. Policy for Surgical Treatments for Minor Skin Lesions	1	Statement stating the exemption of children from these policies, meaning children under 16 has been removed and therefore, will no longer be able to have surgery for Minor Skin Lesions due to cosmetic or psychological reasons. Specific criteria for this procedure have been clarified.
2. Rhinoplasty	1	Sentence stating the exemption of children from these policies has been removed; meaning children under 16 will no longer be able to have surgery for Rhinoplasty due to cosmetic or psychological reasons. Specific criteria for this procedure have been clarified.
3. Surgical removal of Lipoma	1	Not routinely commissioned. Lipoma's will be removed in cases where function of patient is inhibited but not for cosmetic or psychological reasons Policy will now also apply to children under 16 - specifically, psychological distress being removed. Statement referring to policies not applying to children under 16 has been removed in line with other policies.
4. Haemorrhoidectomy - Rectal Surgery & Removal of Haemorrhoidal Skin Tags	1	Removal of Grade 1 and 2 from surgery. This is clinically justified due to simple non-surgical treatments being available for these grades.
5. Policy for Hair Removal Treatments including Depilation, Laser Treatment or Electrolysis – for Hirsutism	1	Treatment criteria has been limited to only include; • Has undergone reconstructive surgery leading to abnormally located hair-bearing skin OR • Is undergoing treatment for pilonidal sinuses to reduce recurrence • All other criteria have been removed for clarity.
6. Surgical Revision of Scars	1	The following more specific criteria has been outlined: • For severe post burn cases or severe traumatic scarring OR • Revision surgery for scars following complications of surgery, keloid formation or other hypertrophic scar formation will only be commissioned where they are significantly functionally disabling or to restore normal function • The statement at the start of each policy, referencing cosmetic or Psychological problems, will not be included as a reason for surgery to take place. This is inclusive of both adults and children.
7. Cataracts Policy	1	The referral criteria has been reviewed and made less ambiguous for clinicians to refer. Additionally, more specific examples of what constitutes as 'quality of life' has been included in the policy to support appropriate referrals.
8. Removal or Replacement of Silicone Implants	2	The criteria for this operation now reflects the public health guidance, which outlines that for implants which have been inserted outside of the NHS, but have defected, the patient must seek advice from the original provider and only in the case of the implants failing and the original provider not being available or refusing to help, will breast implants be removed by the NHS.

Policy name	Suite	What has changed?
9. Male Breast Reduction Surgery for Gynaecomastia	2	The position of this policy has not changed and remains 'not routinely commissioned' however, it was previously written in a way which implied that the procedure was available under certain criteria.
10.Laser Tattoo Removal	2	The position of this policy has not changed and remains 'not routinely commissioned' however, it was previously written in a way which implied that the procedure was available under certain criteria.
11.Apronectomy or Abdominoplasty	2	The position of this policy has not changed and remains 'not routinely commissioned' however, it was previously written in a way which implied that the procedure was available under certain criteria.
12.Other Skin Excisions, Body Contouring Surgery	2	The position of this policy has not changed and remains 'not routinely commissioned' however, it was previously written in a way which implied that the procedure was available under certain criteria.
13.Surgical Treatments for Hair Loss	2	The differences in this policy are as follows: • the title of the policy has been clarified as 'Surgical Treatments for hair loss' • the proposed position for treatments to correct alopecia is that these are no longer commissioned • the proposed position for hair transplantation is that these are no longer commissioned • under the current commissioning policy, there are separate entries for Treatments to Correct Hair Loss for Alopecia, Hair Transplantation and Treatments to Correct Male Pattern Baldness so these have all been merged into one policy statement • clarity around access to wigs via the NHS has been included
14.Rhytidectomy - Face or Brow Lift	2	The criteria has been laid out more clearly and the following criteria have been removed: • To correct the consequences of trauma OR • For significant deformity following corrective surgery. However funding will not be approved to improve previous cosmetic surgery. In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity.
15.Circumcision	2	For Liverpool CCG, this procedure will no longer be available cultural and religious reasons. There is also a change to the criteria regarding pain on arousal as being a clinical reason to require the surgery. The addition of these criteria improves access to this procedure.
16.Pinnaplasty	2	Changing from set criteria to not routinely commissioned. Patients may apply for this procedure via an IFR. Removal of statement making children exempt from policy which means children under 16 will no longer be able to have a Pinnaplasty procedure for cosmetic or psychological reasons.
17.Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias and Surgical correction of Diastasis of the Recti	1	No change
18.Surgery for Asymptomatic Gallstones	1	No change
19.Dilatation and Curettage	1	No change

Policy name	Suite	What has changed?
20.Policy for Private Mental Health Care- Non-NHS Commissioned Services: including Psychotherapy, adult eating disorders, general in-patient care, post-traumatic stress, adolescent mental health	1	No change
21.Policy for Hyaluronic Acid and Derivatives Injections for Peripheral joint pain	1	No change
22.Hip Replacement Surgery	1	No change
23.Knee Replacement Surgery	1	No change
24.Surgical Removal of Ganglions	1	No change
25.Adenoidectomy	1	No change
26.Policy for Tonsillectomy for recurrent Tonsillitis (excluding peri-tonsillar abscess) Adults and Children	1	No change
27.Hysterectomy for Heavy Menstrual Bleeding	1	No change
28.Varicose Veins Treatments	1	No change
29.Reduction Mammoplasty	2	This procedure went out to engagement as a red rated policy because it was proposed that the age criteria for this treatment increased from 18 to 21. However, following feedback from the EIRA and communication and engagement work as well as a lack of clinical evidence that could be cited to justify this change, the proposed change in the age criteria has been withdrawn and will remain at 18.
30.Breast Enlargement	2	This procedure went out to engagement as a red rated policy because it was proposed that the age criteria for this treatment increased from 18 to 21. However, following feedback from the EIRA and communication and engagement work as well as a lack of clinical evidence that could be cited to justify this change, the proposed change in the age criteria has been withdrawn and will remain at 18. There has also been a clarification around congenital absence (the obvious lack of breast tissue that is evident from birth) criteria which states there must be congenital absence with a difference of three cup sizes.
31.Mastopexy - Breast Lift	2	No change
32.Surgical Correction of Nipple Inversion	2	No change
33.Surgical Treatment for Pigeon Chest	2	No change
34.Labiaplasty, Vaginoplasty and Hymenorrhaphy	2	No change
35.Liposuction	2	No change
36.Policy for non-invasive interventions for low Back pain and sciatica	2	Aligned with the National Back Pain Pathway and NG 59.
37.Imaging for patients presenting with back pain.	2	Aligned with the National Back Pain Pathway and NG 59.

Policy name	Suite	What has changed?
38.Injections for back pain	2	Aligned with the National Back Pain Pathway and NG 59. *(Incorporating the previous policies for Facet Joint - Non Specific Back Pain Over 12 Months including radio frequency ablation, Epidural Injection, Radiofrequency Facet Joint Denervation Intra Discal Electro Thermal Annuloplasty (IDET) Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT) Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS))*
39.Spinal Fusion	2	Aligned with the National Back Pain Pathway and NG 59. *(Incorporating the previous policies for fusion,Non-Rigid Stabilisation Techniques,Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine and Transaxial Interbody Lumbosacral Fusion)*
40.Disc and Decompression procedures	2	Aligned with the National Back Pain Pathway and NG 59. *(Incorporating the previous policies for Endoscopic Laser Foraminoplasty, Endoscopic Lumbar Decompression, Percutaneous Disc Decompression using Coblation for Lower Back Pain, Percutaneous Intradiscal Laser Ablation in the Lumbar Spine, Automated Percutaneous Mechanical Lumbar Discectomy and Prosthetic Intervertebral Disc Replacement in the Lumbar Spine)*
41.Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain	2	Aligned with the National Back Pain Pathway and NG 59.
42.Therapeutic Endoscopic Division of Epidural Adhesions	2	Aligned with the National Back Pain Pathway and NG 59.

Decisions taken by the Policy Development Working Group following communications and engagement and Equality Impact and Risk Assessment (EIRA) work

Following the production of the report of findings from the communications and engagement work, the Project team analysed all issues raised through both these elements of the project and called a meeting of the Working Group on 16th November 2017. There were **two** issues that required Commissioning Lead discussion and decision:

1. Increasing the age criteria on the Breast related policies from 18 to 21.

As noted previously, a proposed amendment to the policies for Breast Augmentation and Reduction was to change the age criteria from 18 to 21. The project team and Public Health and GP colleagues were unable to find any evidence to support the suggestion that a womans physiological and hormonal development is more advanced at 21 so the following options were outlined for CCGs:

Option 1	**Option 2**	**Option 3**
Keep the age criteria as they are (18+) No clinical evidence can be sourced that supports this criteria:	Implement the age change in criteria without evidence (21+) No clinical evidence can be sourced that supports this line:	Implement the age change in criteria without evidence but cite that this is the case, therefore suggesting the policies are reviewed for impact after 12 months, taking into account activity, complaints, FOIs, PALs, SARs requests etc. No clinical evidence can be sourced that supports this line
IMPACT OF IMPLEMENTING OPTION 1: No impact will be seen here	**IMPACT OF IMPLEMENTING OPTION 2:** Activity and costs are likely to reduce however, CCGs may be open to legal challenge given that there is no clinical evidence cited to support this change in criteria	**IMPACT OF IMPLEMENTING OPTION 3:** Activity and costs are likely to reduce however; CCGs may be open to legal challenge given that there is no clinical evidence cited to support this change in criteria. If the impact seen is detrimental to patients and CCGs reputation, these policies can be reviewed at an earlier stage and rectified if required
RISK AVOIDED	**RISK ACCEPTED**	**RISK EXPLOITED**

An in depth discussion was held by Working Group members, and an informed decision was taken by representatives from Halton, Knowsely, South Sefton, Southport and Formby and Warrington CCG colleagues to proceed with **option 1 – keep the age criteria for the Breast procedures at 18.**

2. Removal of the children and psychological impact line from the introduction

The second issue requiring a decision by Working Group members was around the suggestion to remove the following line from the introduction to the policy : *Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress.* The policies affected by this line are:

- Rhinoplasty
- Surgical removal of lipoma
- Policy for hair removal
- Surgical removal of scars
- Pinnaplasty
- Removal of Skin lesions

- Surgical treatments for Hair loss

The following options were outlined to the Working Group members:

Option 1	Option 2	Option 3
Keep the original line in the policy **IMPACT OF IMPLEMENTING OPTION 1:** No impact will be seen here	Remove the line regardless of the potential impact **IMPACT OF IMPLEMENTING OPTION 2:** Activity and costs are likely to reduce however; CCGs may be open to legal challenge given that there is no clinical evidence cited to support this change in criteria. Given that these changes affect children this is a particularly emotive issue and is likely to gain significant scrutiny. Mitigation here is around other options that would be available to support children from a psychological point of view.	**There is a subsequent line in the policy that states:** *Psychological distress alone will not be accepted as a reason to fund surgery except where this policy explicitly provides otherwise. Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as a route into aesthetic surgery.* Combining the lines will allow the overall policy to remain clear that psychological distress alone will not be accepted as a route to surgery, however it could also be made clear that children need to meet all the criteria, as well as being able to cite psychological distress as a factor in their application for treatments **IMPACT OF IMPLEMENTING OPTION 3:** No impact will be seen here, and this will bring treatments for children more closely in line with the spirit of the review – to tighten up and strengthen the current criteria, whilst supporting CCGs duty of care towards patients, especially those more vulnerable in society.
RISK AVOIDED	**RISK ACCEPTED**	**RISK TRANSFERED**

This was a more difficult issue to address, with a range of arguments put forward for both retaining and removing the line. The argument for keeping this line in the policy focused on the fact that by removing this line there may be a risk of challenge because children are not the same as adults; they are less resilient to deal with physical and associated psychological issues so this could be a risk from an equality perspective. The main counter point for removing this line from the introduction was that NHS resources should not be used to address wider societal issues such as bullying, especially in relation to cosmetic procedures such as those affected by this change.

The Working Group felt that none of the options outlined would effectively address this issue, so it was suggested that the correct approach would be for all patients regardless of age to have had psychological assessment and support, i.e. input from IAPT for adults and CAMHS for children before surgery is offered as an option. The decision was taken by representatives from Halton, Knowsley, South Sefton, Southport and Formby and Warrington CCG colleagues to proceed with an option similar to **option 3 – a line has been developed based on an existing line in the introduction which now states:**

Psychological distress alone will not be accepted as a reason to fund surgery. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient's psychological wellbeing, their duration and

impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention.

Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as a route into aesthetic surgery. Any application citing psychological distress will need to be considered as an IFR .

Representatives from Liverpool and St Helens CCGs were unable to attend the meeting; however they have since confirmed via email on 15th November and 21st November respectively, that they are in agreement with the decisions taken by their colleagues on the wider Working Group. The minutes of the Working Group meeting where these issues were discussed can be found in appendix 3.

The final version of the revised Policy Introduction can be found at Appendix 4.

Executive Summary

This summary outlines the methodology, summary of results and external factors in relation to suite 1 and suite 2 policies as part of the Procedures of Lower Clinical Priority review work, publically known as 'Reviewing local health policies'. Detailed results analysis and comments from the survey, meetings and focus group can be found amongst appendices 5, 6 and 7.

Introduction

The Health and Social Care Act 2012 says NHS organisations have a duty to promote involvement of each patient and have, in S.14Z2 a duty to involve the public and consult where commissioning arrangements will change and this means that the implementation of changes will have an impact on the manner in which these services are delivered or the range of health services delivered to them.

The following section outlines the methodology used to determine appropriate engagement levels per policy and a summary of the results from the survey, meetings and events in accordance with the Health and Social Care Act 2012.

Methodology

Equality Impact Assessments and their role in the engagement plan

An Equality Impact Assessment was carried out for each of the policies reviewed in suite 1 and 2, which set out the approach for the engagement plans, providing a clear understanding of the change to each policy and what would be proportionate and fit for purpose engagement, considering the level of change. The Gunning principles were applied as follows; Public groups, OSCs and other clinic stakeholders were consulted as part of policy development work. There was then an open public engagement period of 12 weeks where surveys, meetings and focus groups were held. This length of time was chosen to reflect the volume of policies out for engagement. After this engagement period, all responses have been analysed and fed back to each CCG to consider in their final decision making.

NHS England were consulted upon during the development of engagement plans, in relation to the approach to engagement, ensuring the activity carried out would be meaningful and patients and public would be considered proportionately and fairly. Feedback from NHS England confirmed the approach was fit for purpose.

A communications and engagement working group was established with representation from all seven CCGs involved, as well as a project lead, a media lead, 2 senior engagement team members and Cheshire and Merseyside Area Lead from MLCSU. This group met on a monthly basis to discuss and make decisions about engagement plans for each of the policies. Additionally, a working plan was set out on a weekly basis outlining key activity for the upcoming week and any tasks which need to be completed. This allowed for an open, comprehensive and agile approach to the project.

It was clear from both the levels of proposed change and the EIAs that varying levels of engagement would be required for the policies and so a 'levelling' structure was developed. This structure ensured that each policy was given the due regard required and specifically identified and targeted the associated members of the public for their views. Levels were assigned to policies by the communications and engagement working group and approved by commissioners and third sector stakeholders.

Please see below a description of these engagement levels.

Table 1 – Engagement level explanation

Engagement Level	**Description**
1	Survey posted online and offline with no specific target
2	Survey posted online and offline, targeted as specific cohorts of people through social media and support groups/charities. Additional specific FAQs.
3	Survey posted online and offline, targeted as specific cohorts of people through social media and support groups/charities with, additional specific FAQs and 1 event OR face to face meeting with relevant groups

Once an engagement level has been assigned to the policy, an individual plan was developed for each of the policies outlining the specific cohorts of the public who will be targeted for engagement, and how this will be carried out.

For members of the public, clinicians, staff and third sector, 12 week engagement was carried out from 26th June until 18th September 2017 in the following forms.

Survey
The survey was designed in accordance with the Office of National Statistics where protected characteristics were included and measured as part of the survey.

The survey was designed with a mixture of both quantitative and qualitative questions, allowing respondents to provide free text to support the reason why they may have chosen to agree or disagree with the proposed change. For each policy, a plain English document was provided which summarised the policy and provided the rationale for the proposed change to allow participants to make an informed decision.

The following survey was provided in three ways;

1. Online – via elesurvey, a system that is compliant with UK Information Governance laws.

2. Hard copy –provided with a freepost envelope for return

3. Telephone - The phone line was available for members of the public to find out more information or ask questions about the survey and engagement process as well as carrying out the survey over the phone.

Providing the survey in these formats ensured that it was made as accessible as possible for all. In addition, all information about the project was provided in an easy read format and options for those who required the information in an alternative language was also promoted on all CCG websites, on the survey and on promotional materials such as the leaflet.

Meetings and events

Meetings and events attended followed a consistent approach and structure to allow for meaningful analysis and responses to coincide with survey results.

The following structure was used at each of the events and meetings attended;

- Introduction to project
- Approach to engagement outlined
- Discussion with group around aims and objectives
- Overview of policies included in suite 1 and 2
- Any specific policies highlighted by the group for further discussion and evaluation
- Feedback collected
- close

At each event or meeting the following materials were provided;

- Hard copies of the survey, including freepost envelope
- Leaflet explaining the rationale for the project
- All attendees were encouraged to complete the surveys

Throughout the engagement process and analysis of survey and meeting results, it became clear that further clarity and information regarding the removal of the ‘children’s statement’ was required and so a focus group was conducted with the support of Young Peoples Advisory Service to gain better insight to the concerns raised in the survey results about the statement being removed.

For full details of outcomes of meetings and events and list of meetings and events attended, please see appendix 5.

External factors to consider

Media misrepresentation of facts

Although most media coverage for this work was balanced (see Appendix 5 for full media outcome details), for some of the policies, media misrepresentation of proposed changes to the policy caused some respondents to disagree with the change when asked if they agree or disagree, however within their comments supporting their agreement choice, respondents fundamentally disagree with the ‘cut’ of a service, as opposed to the update of criteria. In these instances, it was found that the negative comments supported the proposed change, resulting in quantitative analysis suggesting a larger proportion of people disagree with proposed change than the real number of people.

The following policies were mostly affected by this coverage;

- Hemorrhoidectomy
- Cataract surgery

Demographic responses
The volume of protected characteristics responding to the survey was recorded throughout, particularly those which were identified in the phase 1 EIA as could be more affected by a proposed policy change. It has been evidenced throughout the process that these identified groups have been targeted through support from the third and voluntary sector, as well as targeted online campaigns where appropriate. In some areas, responses from particular groups have been low, due to low interest in the topic and/or low volumes in communities.

Local area response rates
This work was carried out across the footprint of the seven CCGs involved. This meant that the CCGs could benefit from a larger cross section of responses, rather than being limited to their own area for views, particularly where some demographics may be lacking in some areas.

For the areas where response rates for some policies were low, it was identified that in addition to being able to learn from the other areas results, more extensive face to face engagement was required. The low response rates were generally due to one of the following factors;

- A more elderly population
- A low literacy rate
- Low internet access
- Low volume of people from various characteristics living in the area
- Where there is no change to criteria, but there is updated wording – feedback indicated they did not feel compelled to respond as they did not see the change as concerning or a risk.

Where there was little or no response to some policies which have a higher impact on patients and public, such as the age change for breast surgery and the removal of the statement allowing children to have access to surgical treatments based on psychological distress alone, the group worked to target the survey online to these audiences and also increase engagement, with offer of face to face groups and meetings to these target audiences. This additional work is documented in the documents below (see appendices 5, 6 and 7.).

All feedback from meetings and events was then coded in the same way as survey responses to provide consistency of analysis.

Results Summary
In total 187 people responded to the survey and over 120 people were reached via meetings and events across the 7 areas. The total number of responses and detailed responses per policy can be found in appendix 6.

Survey results were monitored on a weekly basis and any areas for concern, such as low response rate, was addressed either by increasing face to face activity or using social media targeting.

There was additional focus in areas where patient's impact was higher, for example, age changes or psychological distress restriction.

On review of results analysis as a project as well as local results, there were two key areas for concern raised by respondents for commissioners to consider;

1. Disagreement with changing the age of breast surgery from 18 to 21 years.
2. Some disagreement with the removal of the statement, currently allowing children under the age of 16 to have access to treatments purely based on cosmetic of psychological distress.

Based on these results and some additional face to face engagement with YPAS, MLCSU provided the CCGs with three options for addressing these issues, each relating the risk each option presents. These were then discussed as a working group and an option chosen, which takes into consideration the engagement work. This has been explored in detail at pages 11 to 13.

Once all Governing Bodies have reviewed and agreed on proposed updates to policies, a public facing summary document will be produced to share with the third and voluntary sector and to those who took part in the survey in order to demonstrate how their views made an impact on decision making.

Approach to Equality Impact and Risk Assessments (EIRA)

The Equality and Inclusion Team have equality impact and risk assessed all policies in suites 1 and 2 of the Policy Development project. Appendix 8 summarises the potential impact of changes proposed against all red rated policies and includes recommendations and actions that were considered by the policy group to ensure the CCGs meet their equality duty of "due regard" in relation to the Equality Acts Public Sector Equality Duty and to minimise any potential risk of challenge.

Back pain policies were noted as green policies and did not undergo engagement work under the Policy Review Group but instead went through a period of 'communication' during summer 2017. These policies were reviewed in alignment with the Walton Centre Vanguard work and the recently published NICE Guidance *Low back pain and sciatica in over 16s: assessment and management (NG59), November 2016*.

Draft Stage 1 EIAs from suite 2 that have previously been discussed at the policy group have been shared with the Merseyside Equality Lead – Andy Woods.

Considerations from meetings with the Working Group:

- All draft policies ragged as red have had a draft pre-engagement EIA completed – this is the stage 1 reports.
- The policies to undergo engagement were then updated with engagement feedback. All the EIAs have been revised to account for the proposed introduction change regarding children and young people under the age of 16 not receiving treatment based on psychological distress. Suite 2 Stage 2 EIAs have now noted the decision made at the Policy Development Group meeting on 14th November 2017 to retain the introduction line with a caveat that a medical intervention can be considered for children on the grounds of psychological distress on the grounds of possible challenge under the protected group of 'Disability'.
- The Suite 2 Stage 2 EIAs in relation to Breast treatment policies have been updated to reflect the decision made at the Policy Development Group meeting on 14th November 2017 to retain the minimum age eligibility criteria at 18 to avoid any possible challenge on indirect discrimination under the protected group of age.
- All updated EIA's have been converted into PDF and are included at appendix 9. These completed documents contain the stage 1 and stage 2 reports in one PDF.
- Discussion regarding future monitoring of IFR requests to include protected characteristics in order to identify areas of potential discrimination. Current monitoring of requests is limited and it is difficult to demonstrate that all groups are being treated fairly as data is not collected at protected group level. This issue sits within the IFR Process
- Consideration of wider governance and ensuring that decision makers / Governance Boards / committees within the CCG's know their legal duties – Public Sector Equality Duty.– CCG's to be aware of this. Previous paper was distributed to policy group members.
- It is recommended that EIAs are reviewed at least every 3 years.

Summary of CCG GB Dates and actions required from CCG Governing Bodies

ACTION: All CCG Governing Bodies are asked to confirm their acceptance of the proposals within this paper so that policies can go live with providers from week commencing Monday 15th January 2018

South Sefton CCG	Southport & Formby CCG	Liverpool CCG	St Helens CCG	Halton CCG	Knowsley CCG	Warrington CCG
19th December 2017	19th December 2017	9th January 2018	10th January 2018	4th January 2018	tbc	10th January 2018
Tuesday	Tuesday	Tuesday	Wednesday	Thursday	tbc	Wednesday

Policy Go Live

All CCGs should go live with their revised commissioning policies on the same date to ensure minimum disruption to providers, patients and the general public.

Policy go-live was originally identified as Wednesday 17th January 2018, however following discussion with the Working Group it has been agreed that once notification from all CCGs has been received that they have ratified the proposed policies, a formal letter will be issued to all providers, including a copy of the final revised policy, giving them the required 4 weeks' notice of the impending policy changes.

Midlands and Lancashire Commissioning Support Unit

NHS Halton Clinical Commissioning Group
NHS Knowsley Clinical Commissioning Group
NHS Liverpool Clinical Commissioning Group
NHS St Helens Clinical Commissioning Group
NHS South Sefton Clinical Commissioning Group
NHS Southport and Formby Clinical Commissioning Group
NHS Warrington Clinical Commissioning Group

Collaborative Policy Development Project: Governing Body paper seeking sign off of all policies reviewed to date, ahead of implementation with Providers

Appendix 1

Rationale for decisions tracker – suites 1 and 2 policies

December 2017

Contents

Suite 1 Red rated Policies

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Policy for Surgical Treatments for Minor Skin Lesions	Working Group Meeting 1 minutes	Ensure 5 different pathways identified: • Suspected or proven malignancy (cancerous) • Symptomatic e.g. ongoing pain or functional impairment. • Risk of infection. • Significant facial disfigurement. • All vascular lesions on the face except benign, acquired vascular lesions such as thread veins Because if there is a suspicion of cancer this needs to go to 2ndary care, the rest to community providers	Working Group	19/10/2016	Yes
	Working Group Meeting 1 minutes	Remove reference to Laser treatment as this isn't relevant to this policy	Working Group	19/10/2016	Yes
	Working Group Meeting 3 minutes	Remove proven malignancy criteria as this would go to secondary care anyway HK felt we should keep this line in because it gives assurance and avoids doubt. JN noted that DOBs concerns were around the policy not clearly referring patients under 2ww . WG agreed therefore to add the following to clarify: If suspected or proven malignancy refer via appropriate pathway	Denis O'Brien (Liverpool CCG GP)	13/12/2016	Yes
	GP and Provider feedback - Working Group meeting Minutes 4	GPs and Providers are largely content with the proposed policy; however we may need to consider providing more guidance on correct community provider referral pathways.	GP and Provider feedback	07/02/2017	n/a - Policy ready for engagement The Working Group agreed therefore that this policy is now ready for engagement.

	Working Group meeting 11 Minutes	During the summer period (2017) a review of the introduction to the policy was carried out and it was proposed that the following line from the introduction to the policy was removed because it is not clinically appropriate: Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress. This proposed amendment was discussed at length by members following findings of the engagement and EIRA process at WG11 on 14th November as this change affects a small number of cosmetic procedures Options were put to the WG and it was suggested that the correct approach would be for all patients regardless of age to have had psychological assessment and support, i.e. input from IAPT for adults and CAMHS for children before surgery is offered as an option. A line has been developed based on an existing line in the introduction which now states: Psychological distress alone will not be accepted as a reason to fund surgery. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient's psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention. Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as a route into aesthetic surgery. Any application citing psychological distress will need to be considered as an IFR.	Working Group	n/a	Yes – revised line to be implemented in the policy introduction.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Rhinoplasty	Working Group Meeting 2 minutes	implement the Midlands Rhinoplasty policy because MS noted that the main difference between the C&M and Midlands policy on Rhinoplasty is the inclusion of Trauma in the C&M policy criteria, otherwise it is very similar. JW informed the Working Group that deformity caused by trauma is the main way that applications for this treatment are approved at the IFR Panel. The Working Group therefore felt is was necessary to remove the trauma criteria from the C&M policy because if the patient experienced trauma that caused nasal deformity but this was not addressed at the time, the patient should be referred back to the provider for further treatment. The Working Group agreed that functionality is the key issue on this policy.	Working Group	16/11/2016	yes
	GP and Provider feedback - Working Group meeting Minutes 4	GPs and Providers are largely content with proposed policy. Feedback from Working Group required on the comments from Knowsley CCG in relation to trauma: Inequity if we don't offer rhinoplasty following trauma – as we are suggesting we do treat scarring post burns which could be classed as 'trauma'. Suggested inclusion - Rhinoplasty offered for severe deformity caused by trauma. Notes from the Working Group held on Tuesday 16th November state: '…Deformity caused by trauma is the main way that applications for this treatment are approved at the IFR Panel. The Working Group therefore felt it was necessary to remove the trauma criteria from the C&M policy because if the patient experienced trauma that caused nasal deformity but this was not addressed at the time, the patient should be referred back to the provider for further treatment. The Working Group agreed that functionality is the key issue on this policy.'	GP and Provider feedback	07/02/2017	no
	GP and Provider feedback - Working Group meeting Minutes 4	Policy ready for engagement once we address questions around: • Clarifying what 'problems' might mean The Working Group agreed that 'breathing' should be included here. • And seek WG advice on the comments from Knowsley CCG The Working Group referred back to the minutes of the Working Group held in November 2016: 'Deformity caused by trauma is the main way that applications for this treatment are approved at the IFR Panel. The Working Group therefore felt it was necessary to remove the trauma criteria from the C&M policy because if the patient experienced trauma that caused nasal deformity but this was not addressed at the time, the patient should be referred back to the provider for further treatment. The Working Group agreed that functionality is the key issue on this policy'	GP and Provider feedback	07/02/2017	Yes
	Working Group Meeting 4 Minutes	Amend wording around breathing problems in the rhinoplasty policy.	Working Group	07/02/2017	Yes - The Working Group agreed therefore that once these actions have been completed this policy is now ready for engagement.

	Working Group meeting 11 Minutes	During the summer period (2017) a review of the introduction to the policy was carried out and it was proposed that the following line from the introduction to the policy was removed because it is not clinically appropriate: Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress. This proposed amendment was discussed at length by members following findings of the engagement and EIRA process at WG11 on 14th November as this change affects a small number of cosmetic procedures Options were put to the WG and it was suggested that the correct approach would be for all patients regardless of age to have had psychological assessment and support, i.e. input from IAPT for adults and CAMHS for children before surgery is offered as an option. A line has been developed based on an existing line in the introduction which now states: Psychological distress alone will not be accepted as a reason to fund surgery. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient's psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention. Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as a route into aesthetic surgery. Any application citing psychological distress will need to be considered as an IFR .	Working Group	n/a	Yes – revised line to be implemented in the policy introduction.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Policy for Surgical removal of Lipoma	Working Group Meeting 2 minutes	Project Team to remove the reference to secondary care in the title of the C&M Lipoma policy as this is not relevant wording to use	Working Group	16/11/2016	Yes
	Working Group Meeting 2 minutes	Project Team to review the Midlands Lipoma policy to ensure we have included all the relevant criteria.	Working Group	16/11/2016	yes
	Working Group Meeting 2 minutes	Project Team to implement the Midlands Lipoma policy for removal of Lipoma (removal of lipomata policy) because JW informed the Working Group that this procedure is probably carried out for cosmetic and functional reasons and that if the criteria is tightened so that it is only carried out for Lipomas on the face, volumes of activity may reduce. HK noted that we will need to include criteria in this policy around suspected malignancy and to provide histological evidence where there are multiple subcutaneous lesions.	Working Group	16/11/2016	yes
	Working Group Meeting 2 minutes	Project Team to ensure the wording in the revised Lipoma Policy is similar to the revised skin lesions policy	Working Group	16/11/2016	yes
	GP and Provider feedback - Working Group meeting Minutes 4	GPs and Providers are largely content with proposed policy. Size of lipoma does not require clarification because if there is significant functional impairment a referral can be made.	GP and Provider feedback	07/02/2017	n/a - Policy ready for engagement The Working Group agreed therefore that this policy is now ready for engagement.

	Working Group meeting 11 Minutes	During the summer period (2017) a review of the introduction to the policy was carried out and it was proposed that the following line from the introduction to the policy was removed because it is not clinically appropriate: Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress. This proposed amendment was discussed at length by members following findings of the engagement and EIRA process at WG11 on 14th November as this change affects a small number of cosmetic procedures Options were put to the WG and it was suggested that the correct approach would be for all patients regardless of age to have had psychological assessment and support, i.e. input from IAPT for adults and CAMHS for children before surgery is offered as an option. A line has been developed based on an existing line in the introduction which now states: Psychological distress alone will not be accepted as a reason to fund surgery. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient's psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention. Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as a route into aesthetic surgery. Any application citing psychological distress will need to be considered as an IFR .	Working Group	n/a	Yes – revised line to be implemented in the policy introduction.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Haemorrhoidectomy – rectal surgery & removal of haemorrhoidal skin tags	Working Group Meeting 2 minutes	Implement the criteria from the Midlands Haemorroidectomy policy because the Midlands policy is based on more recent evidence from the Royal College of Surgeons (2013).	Working Group	16/11/2016	Yes
	Working Group Meeting 2 minutes	Maintain the current C&M criteria for removal of skin tags because JN noted that the Midlands policy is more robust around Haemorrhoidectomy but that there is no reference to removal of skin tags. HK conformed that the removal of skin tags is not routinely commissioned and that this will be maintained in the C&M Haemorrhoidectomy policy. The Group agreed that we will implement the Midlands criteria for Haemorrhoidectomy - Rectal Surgery & Removal of Haemorrhoidal Skin Tags and maintain the policy around the removal of skin tags being not routinely commissioned.	Working Group	16/11/2016	Yes
	Email from MM Colleagues on 30/11/2016	Addition of sentence to the rationale section: 'or using standard topical measures' for clarity	MM Team	30/11/2016	Yes

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Policy for Hair Removal Treatments including depilation, laser treatment or electrolysis – for hirsutism	Working Group Meeting 2 minutes	keep the C&M title but use Midlands criteria because JW suggested that for the policy around hair Removal Treatments we should use the C&M policy title but implement the Midlands criteria because this is a cosmetic procedure. The Working Group agreed with these suggestions.	Working Group	16/11/2016	Yes
	Email from MM team - 09.12.2016	Second sentence in first paragraph is misleading and implies laser and electrolysis are the usual lines of treatment. It should read 'Permanent depilation may be achieved by electrolysis or laser therapy.	MM Team	09/12/2016	Yes
	Email from MM team - 09.12.2016	Medical treatments bullet point should read 'Eflornithine or co-cyprindiol tablets (anti-androgen)'. There is not a range of anti-androgens licensed for hair removal.	MM Team	09/12/2016	Yes
	Email from MM team - 09.12.2016	Everything in the box on page 2 from Hair depilation……. to the end of the medical treatments bullet point should come out of the box and go under the heading as an introduction as with the lipoma and adenoidectomy policy.	MM Team	09/12/2016	Yes
	Email from MM team - 09.12.2016	The statement box should begin with 'Hair depilation is restricted.' And then the rest that follows is fine.	MM Team	09/12/2016	Yes
	GP and Provider feedback - Working Group meeting Minutes 4	During the summer period (2017) a review of the introduction to the policy was carried out and it was proposed that the following line from the introduction to the policy was removed because it is not clinically appropriate: Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress. This proposed amendment was discussed at length by members following findings of the engagement and EIRA process at WG11 on 14th November as this change affects a small number of cosmetic procedures Options were put to the WG and it was suggested that the correct approach would be for all patients regardless of age to have had psychological assessment and support, i.e. input from IAPT for adults and CAMHS for children before surgery is offered as an option. A line has been developed based on an existing line in the introduction which now states: Psychological distress alone will not be accepted as a reason to fund surgery. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient's psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their	Working Group	n/a	Yes – revised line to be implemented in the policy introduction.

		coping mechanism removed by inappropriate surgical intervention. Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as a route into aesthetic surgery. Any application citing psychological distress will need to be considered as an IFR .			
	Working Group meeting 11 Minutes	During the summer period (2017) a review of the introduction to the policy was carried out and it was proposed that the following line from the introduction to the policy was removed because it is not clinically appropriate: Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress. This proposed amendment was discussed at length by members following findings of the engagement and EIRA process at WG11 on 14th November as this change affects a small number of cosmetic procedures Options were put to the WG and it was suggested that the correct approach would be for all patients regardless of age to have had psychological assessment and support, i.e. input from IAPT for adults and CAMHS for children before surgery is offered as an option. A line has been developed based on an existing line in the introduction which now states: Psychological distress alone will not be accepted as a reason to fund surgery. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient's psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention. Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as a route into aesthetic surgery. Any application citing psychological distress will need to be considered as an IFR .	Working Group	n/a	Yes – revised line to be implemented in the policy introduction.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Surgical Revision of Scars	Working Group Meeting 2 minutes	implement the Midlands Scars policy because the Working Group agreed that the Midlands policy for the Surgical revision of scars is similar to the C&M policy, although slightly more defined. The Working Group agreed to implement the Midlands policy for Surgical revision of scars and the Project Team will complete an evidence review for this policy.	Working Group	16/11/2016	yes
	Working Group Meeting 2 minutes	complete evidence review	Working Group	16/11/2016	no
	Emails from JW and KC IFR Panel members	I think removing severe post-surgical scarring, and including significantly functionally disabling will help. Agree, it's currently reading in bullet 2 "deformity". I would keep bullet 1 to post burn and traumatic only and include significantly functionally disabling in 2.	IFR Panel members	20/12/2016	yes
	GP and Provider feedback - Working Group meeting Minutes 4	GPs and Providers are largely content with proposed policy. IFR Panel members discussed use of the word 'severe' at length and agreed that this can be a subjective descriptor, therefore decision was taken to remove this word and replace with 'significantly functionally disabling'.	GP and Provider feedback	07/02/2017	n/a - Policy ready for engagement The Working Group agreed therefore that this policy is now ready for engagement.
	Working Group meeting 11 Minutes	During the summer period (2017) a review of the introduction to the policy was carried out and it was proposed that the following line from the introduction to the policy was removed because it is not clinically appropriate: Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress. This proposed amendment was discussed at length by members following findings of the engagement and EIRA process at WG11 on 14th November as this change affects a small number of cosmetic procedures Options were put to the WG and it was suggested that the correct approach would be for all patients regardless of age to have had psychological assessment and support, i.e. input from IAPT for adults and CAMHS for children before surgery is offered as an option. A line has been developed based on an existing line in the introduction which now states: Psychological distress alone will not be accepted as a reason to fund surgery. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient's psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their	Working Group	n/a	Yes – revised line to be implemented in the policy introduction.

		coping mechanism removed by inappropriate surgical intervention. Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as a route into aesthetic surgery. Any application citing psychological distress will need to be considered as an IFR .			

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Cataracts Policy	Working Group Meeting 1 minutes	Project team to compare the current policy to the revised criteria recently implemented in South Sefton and Southport and Formby CCGs, then come back to the working Group	Working Group	19/10/2016	n/a
	Working Group Meeting 2 minutes	Amendments to policy background, criteria re Glare and 2nd eye referral because the background requires updating, the criteria for glare following extensive discussion was felt necessary and the WG felt it needed to be clear in the policy that a separate referral for the second eye is not necessary but is carried out as part of the patient's regular follow up appointments following surgery on the first eye.	Working Group	16/11/2016	yes
	Working Group Meeting 4 minutes	MOB explained to the Working Group that the Cataracts policy has been reviewed by three ophthalmic surgeons, including Mike Briggs the Clinical Director at St Pauls Eye Unit who has provided comments on the draft we are reviewing. Both JH and JW felt that we should be guided by Mike Briggs' comments/draft. JW noted that we should soften the wording around the list of factors affecting quality of life to ensure it is clear this list is to provide guidance and is not prescriptive, or one where multiple factors need to be present. It should however state that a description of the impact of the cataract on the patients quality of life should be documented. The focus should be on the symptoms rather than visual acuity, but VA should still form part of the policy. The final point to note here is that we should remove the second bullet point for the second eye criteria otherwise, this criteria set is too harsh. JW noted that visual acuity is a clinical guideline but this is difficult to administer from a Prior Approvals point of view. You would have to be led by the ophthalmologist and the responsibility lies with them. The referral is for the optometrist so it is really just screening and when a referral gets to the ophthalmologist that is when the decision is made to proceed. The glare has to outweigh the fact that a patient may be able to see reasonably well. Maybe list the criteria in the PA form and then it can be taken to IFR panel.	Working Group	07/02/2017	yes
	Working Group Meeting 6 minutes	These criteria are no different from those we already work with except they don't seem to stipulate a level of vision for second eye surgery which they had previously advised as 6/12 or worse. The Working Group agreed this policy is now ready for consultation	Working Group	25/04/2017	yes

Suite 2 Red rated Policies

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Removal or Replacement of Silicone Implants	Draft policy document and Working Group meeting 5 meeting minutes (28/03/2017)	Removal/replacement implants. - Fri 03/02/2017 10:57 IFR panel feedback We get frequent requests for revision and replacement. Most have had the original surgery in the private sector. The patients mostly present with pain and capsular contracture, there are very few ruptures. Despite what the policy states we tend to approve removal/capsulotomy/capsulectomy due to the patients clinical situation, to relieve the pain. Rarely do we approve replacement. The panels feel uncomfortable declining removal if the patient is in pain. So should we keep the policy as it is and enforce it more strictly, but clinically this is a difficult position to justify, or accept that we should remove if causing functional difficulties and change the policy to reflect this. Another position would be to remove only if rupture?? Working Group meeting 5 Tues 28/03/2017 13:00 agreed position: The WG had a detailed discussion around this policy. It was felt that the line referring to the implants being commissioned originally by the NHS was no longer appropriate given the wide range of private suppliers now in the market. JW noted that if a patient presents with pain caused by the implants or rupture the NHS should assist the patient regardless of where the implants came from as it has a duty of care towards patients. GMW noted that she was uncomfortable with this as the NHS potentially ends up stepping in to fix problems created in the private sector. It was then suggested that the patient should be referred back to the original provider for help and if this is not possible, then the implants could be removed by the NHS on rupture. JW noted this is appropriate to tackle possible infection and JN noted that this would stop such cases being shunted around the system. AH pointed out that the DH guidance around PIP implants was that they should be removed if necessary. Therefore the agreed criteria here would indicate that the patient would need to be referred back to the original provider for help and if this is not possible the NHS will remove (but not replace) the implants following rupture or implant failure. We will need to ensure the DH guidance is cited as evidence.	IFR membership and further discussion with the PDP Working Group (VCF feedback indicated agreement with proposals made by IFR Panel)	IFR Panel: 03/03/2017 VCF: n/a PDP WG Mtg 5: 28/03/2017	IFR Panel: Yes VCF: n/a PDP WG Mtg 5: Policy and suggested amendments discussed at length by the WG. he agreed criteria here would indicate that the patient would need to be referred back to the original provider for help and if this is not possible the NHS will remove (but not replace) the implants following rupture or implant failure.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Male Breast Reduction Surgery for Gynaecomastia	Draft policy document and Working Group meeting 5 meeting minutes (28/03/2017)	Gynaecomastia Tue 14/02/2017 11:34 – IFR panel feedback I would favour a tightening of the policy to exceptional only. Tue 21/02/2017 15:50 IFR Panel midlands better- exceptional only. Working Group meeting 5 Tues 28/03/2017 13:00 agreed position: The WG agreed to maintain the position that this procedure is not routinely commissioned as this is still appropriate	IFR membership and further discussion with the PDP Working Group (VCF feedback indicated agreement with proposals made by IFR Panel)	IFR Panel: 14/03/2017 and 21/02/2017 VCF: n/a PDP WG Mtg 5: 28/03/2017	IFR Panel: yes VCF: n/a PDP WG Mtg 5: Yes. The WG agreed to maintain the position that this procedure is not routinely commissioned as this is still appropriate

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Laser Tattoo Removal	Draft policy document and Working Group meeting 5 meeting minutes (28/03/2017)	Tattoo removal IFR panel Tue 07/03/2017 15:41 Tattoo removal. I think the tighter Midlands policy makes more sense. The C&M policy is very subjective VCF Feedback Thu 16/03/2017 08:46 Laser tattoo removal - GP's prefer the midlands one as it is more straight forward and less subjective Working Group meeting 5 Tues 28/03/2017 13:00 agreed position: The WG agreed to implement the position that this procedure is not routinely commissioned as this is still appropriate	IFR and VCF membership and further discussion with the PDP Working Group	IFR Panel: 07/03/2017 VCF: 16/03/2017 PDP WG Mtg 5: 28/03/2017	IFR Panel: Yes VCF: Yes PDP WG Mtg 5: Yes. The WG agreed to implement the position that this procedure is not routinely commissioned as this is still appropriate

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Apronectomy or Abdominoplasty	Draft policy document and Working Group meeting 5 meeting minutes (28/03/2017)	Apronectomy or abdominoplasty - Wed 08/03/2017 18:36 IFR Panel KC felt that there will be patients with abscesses and infections who will be unable to demonstrate exceptionality so the policy needs to contain criteria that will support these patients. KC suggested we should include 'significantly functionally disabling' within the criteria for example 'causes very serve functional problems'. She also felt that a criterion around the patient having had '2 months of antibiotics' was required. JW noted that there are a group of patients with Stoma bags who will suffer infections no matter what they do to keep the areas clean. The panel felt the BMI should be kept as it is. The panel felt that we should tighten up the current criteria to support the relatively small cohort of patients who experience functional issues and infections but that will prevent cosmetic requests VCF Feedback Wed 15/03/2017 08:44 -Apronectomy - the issue is to differentiate the functional appronectomies from the cosmetic appronectomies. I think the Merseyside guidance is better than the midlands as it gives indications of how to differentiate between the two, whereas in the midlands guidance everything goes to the panel to determine if exceptionality is met. In the Mersey guidance I think the 6 m of skin conditions is satisfactory and don't think quantifying the amount of antibiotics is necessary. I'm not sure of the need to change 'significant problems with daily living' to 'significantly functionally disabling '. VCF Feedback Wed 15/03/2017 08:44 Only comment I would add is around apronectomy. I feel very sorry for these individuals who have lost vast amounts of weight and have an awful redundant appendage hanging from the abdomens. Getting to a BMI < 25 in these circumstances is heroic indeed, and I feel that allowance should be made for the weight of the apron itself – often a few Kg – which could be the difference between being allowed surgery and not. It wouldn't be difficult to get an estimate of the weight of the apron – or more simply allow a BMI of 26 or 27 for eligibility Working Group meeting 5 Tues 28/03/2017 13:00 agreed position: The WG agreed to implement the position that this procedure is not routinely commissioned. This is because the WG agreed that this is a cosmetic procedure.	IFR and VCF membership and further discussion with the PDP Working Group	IFR Panel: 08/03/2017 VCF: 15/03/2017 PDP WG Mtg 5: 28/03/2017	IFR Panel: Yes - suggested amendments worked into a revised version that was presented to the WG on 28/03/17 VCF: Yes - suggested amendments worked into a revised version that was presented to the WG on 28/03/17 PDP WG Mtg 5: The WG agreed to implement the position that this procedure is not routinely commissioned. This is because the WG agreed that this is a cosmetic procedure.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Other Skin Excisions, Body Contouring Surgery	Draft policy document and Working Group meeting 5 meeting minutes (28/03/2017)	Other Skin Excisions, Body Contouring Surgery - Wed 08/03/2017 18:36 IFR Panel The panel noted that they are content with the Midlands criteria and would be comfortable using this going forward VCF Feedback Wed 15/03/2017 08:44 Body contouring – I feel that approonectomy is a form of body contouring so the same criteria should apply, ie significant functional problems or skin conditions for 6 months Working Group meeting 5 Tues 28/03/2017 13:00 agreed position: The WG agreed to maintain the position that this procedure is not routinely commissioned. This is because the WG agreed that this is a cosmetic procedure.	IFR and VCF membership and further discussion with the PDP Working Group	IFR Panel: 08/03/2017 VCF: 15/03/2017 PDP WG Mtg 5: 28/03/2017	IFR Panel: Yes - suggested amendments worked into a revised version that was presented to the WG on 28/03/17 VCF: Yes - suggested amendments worked into a revised version that was presented to the WG on 28/03/17 PDP WG Mtg 5: The WG agreed to implement the position that this procedure is not routinely commissioned. This is because the WG agreed that this is a cosmetic procedure.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Surgical Treatments for Hair Loss	Draft policy document and Working Group meeting 5 meeting minutes (28/03/2017)	Alopecia IFR panel Tue 07/03/2017 15:41Alopecia. Think both policies say the same thing. C&M policy contained the comments about Intralace as this is an occasional request through IFR. I would favour going with the Midlands policy as it's neater. VCF Feedback Mon 13/03/2017 13:53 Thanks Michael Agree with the comments made already. With regards to wigs, we have added the following info which may be worth including (maybe in part?) – it took us ages to find it! Please see NHS wig policy http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Wigsandfabricsupports.aspx To prescribe a wig, complete an appliance request form and send to orthotics who will arrange an appointment. Current cost is £67.75 for an acrylic wig - allowed 2 per year. There is no charge for chemotherapy patients VCF Feedback Thu 16/03/2017 08:46 Appreciate the Midlands alopecia is predominantly about alopecia areata – could we not amend this to cover the other 2 also, and have a single policy for all alopecia. Overall I think the Midlands policy is better, but would include the reference to NHS wigs. VCF Feedback Thu 16/03/2017 08:46 Alopecia - don't like the midlands suggestion that pts can go to gp for prescription only medication as it appears that we are encouraging the use of finasteride or steroids, whereas in reality most gps are probably against prescribing them. Working Group meeting 5 Tues 28/03/2017 13:00 agreed position: The WG confirmed that this procedure needs to be titled 'Surgical treatments for hair loss' and that the overall position is that these procedures are not routinely commissioned as they are cosmetic. The WG said that the policy needs to list the following treatments: • Treatment for Alopecia • Hair transplantation • Hair intralace system • Treatments for Male Pattern Baldness Are all not routinely commissioned but that this excludes access to wigs.	IFR and VCF membership and further discussion with the PDP Working Group	IFR Panel: 07/03/2017 VCF: 13/03/2017 and 16/03/2016 PDP WG Mtg 5: 28/03/2017	IFR Panel: Yes, draft policies written and shared with WG on 28/03/2017 VCF: Yes, draft policies written and shared with WG on 28/03/2017 PDP WG Mtg 5: The WG confirmed that this procedure needs to be titled 'Surgical treatments for hair loss' and that the overall position is that these procedures are not routinely commissioned as they are cosmetic. The WG said that the policy needs to list the following treatments: • Treatment for Alopecia • Hair transplantation • Hair intralace system • Treatments for Male Pattern Baldness Are all not routinely commissioned but that this excludes access to wigs.
	Working Group meeting 11 Minutes	During the summer period (2017) a review of the introduction to the policy was carried out and it was proposed that the following line from the introduction to the policy was removed becuase it is not clinically appropriate : Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or	Working Group	n/a	Yes – revised line to be implemented in the policy introduction.

		other body lesions, where such conditions cause obvious psychological distress. This proposed amemdment was discussed at length by members following findings of the engagement and EIRA process at WG11 on 14th November as this change affects a small number of cosmetic procedures Options were put to the WG and it was suggested that the correct approach would be for all patients regardless of age to have had psychological assessment and support, i.e. input from IAPT for adults and CAMHS for children before surgery is offered as an option. A line has been developed based on an existing line in the introduction which now states: Psychological distress alone will not be accepted as a reason to fund surgery. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient's psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention. Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as a route into aesthetic surgery. Any application citing psychological distress will need to be considered as an IFR .			

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Rhytidectomy - Face or Brow Lift	Draft policy document and Working Group meeting 5 meeting minutes (28/03/2017)	Rhytidectomy - Face or Brow Lift - Wed 08/03/2017 18:36 IFR Panel The panel noted that they are content with the Midlands criteria and would be comfortable using this going forward VCF Feedback Wed 15/03/2017 08:44 - Rhytidectomy no issues Working Group meeting 5 Tues 28/03/2017 13:00 agreed position: The WG agreed to implement the midlands criteria but with some changes. It was felt that each criteria would require an 'OR' i.e.: • Recognised diagnosis of Congenital (present from birth) facial abnormalities OR • Facial palsy (congenital or acquired paralysis) OR OR • As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis The WG agreed that the final two criteria need to be removed because these would be carried out as non-elective surgery.	IFR and VCF membership and further discussion with the PDP Working Group	IFR Panel: 08/03/2017 VCF: 15/03/2017 PDP WG Mtg 5: 28/03/2017	IFR Panel: Yes VCF: n/a PDP WG Mtg 5: TThe WG agreed to implement the midlands criteria but with some changes. It was felt that each criteria would require an 'OR' i.e.: • Recognised diagnosis of Congenital (present from birth) facial abnormalities OR • Facial palsy (congenital or acquired paralysis) OR OR • As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis The WG agreed that the final two criteria need to be removed because these would be carried out as non-elective surgery.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Circumcision	Draft policy document and Working Group meeting 5 meeting minutes (28/03/2017)	Circumcision Tue 14/02/2017 11:34 – IFR panel feedback The two policies say very much the same thing, so I wouldn't recommend changing particularly. VCF Feedback Wed 01/03/2017 09:47 can the csu please tell me if St Helens agree to this for cultural and religious reasons? Working Group meeting 5 Tues 28/03/2017 13:00 agreed position: The WG agreed that the title of this policy should read 'Policy for male circumcision for medical reasons only' to provide clarity and that the criteria need to contain the following line: 'this is not offered for social, cultural or religious reasons'.	IFR and VCF membership and further discussion with the PDP Working Group	IFR Panel: 14/02/2017 VCF: 01/03/2017 PDP WG Mtg 5: 28/03/2017	IFR Panel: n/a VCF: n/a PDP WG Mtg 5: The WG agreed that the title of this policy should read 'Policy for male circumcision for medical reasons only' to provide clarity and that the criteria need to contain the following line: 'this is not offered for social, cultural or religious reasons'.
	Draft policy document and Working Group meeting 6 meeting minutes (25/04/2017)	Working Group discussed points raised by S&O Trust colleagues: 1. Should paraphimosis be removed as a criteria? 2. Do we need to reword criteria around irreducible phimosis? 3. Discussion required in relation to circumcision for recurrent UTIs. 4. Should we clarify that congenital abnormalities excludes hypospadias and congenital megaprepuce? The Working Group noted all the points raised and felt that we should go back to using the current criteria set in the original policy, but that we will add in the criteria relating to tight foreskin causing pain on arousal because this is a clearer set of criteria. The working Group also noted that the Project Team will need to run this suggestion past Public Health colleagues. ACTION: MOB to implement the current circumcision criteria with the additional criteria around pain on arousal. ACTION: MOB to run circumcision policy by Public Health colleagues for their review	S&OHT	PDP WG Mtg 6: 25/04/2017	PDP WG Mtg 6: WG agreed to implement the current circumcision criteria with the additional criteria around pain on arousal based on the S&OHT feedback

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Pinnaplasty	Emails from VCF and IFRP members in March 2017	VCF and IFR Panel members agree this policy should be NRC	IFR Panel and VCF members	31/03/2017	Yes- proposed policy shared with WG on 25/04/2017
	Draft policy document and Working Group meeting 6 meeting minutes (25/04/2017)	Working Group members agreed that this treatment should become a not routinely commissioned procedure. They also felt that this policy does need to be shared for comment with GP and Lead providers for comment. JN noted that it will need to be reviewed by the childrens lead at Alder Hey and that therefore all other CCG GP and Provider leads should also see the proposed policy.		**PDP WG Mtg 6:** 25/04/2017	yes
	Working Group meeting 11 Minutes	During the summer period (2017) a review of the introduction to the policy was carried out and it was proposed that the following line from the introduction to the policy was removed because it is not clinically appropriate: Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress. This proposed amendment was discussed at length by members following findings of the engagement and EIRA process at WG11 on 14th November as this change affects a small number of cosmetic procedures Options were put to the WG and it was suggested that the correct approach would be for all patients regardless of age to have had psychological assessment and support, i.e. input from IAPT for adults and CAMHS for children before surgery is offered as an option. A line has been developed based on an existing line in the introduction which now states: Psychological distress alone will not be accepted as a reason to fund surgery. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient's psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention. Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as a route into aesthetic surgery. Any application citing psychological distress will need to be considered as an IFR .	Working Group	n/a	Yes – revised line to be implemented in the policy introduction.

Suite 1 Green rated Policies

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Surgery for Asymptomatic Hernias & Diastasis of the Recti	Working Group Meeting 2 minutes	complete evidence review	Working Group	16/11/2016	Yes
	GP and Provider feedback - Working Group meeting Minutes 4	GPs and Providers are largely content with proposed policy, however point raised by Aintree needs to be raised with the Working Group Most incisional hernias will enlarge and become symptomatic. Trust clinicians are concerned that the application of this guidance will mean that this will turn a relatively simple repair into a major complex reconstruction over time. MOB noted that the key concern is that by not having any criteria against this treatment, the majority of hernias will get worse therefore requiring a more significant procedure. It must be noted however that the current policy does not contain criteria either. The Working Group advised that the project team will need to look at the level of data for this without complicating causes and compare their activity rates against other providers as well as triangulate the data with symptomatic hernias. ACTION: investigate further data on treatment for asymptomatic hernias, review data without complicating issues, compare activity against other providers and triangulate the data with symptomatic hernias.	GP and Provider feedback	07/02/2017	n/a - The Working Group agreed therefore that this policy is now ready for engagement.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Surgery for Asymptomatic Gallstones	Working Group Meeting 2 minutes	None - WG agreed to maintain current policy position. It was noted that the IFR panel had never seen an application for this treatment	Working Group	16/11/2016	n/a
	GP and Provider feedback - Working Group meeting Minutes 4	GPs and Providers are largely content with proposed policy.	GP and Provider feedback	07/02/2017	n/a - The Working Group agreed therefore that this policy is now ready for engagement.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Dilatation and Curettage	Working Group Meeting 2 minutes	Maintain the current C&M Criteria as this requires no change	Working Group	16/11/2016	n/a
	GP and Provider feedback - Working Group meeting Minutes 4	No feedback received against this policy.	GP and Provider feedback	07/02/2017	n/a - The Working Group agreed therefore that this policy is now ready for engagement.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Policy for Private Mental Health Care – Non-NHS Commissioned Services: including Psychotherapy, adult eating disorders, general in-patient care, post-traumatic stress, adolescent mental health	Working Group Meeting 2 minutes	Amend policy to make clear its not commissioned because JW advised the Working Group that the inclusion of this policy was under the direction of the Cheshire CCGs when the policy was originally created in 2013. This was because those CCGs worked with a large number of private Mental Health Service providers. The working Group agreed that this is more of a contractual agreement issue rather than a required policy. HP suggested that this policy needs to be reworded to make it clear that Private Mental Health Care is not routinely commissioned.	Working Group	16/11/2016	yes
	Email from Jha - 16/12/2016	remove evidence section as not relevant	JHA	16/12/2016	Yes
	GP and Provider feedback - Working Group meeting Minutes 4	GP and Provider feedback here suggests that we either need to remove the policy altogether or refer to community provider and inpatient services, across the Merseyside footprint. Alternatively we would need to develop pathways between the IFR teams and CCCGs to manage these cases where they are complex and high cost. It is not clear how we might do this however.	GP and Provider feedback	07/02/2017	Policy ready for engagement, although there is a question around removal of this policy altogether or developing pathways instead which needs to be addressed by the Working Group. The Working Group agreed that because the NHS does not provide private care this policy should be removed altogether. The Working Group agreed therefore that this policy is now ready for engagement.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Policy for Hyaluronic acid & Derivatives injections for peripheral joint pain	Working Group Meeting 2 minutes	complete evidence review	Working Group	16/11/2016	Yes
	GP and Provider feedback - Working Group meeting Minutes 4	GPs and Providers are largely content with proposed policy.	GP and Provider feedback	07/02/2017	n/a Policy ready for engagement The Working Group agreed therefore that this policy is now ready for engagement.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Hip Replacement Surgery	Working Group Meeting 1 minutes	Separate policies for Hip and Knee Surgery - WG felt this was required for clarity	Working Group	19/10/2016	Yes
	Working Group Meeting 1 minutes	Revise the presentation of these procedures - WG felt this was required for clarity	Working Group	19/10/2016	Yes
	Working Group Meeting 1 minutes	Include references to MCAS service where these are in place as a number of CCGs have triage processes in place and this needs to be reflected	Working Group	19/10/2016	Yes
	Working Group Meeting 1 minutes	Review Patient Outcomes Data to inform the review of this policy. We will may be able to source this data from the National Joint Registry website.	Working Group	19/10/2016	No
	Working Group Meeting 1 minutes	HK advised we will also look at NICE guidance around these procedures.	Working Group	19/10/2016	Yes
	Working Group Meeting 3 minutes	As for knee document, the first page reads mostly as a PII, although the last paragraph appears to be aimed at clinicians which is confusing. - The Project Team will take this point away and will rethink the presentation of the document.	Denis O'Brien (Liverpool CCG GP)	13/12/2016	yes
	Working Group Meeting 3 minutes	This document should really be more or less an exact replica of the knee document, as the same criteria and considerations apply. - Working Group noted this feedback.	Denis O'Brien (Liverpool CCG GP)	13/12/2016	yes
	GP and Provider feedback - Working Group meeting Minutes 4	GPs and Providers are largely content with proposed policy. Question around returning to MCAS needs to be addressed by CCGs. We need to consider adding a like that says a shared decision making engagement/conversation must be evidenced.	GP and Provider feedback	07/02/2017	N/A
	Working Group Meeting 3 minutes	In addition, Ruth Hunter has asked if we can debate reducing the BMI for Hips as being set at 40 as she feels this is high. - The Working Group discussed this point and it was noted there is no guidance available currently to suggest what the BMI score should be, therefore the Working Group decided to keep the BMI score as it is at the moment. JM noted that a high BMI wouldn't come under a protected characteristic in terms of EIA.	Ruth Hunter (St Helens CCG)	13/12/2016	no

	GP and Provider feedback - Working Group meeting Minutes 4	Policy ready for engagement, however need to address questions around returning to MCAS and whether we need to add a line around shared decision making/engagement with the patient The only change in THR & TKR policy seems to be that MCAS now needs to be involved initially in both cases. The only difference to this we felt would be in a case where a patient has been referred into the system to see an orthopaedic colleague with another sub-speciality diagnosis e.g. back pain. If it was found that the clinical problem was actually hip or knee should the patient then be referred onto for a Consultant orthopaedic hip or knee opinion within the department without returning to MCAS? In addition to the feedback above, Ruth Hunter for St Helens CCG has also shared a paper on BMI evidence for discussion by the Working Group. The Working Group acknowledged the Provider feedback and Ruth Hunter's paper and asked whether this was a pathway issue. AG noted that NICE Guidance states that obesity should not be a barrier for referral for joint surgery. She also noted that some policies refer to 6 months of conservative treatments ACTION: MOB to share the hips and knees policies with AG for her input and feedback.	GP and Provider feedback	07/02/2017	N/A - Policy ready for engagement

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Knee Replacement Surgery	Working Group Meeting 1 minutes	Separate policies for Hip and Knee Surgery - WG felt this was required for clarity	Working Group	19/10/2016	yes
	Working Group Meeting 1 minutes	Revise the presentation of these procedures - WG felt this was required for clarity	Working Group	19/10/2016	Yes
	Working Group Meeting 1 minutes	Include references to MCAS service where these are in place as a number of CCGs have triage processes in place and this needs to be reflected	Working Group	19/10/2016	Yes
	Working Group Meeting 1 minutes	Review Patient Outcomes Data to inform the review of this policy. We will may be able to source this data from the National Joint Registry website.	Working Group	19/10/2016	No
	Working Group Meeting 1 minutes	HK advised we will also look at NICE guidance around these procedures.	Working Group	19/10/2016	yes
	Working Group Meeting 3 minutes	Happy to use a pain rating scale to determine severity JW felt that the only way to address this was with a simple visual scale (1-10 analogue scale). JHA noted that functionality would also need to be considered. The Working Group then noted that using a scale can be subjective so an alternative might be to develop a referral template letter that ensures referrers go through each criterion which might help. The Working Group therefore agreed to maintain the draft criteria as it stands as it is difficult to amend this any further	Denis O'Brien (Liverpool CCG GP)	13/12/2016	no
	Working Group Meeting 3 minutes	Should joint injections be explicitly mentioned in proposed eligibility criteria 2? JN asked whether this is in the NG and if so, do we need to add it? JW suggested that it was not clear what effect this would change have and the Working Group decided that this does not need to be included here.	Denis O'Brien (Liverpool CCG GP)	13/12/2016	no
	Working Group Meeting 3 minutes	Criterion 3: is anxious regarding the word "severe" (in relation to x-ray)– as the whole clinical picture needs to be assessed. Would be uncomfortable turning someone down with severe uncontrolled symptoms just because their knee x-ray was not severe enough – treat the patient, not the x-ray! Perhaps use "significant" or "moderate to severe" instead. Believes point 4 is the get out anyway, but would be happier with a change of wording. Patients do less well if we wait too long and the joint has a significantly compromised range of movement - The Working Group noted this point and the discussion focused on the terminology radiologists would use. It was agreed that they are not know to use terms such as 'significant' therefore the Working Group decided to maintain the current draft policy including terminology currently being drafted.	Denis O'Brien (Liverpool CCG GP)	13/12/2016	no

	Working Group Meeting 3 minutes	In addition, Ruth Hunter has asked if we can debate reducing the BMI for knees to 35? - The Working Group discussed this point and it was noted there is no guidance available currently to suggest what the BMI score should be, therefore the Working Group decided to keep the BMI score as it is at the moment. JM noted that a high BMI wouldn't come under a protected characteristic in terms of EIA.	Ruth Hunter (St Helens CCG)	13/12/2016	no
	Working Group Meeting 3 minutes	Question from Ruth Hunter: Did the group decide against a pain scale for Hip and Knee replacement surgery? - The Working Group acknowledged RH's point. It was felt that again any type of scaling would be subjective so as an alternative we could develop a referral template letter that ensures referrers go through each criterion which might help. The Working Group therefore agreed to maintain the draft criteria as it stands as it is difficult to amend this any further	Ruth Hunter (St Helens CCG)	13/12/2016	no
	GP and Provider feedback - Working Group meeting Minutes 4	GPs and Providers are largely content with proposed policy. Question around returning to MCAS needs to be addressed by CCGs. We need to consider adding a like that says a shared decision making engagement/conversation must be evidenced.	GP and Provider feedback	07/02/2017	Yes - discussed at WG
	GP and Provider feedback - Working Group meeting Minutes 4	Policy ready for engagement, however need to address questions around returning to MCAS and whether we need to add a line around shared decision making/engagement with the patient The only change in THR & TKR policy seems to be that MCAS now needs to be involved initially in both cases. The only difference to this we felt would be in a case where a patient has been referred into the system to see an orthopaedic colleague with another sub-speciality diagnosis e.g. back pain. If it was found that the clinical problem was actually hip or knee should the patient then be referred onto for a Consultant orthopaedic hip or knee opinion within the department without returning to MCAS? In addition to the feedback above, Ruth Hunter for St Helens CCG has also shared a paper on BMI evidence for discussion by the Working Group. The Working Group acknowledged the Provider feedback and Ruth Hunter's paper and asked whether this was a pathway issue. AG noted that NICE Guidance states that obesity should not be a barrier for referral for joint surgery. She also noted that some policies refer to 6 months of conservative treatments ACTION: MOB to share the hips and knees policies with AG for her input and feedback.	GP and Provider feedback	07/02/2017	N/A - Policy ready for engagement

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Surgical Removal of Ganglions	Working Group Meeting 2 minutes	Maintain current C&M policy because The Working Group agreed that the current C&M policy criteria for this procedure are still applicable.	Working Group	16/11/2016	Yes
	Working Group Meeting 2 minutes	complete evidence review	Working Group	16/11/2016	no
	Email from Kit Chung: IFR Panel feedback	Inconsistent and suggests use of Midlands Criteria	KC - IFR Panel	13/12/2016	Yes - removed the RCS line from rationale as a suggested amendment
	GP and Provider feedback - Working Group meeting Minutes 4	GPs and Providers are largely content with proposed policy. Request from Royal Liverpool around agreements they will never receive referrals for removal of ganglions needs to be highlighted to the Working Group. The policy refers to all ganglions regardless of location on the body, otherwise it would specify exceptions.	GP and Provider feedback	07/02/2017	Policy ready for engagement.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Adenoidectomy	Working Group Meeting 2 minutes	Implement Midlands policy for adenoidectomy but remove some irrelevant material because MS confirmed that Adenoidectomy procedures are only carried out for children in the C&M footprint alongside other procedures as it should not be carried out in isolation. The Working Group noted that the Midlands criteria also applies to adults. HK confirmed that the Midlands policy is in line with RCS recommendations.The Working Group agreed that the current C&M Adenoidectomy policy is quite clear but that we will pick up the Midlands policy. There is some irrelevant material contained in the Midlands policy that will be removed. The Working Group also agreed that we will need to include the NICE 'Do Not Do' recommendation in the evidence section of the policy.	Working Group	16/11/2016	yes
	Working Group Meeting 2 minutes	include the NICE DND recommendation in the evidence section for adenoidectomy	Working Group	16/11/2016	Yes
	Working Group Meeting 2 minutes	seek data on how many adenoid procedures are being carried out on adults and children	Working Group	16/11/2016	no
	GP and Provider feedback - Working Group meeting Minutes 4	GPs and Providers are largely content with proposed policy. Link to the high value pathway is included in the policy development template for this condition. However, it is not clear what letter Warrington GPs are referring too or what they mean: Is this across all trusts? Recent letter from a different trust (I think South Manchester) - requesting locally. The Working Group agreed that this is a question that sits outside the remit of this Project but as a rule of thumb. it is the funding commissioners policy that applies. The Working Group agreed therefore that this policy is now ready for engagement.	GP and Provider feedback	07/02/2017	n/a - Policy Ready for engagement

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Policy for Tonsillectomy for recurrent Tonsillitis (excluding peri-tonsilar abscess) adults and children	Working Group Meeting 2 minutes	Implement the criteria from the Midlands Tonsillectomy policy; minus the criteria for a positive culture of group A beta haemolytic streptococci. This is because it was acknowledged that in the C&M footprint the evidence of episodes is often not provided, whereas the Midlands policy is more defined and requires evidence of the episodes to be submitted. HK confirmed that the number of episodes of sore throats (7, 5 and 3) in the Midlands policy are based on Royal College of Surgeons and SIGN guidance.	Working Group	16/11/2016	Yes
	Working Group Meeting 2 minutes	Conduct an evidence review of the guidance for Tonsillectomy and look at the aural temperature (38.3°C) characteristic to determine where this may originate from.	Working Group	16/11/2016	yes
	Working Group Meeting 2 minutes	Make clear that Tonsillectomy should not be carried out for tonsil stones and halitosis	Working Group	16/11/2016	Yes
	Working Group Meeting 2 minutes	Amend the formatting of the Tonsillectomy policy to make it clearer.	Working Group	16/11/2016	Yes
	GP and Provider feedback - Working Group meeting Minutes 4	OSA – should criteria around this be introduced? The Working Group agreed that this criteria would apply within a different policy so it is not appropriate within this criteria set.	GP and Provider feedback	07/02/2017	n/a
	GP and Provider feedback - Working Group meeting Minutes 4	MOB to add clarity to tonsillectomy policy around referring clinician responsibility as it is important to clarify responsibility for evidence	GP and Provider feedback	07/02/2017	Yes
	GP and Provider feedback - Working Group meeting Minutes 4	MOB to include an appendix of what a prior approvals form may look like within this policy to support roll out of the policy	GP and Provider feedback	07/02/2017	Yes - The Working Group agreed therefore that once these actions have been completed this policy is now ready for engagement.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Hysterectomy for Heavy Menstrual bleeding	Working Group Meeting 1 minutes	Revise wording so it's clear this procedure isn't offered for patients wishing to cease menstruation as this is unclear in the present policy	Working Group	19/10/2016	Yes
	Working Group Meeting 1 minutes	Change C&M title to reflect the Midlands Policy title because WG felt the Midlands title is more appropriate	Working Group	19/10/2016	Yes
	Email from MM colleagues 17/11/2016	Amendments to criteria and evidence base, based on feedback from MM team 17/11/2016	MM Team	17/11/2016	Yes
	Email from MM colleagues 08/12/2016	Amendments to layout of Norethisterone and ulipristal acetate medications criteria based on feedback from MM team on 08/12/2016	MM Team	08/12/2016	yes
	GP and Provider feedback - Working Group meeting Minutes 4	GPs and Providers are largely content with proposed policy.	GP and Provider feedback	07/02/2017	n/a - Policy ready for engagement The Working Group agreed therefore that this policy is now ready for engagement.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Varicose Veins Treatments	Working Group Meeting 2 minutes	Use bullets 2,3 and 4 from Midlands policy to update the C&M policy because RH noted that although the clinical evidence available suggests that this is an effective procedure in reality the evidence is lacking. The Working Group agreed that there was little justification to offer these procedures based on the current guidance. HK suggested therefore that the Project Team would complete an evidence review for this policy but maintain the current C&M criteria. However we will need to make it clear that the treatment is only available in certain circumstances and if these are not met, then an IFR application is required.	Working Group	16/11/2016	Yes
	Working Group Meeting 2 minutes	reword varicose veins opening statement to produce clarity	Working Group	16/11/2016	Yes
	Working Group Meeting 2 minutes	Complete varicose veins evidence review	Working Group	16/11/2016	yes
	Email from Kit Chung: IFR Panel feedback	Thrombophlebitis- do we need to define it more? Do we accept a patient reporting to clinician that they have had it but not consulted, or does it need to be a documented event by a clinician?	KC - IFR Panel	06/12/2016	No - Policy is due to go out to consultation with GPs and Secondary care in January so we'll gather more feedback on this.
	Email from Kit Chung: IFR Panel feedback	Midlands policy includes varicose veins which have bled and are at risk of bleeding again - that isn't in the amended policy. Maybe it should be?	KC - IFR Panel	06/12/2016	Yes
	Working Group Meeting 4 Minutes	MOB to change the wording in the varicose veins policy to refer to The Working Group agreed to change the wording here to inappropriate or declined (compression hosiery) and documented evidence of (thrombophlebitis).	Working Group	07/02/2017	Yes
	GP and Provider feedback - Working Group meeting Minutes 4	GPs and Providers are largely content with proposed policy. However it would be helpful to pick up the comments around replacing 'unsuitable' with 'inappropriate or declined' as well as documenting episodes of thrombophlebitis. Concern raised around the reference to a C&M document saying all criteria must be met as well as an actual IFR application.	GP and Provider feedback	07/02/2017	

	GP and Provider feedback - Working Group meeting Minutes 4	Policy ready for engagement following small amendments if agreed by WG: • change compression hosiery being unsuitable to being inappropriate or declined. The Working Group agreed to change the wording here • Refer to documented episodes of thrombophlebitis. The Working Group agreed to change the wording here • Project Team also needed clarity from the Working Group about letter stating all criteria must be met as well as an IFR for this treatment • We were worried in the last few months when a Cheshire & Merseyside document came out suggesting 1) that all patients that qualify for NHS treatment on the CCG guidelines still need an application for funding – and the suggestion that we the surgeons had to apply and 2) the GP could send anyone with varicose veins for a vascular appointment thus blocking all our clinics and devolving themselves of any responsibility for their own guidelines. The Working Group felt that this is a process issue to be picked up by the CCG ACTION: MOB to change the wording in the varicose veins policy to refer to The Working Group agreed to change the wording here to inappropriate or declined (compression hosiery) and documented evidence of (thrombophlebitis).	GP and Provider feedback	07/02/2017	Yes - The Working Group agreed therefore that this policy is now ready for engagement.

Suite 2 Green rated Policies

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Reduction Mammoplasty	Draft policy document and Working Group meeting 5 meeting minutes (28/03/2017)	Reduction mammoplasty. - Fri 03/02/2017 10:57 IFR panel feedback Current criteria seem to work well, and are stricter than Midlands. Would advocate keeping to current policy. VCF Feedback Wed 01/03/2017 09:47 Reduction mammoplasty, age over 21 years Working Group meeting 5 Tues 28/03/2017 13:00 agreed position: WG agreed with the proposed criteria as this is still appropriate.	IFR and VCF membership and further discussion with the PDP Working Group	IFR Panel: 03/02/2017 VCF: 01/03/2017 PDP WG Mtg 5: 28/03/2017	IFR Panel: Yes VCF: Yes PDP WG Mtg 5: Yes - WG agreed with the proposed criteria as this is still appropriate.
	Working Group meeting 6 meeting minutes (28/03/2017)	1. BMI – either amend or remove the criteria or round BMI scores to the nearest round number? 2. Do we have any evidence to support age criteria of 21 being more clinically appropriate than 18? 3. Do we wish to continue using cup sizes or should we move to using grams? Concern is over the stipulation of H cup sized breasts and reduction of 3 cups sizes as cup sizes are notoriously inaccurate. Many patients are in the wrong sized bra (even the so called professionally fitted ones). Would it not be best to stipulate a volume / weight reduction eg 500grams (which would equate to around 3 cup sizes) Concern is over the massive volume difference in asymmetry cases. It is not advisable to insert a 450cc implant as they run into problems due to the weight and stretching of the skin. Anything over 300cc's is risky. (300cc's would be 2 cup sizes and is still a huge difference for a patient) Asymmetry cases – 3 cups sizes equates to 450cc volume which is an enormous difference between breasts. Nearly half a litre. With this statement none of the patients that are referred would be suitable and therefore all need to go through special funding. The patients seen are usually all extremely upset when advised they do not meet the criteria.	SHKHT	PDP WG Mtg 6: 25/04/2017	PDP WG Mtg 6: BMI and cup sizes vs grams points were noted by the Group but it was felt that the current criteria is robust and does not require amendment. Age criteria amendment has been noted and we will look for evidence to support this change, with acknowledgement that if no evidence is available we will revisit this criteria
	Working Group meeting 12 meeting minutes (14/11/2017)	The request to amend the age criteria from 18 to 21 was discussed at length by members following findings of the engagement and EIRA process. No evidence to support this change can be found and feedback on this criteria indicates disagreement with this position from survey respondents and from and equality impact point of view	WG members	N/A	The decision has been taken by Working Group members not to implement this proposal for the reasons cited. This proposed criteria cannot be evidenced or justified

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Breast Enlargement	Draft policy document and Working Group meeting 5 meeting minutes (28/03/2017)	Breast enlargement. - Fri 03/02/2017 10:57 IFR panel feedback We rarely approve requests under this criteria, although we do see them frequently and they are emotive. Midlands policy is more restrictive, although I do not think there should be reference to cancer treatments. I would be in favour of an exceptionality only policy. VCF Feedback Wed 01/03/2017 09:47 I think this should be exceptionality only for cancer or 3 whole cup sizes difference (ie obvious asymmetry)and BMI 25 Working Group meeting 5 Tues 28/03/2017 13:00 agreed position: WG felt that we need to be able to justify raising the age to 21. It was noted that by 21 an individual's growth and maturation should be complete therefore it is clinically appropriate. RH and HK will look for further evidence to support this position. JN noted that within Liverpool CCG there have been 68 reduction mammoplasty procedures in the last 12 months and only 3 of these were for patients under 21. The WG felt that criteria is necessary for this procedure, however following debate, it was noted that the cancer criteria was inappropriate but the 21 age criteria was necessary to be consistent with the reduction mammoplasty criteria.	IFR and VCF membership and further discussion with the PDP Working Group	IFR Panel: 03/03/2017 VCF: 01/03/2017 PDP WG Mtg 5: 28/03/2017	IFR Panel: Yes VCF: Yes PDP WG Mtg 5: Yes. The WG felt that criteria is necessary for this procedure, however following debate, it was noted that the cancer criteria was inappropriate but the 21 age criteria was necessary to be consistent with the reduction mammoplasty criteria.
	Working Group meeting 12 meeting minutes (14/11/2017)	The request to amend the age criteria from 18 to 21 was discussed at length by members following findings of the engagement and EIRA process. No evidence to support this change can be found and feedback on this criteria indicates disagreement with this position from survey respondents and from and equality impact point of view	WG members	N/A	The decision has been taken by Working Group members not to implement this proposal for the reasons cited. This proposed criteria cannot be evidenced or justified

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Mastopexy – Breast lift	Draft policy document and Working Group meeting 5 meeting minutes (28/03/2017)	Mastopexy - Fri 03/02/2017 10:57 IFR panel feedback I would suggest remove the section which states: "May be considered as part of other breast surgery to achieve an appropriate cosmetic result subject to prior approval." Think that wording has allowed this operation to be done more often than it was intended. Working Group meeting 5 Tues 28/03/2017 13:00 agreed position: The WG agreed to maintain the position that this procedure is not routinely commissioned as this is still appropriate.	IFR membership and further discussion with the PDP Working Group (VCF feedback indicated agreement with proposals made by IFR Panel)	IFR Panel: 03/03/2017 VCF: n/a PDP WG Mtg 5: 28/03/2017	IFR Panel: Yes VCF: n/a PDP WG Mtg 5: Yes. The WG agreed to maintain the position that this procedure is not routinely commissioned as this is still appropriate.
	Working Group meeting 6 meeting minutes (28/03/2017)	Mastopexy/Breast lift - Will it be funded as part of symmetrisation to reconstruction?	SHKHT	PDP WG Mtg 6: 25/04/2017	PDP WG Mtg 6: WG noted that there will be an option to consider this under IFR as this is the most appropriate approach.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Surgical Correction of Nipple Inversion	Draft policy document and Working Group meeting 5 meeting minutes (28/03/2017)	Nipple inversion - Fri 03/02/2017 10:57 IFR panel feedback Would keep to current policy Working Group meeting 5 Tues 28/03/2017 13:00 agreed position: The WG agreed to maintain the position that this procedure is not routinely commissioned as this is still appropriate.	IFR membership and further discussion with the PDP Working Group (VCF feedback indicated agreement with proposals made by IFR Panel)	IFR Panel: 03/03/2017 VCF: n/a PDP WG Mtg 5: 28/03/2017	IFR Panel: Yes VCF: n/a PDP WG Mtg 5: Yes. The WG agreed to maintain the position that this procedure is not routinely commissioned as this is still appropriate.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Surgical Treatment for Pigeon Chest	Draft policy document and Working Group meeting 5 meeting minutes (28/03/2017)	Pigeon Chest Tue 14/02/2017 11:34 – IFR panel feedback I would keep policy unchanged. Working Group meeting 5 Tues 28/03/2017 13:00 agreed position: The WG agreed to maintain the position that this procedure is not routinely commissioned as this is still appropriate.	IFR membership and further discussion with the PDP Working Group (VCF feedback indicated agreement with proposals made by IFR Panel)	IFR Panel: 14/03/2017 VCF: n/a PDP WG Mtg 5: 28/03/2017	IFR Panel: yes VCF: n/a PDP WG Mtg 5: Yes. The WG agreed to maintain the position that this procedure is not routinely commissioned as this is still appropriate

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Labiaplasty, Vaginoplasty and Hymenorrhaphy	Draft policy document and Working Group meeting 5 meeting minutes (28/03/2017)	Labiaplasty, Vaginoplasty and Hymenorrhaphy Wed 08/03/2017 18:36 IFR Panel JW noted that with regard to the Midlands Policy trauma after childbirth should not be included as a criteria as this is common. The panel felt that except where the surgery was to correct abnormalities following FGM these procedures should not be commissioned. However if we were to include a criteria around trauma the panel agreed that the criteria would need to read 'severe functional problems after trauma' and that an indication of the number of infections the patient had experienced what treatment they had been given and a full detailed explanation would be needed. VCF Feedback Wed 15/03/2017 08:44 Labiaplasty – I feel the midlands guidance is better and should include ' severe functional problems after trauma or FGM' Working Group meeting 5 Tues 28/03/2017 13:00 agreed position: The WG agreed to maintain the position that these procedures are not routinely commissioned as this is still appropriate.	IFR and VCF membership and further discussion with the PDP Working Group	IFR Panel: 08/03/2017 VCF: 15/03/2017 PDP WG Mtg 5: 28/03/2017	IFR Panel: Yes, draft policies written and shared with WG on 28/03/2017 VCF: Yes, draft policies written and shared with WG on 28/03/2017 PDP WG Mtg 5: The WG agreed to maintain the position that these procedures are not routinely commissioned as this is still appropriate.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Liposuction	Draft policy document and Working Group meeting 5 meeting minutes (28/03/2017)	Liposuction Wed 08/03/2017 18:36 IFR Panel The panel noted that they are content with the Midlands criteria and would be comfortable using this going forward. VCF Feedback Wed 15/03/2017 08:44 Liposuction - no issues Working Group meeting 5 Tues 28/03/2017 13:00 agreed position: The WG agreed to maintain the position that this procedure is not routinely commissioned as this is still appropriate.	IFR and VCF membership and further discussion with the PDP Working Group	IFR Panel: 08/03/2017 VCF: 15/03/2017 PDP WG Mtg 5: 28/03/2017	IFR Panel: Yes VCF: n/a PDP WG Mtg 5: The WG agreed to maintain the position that this procedure is not routinely commissioned as this is still appropriate.

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Policy for non-invasive interventions for low Back pain and sciatica	Document: Revised back pain policies - V3.0 - 2017-04-27	Meeting with Judith Nielson (LCCG) and Moira Harrison (SS&SFCCG) on 27th April 2017 • The draft policy needs to be aligned with NG 59 • Policy position to be broken down into the following headings and to reflect NG 59: · Acupuncture · Manual Therapy · Orthotics · Electrotherapy · Pharmacological interventions	Working Group - at the April 2017 WG meeting it was agreed that JN and MH's expertise to review these policies was the most appropriate approach to develop the current drafts	27/04/2017	Yes

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Imaging for patients presenting with back pain	Document: Revised back pain policies - V3.0 - 2017-04-27	Meeting with Judith Nielson (LCCG) and Moira Harrison (SS&SFCCG) on 27th April 2017 • The draft policy needs to be aligned with NG 59 • There is no specific C&M policy around X rays and MRI scans, however it is noted in the comments section of 16.1 that 'X Rays and MRI scans should not be offered unless in a context of referral for surgery.'	Working Group - at the April 2017 WG meeting it was agreed that JN and MH's expertise to review these policies was the most appropriate approach to develop the current drafts	27/04/2017	Yes

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Injections for back pain	Document: Revised back pain policies - V3.0 - 2017-04-27	Meeting with Judith Nielson (LCCG) and Moira Harrison (SS&SFCCG) on 27th April 2017 • The draft policy needs to be aligned with NG 59 • Policy needs to be clear that therapeutic Facet Joint injection, therapeutic medial branch block, prolotherapy, Botulinum Toxin and Trigger Point Injections are not routinely commissioned • Criteria for Epidural Injections needs to be laid out • New policy position needs to combine the following treatments currently listed in the 2014/15 Policy: 1. Facet Joint - Non Specific Back Pain Over 12 Months including radio frequency ablation 2. Epidural Injection 3. Radiofrequency Facet Joint Denervation Intra Discal Electro Thermal Annuloplasty (IDET) Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT) Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS)	Working Group - at the April 2017 WG meeting it was agreed that JN and MH's expertise to review these policies was the most appropriate approach to develop the current drafts	27/04/2017	Yes

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Spinal Fusion	Document: Revised back pain policies - V3.0 - 2017-04-27	Meeting with Judith Nielson (LCCG) and Moira Harrison (SS&SFCCG) on 27th April 2017 The draft policy needs to be aligned with NG 59 New policy position needs to combine the following treatments currently listed in the 2014/15 Policy: 1. Fusion 2. Transaxial Interbody Lumbosacral Fusion 3. Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine 4. Non-Rigid Stabilisation Techniques New policy needs to make clear the following are NRC: • Fusion • Non-rigid stabilisation techniques • Lateral body fusion in the lumbar spine • Transaxial interbody lumbrosacral fusion • Anterior lumbar interbody fusion (ALIF) • Posterior lumbar interbody fusion (PLIF) • Or any other combination of approach where surgical fixation is performed	Working Group - at the April 2017 WG meeting it was agreed that JN and MH's expertise to review these policies was the most appropriate approach to develop the current drafts	27/04/2017	Yes

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Disc and Decompression procedures	Document: Revised back pain policies - V3.0 - 2017-04-27	Meeting with Judith Nielson (LCCG) and Moira Harrison (SS&SFCCG) on 27th April 2017 The draft policy needs to be aligned with NG 59 Clarity is required in relation to spinal decompression, with specific critieria laid out in alignment with NG 59 The following procedures (all remaining NRC) need to be combined within this policy: • Endoscopic Laser Foraminoplasty • Endoscopic Lumbar Decompression • Percutaneous Disc Decompression using Coblation for Lower Back Pain • Percutaneous Intradiscal Laser Ablation in the Lumbar Spine • Automated Percutaneous Mechanical Lumbar Discectomy • Prosthetic Intervertebral Disc Replacement in the Lumbar Spine • Intradiscal Electro Thermal Annuloplasty (IDET) • Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)	Working Group - at the April 2017 WG meeting it was agreed that JN and MH's expertise to review these policies was the most appropriate approach to develop the current drafts	27/04/2017	Yes

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain	Document: Revised back pain policies - V3.0 - 2017-04-27	Meeting with Judith Nielson (LCCG) and Moira Harrison (SS&SFCCG) on 27th April 2017 The draft policy needs to be aligned with NG 59 - no change	Working Group - at the April 2017 WG meeting it was agreed that JN and MH's expertise to review these policies was the most appropriate approach to develop the current drafts	27/04/2017	Yes

Policy Name	Where are the changes captured?	Amendments Requested	By Who?	Changes requested date	Changes Requested Actioned?
Therapeutic Endoscopic Division of Epidural Adhesions	Document: Revised back pain policies - V3.0 - 2017-04-27	Meeting with Judith Nielson (LCCG) and Moira Harrison (SS&SFCCG) on 27th April 2017 The draft policy needs to be aligned with NG 59 - no change	Working Group - at the April 2017 WG meeting it was agreed that JN and MH's expertise to review these policies was the most appropriate approach to develop the current drafts	27/04/2017	Yes

Midlands and Lancashire Commissioning Support Unit

NHS Halton Clinical Commissioning Group
NHS Knowsley Clinical Commissioning Group
NHS Liverpool Clinical Commissioning Group
NHS St Helens Clinical Commissioning Group
NHS South Sefton Clinical Commissioning Group
NHS Southport and Formby Clinical Commissioning Group
NHS Warrington Clinical Commissioning Group

Collaborative Policy Development Project: Governing Body paper seeking sign off of all policies reviewed to date, ahead of implementation with Providers

Appendix 2

Comparison document demonstrating the proposed changes for PLCP Policy 2018-19 against the current PLCP Commissioning Policy 2014/15

December 2017

Contents

Guidance for reading the comparison tables

The current procedure or treatment name is listed in the first column of each table, with the current criteria from the Cheshire and Merseyside Commissioning Policy 2014/15 listed in the second column.

The third column captures the proposed policy wording and in some instances, a change to the policy title as well, for example ***Policy for non-invasive interventions for low Back pain and sciatica*** at page 40.

The final column summarises the difference between the current and the proposed policy.

Suite 1 Red rated Policies

Procedure	C&M Current Policy	Proposed Policy criteria 2018/2019	Difference
Policy for Surgical Treatments for Minor Skin Lesions	Will be commissioned in any of the following circumstances: • Symptomatic e.g. ongoing pain or functional impairment. • Risk of infection. • Significant facial disfigurement. All vascular lesions on the face except benign, acquired vascular lesions such as thread veins.	The CCG will only fund this treatment if the patient meets ONE of the following: • Suspected or proven malignancy (cancerous) (if suspected or proven malignancy refer via appropriate pathway) ***OR*** • Symptomatic e.g. ongoing pain or functional impairment. ***OR*** • Risk of infection. ***OR*** • Significant facial disfigurement. ***OR*** • All vascular lesions on the face except benign, acquired vascular lesions such as thread veins. *For any of the above scenarios, referral for treatment should be made to a community provider*	*Policies are aligned* *Suspected or proven malignancy (cancerous) (if suspected or proven malignancy refer via appropriate pathway) added.* *Layout has been simplified and criteria are now clearer.*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Rhinoplasty	This procedure is NOT available under the NHS on cosmetic grounds. • Only commissioned in any of the following circumstances: • Objective nasal deformity caused by trauma. • Problems caused by obstruction of nasal airway. • Correction of complex congenital conditions e.g. cleft lip and palate. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	The CCG will fund this treatment if the patient meets the following criteria: • Documented medical problems caused by obstruction of the nasal airway **OR** • Correction of complex congenital conditions e.g. Cleft lip and palate This means **(for patients who DO NOT meet the above criteria or require the procedure for cosmetic reasons)** 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.	*There is some difference between the current and new criteria, with tightening of the proposed criteria to remove the criteria around nasal deformity caused by trauma.* *Proposed policy does not refer to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.* *Proposed policy states 'This means **(for patients who DO NOT meet the above criteria or require the procedure for cosmetic reasons)** 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.'*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Surgical removal of Lipoma	Will only be commissioned where severely functionally disabling and/ or subject to repeated trauma due to size and/or position. Lipomas that are under 5cms should be observed only unless the above applies.	The CCG will fund this treatment if the patient meets the following criteria: • Lipoma is on the face or neck ***AND*** one of the following: • suspected malignancy **OR** • significant functional impairment caused by the lipoma **OR** • to provide histological evidence in conditions where there are multiple subcutaneous lesions This excludes lipomas unless they are on the face (including pinna) or the neck and they become infected or be symptomatic. Lipomas on other areas of the body should be referred back to primary care as agreed locally This means **(for patients who DO NOT meet the above criteria)** 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.	*There is some difference between the current and new criteria, with tightening of the proposed criteria to include the Lipoma now having to be on the face or neck in addition to one if the additional criterion listed.* *Lipoma needs to be present on the face or neck*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Haemorrhoidectomy - Rectal Surgery & Removal of Haemorrhoidal Skin Tags	Surgery commissioned for symptomatic: • Grade III and IV haemorrhoids. • Grade I or II haemorrhoids if they are large, symptomatic, and have not responded to the following non-surgical or out-patient treatments:- o Diet modification to relieve constipation. o Topical applications. o Stool softeners and laxatives. o Rubber band ligation. o Sclerosant injections. o Infrared coagulation. • Surgical treatment options include:- o Surgical excision (haemorrhoidectomy). o Stapled haemorrhoidopexy. o Haemorrhoidal artery ligation. Removal of skin tags is not routinely commissioned.	a) Haemorrhoidectomy for grades 1 or 2 is not routinely commissioned. b) Haemorrhoidectomy for grades 3 or 4 will be funded if the patient meets one or more of the following criteria. • Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding **OR** • Irreducible and large external haemorrhoids **Removal of skin tags is not routinely commissioned.** This means **(for patients who DO NOT meet the specified criteria)** that 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.	*There is some difference between the current and new criteria, with Specific criteria for grade 3 and 4 haemorrhoids being introduced.* *In addition the proposed policy no longer commissions haemorrhoidectomy for grade 1 or 2 Haemorrhoids.* *Proposed policy states: 'Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding'* *Proposed policy no longer states that patients must have 'responded to the following non-surgical or out-patient treatments:-* *o Diet modification to relieve constipation.* *o Topical applications.* *o Stool softeners and laxatives.* *o Rubber band ligation.* *o Sclerosant injections.* *o Infrared coagulation.* • *Surgical treatment options include:-* *o Surgical excision (haemorrhoidectomy).* *o Stapled haemorrhoidopexy* *o Haemorrhoidal artery ligation.'* *Layout has been simplified and criteria are now clearer.*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Policy for Hair Removal Treatments including Depilation, Laser Treatment or Electrolysis – for Hirsutism	Routinely commissioned in the case of those undergoing treatment for pilonidal sinuses to reduce recurrence. In other circumstances only commissioned if all of the following clinical circumstances are met; • Abnormally located hair-bearing skin following reconstructive surgery located on face and neck. • There is an existing endocrine medical condition and severe facial hirsutism. 1. Ferryman Gallwey (*A method of evaluating and quantifying hirsutism in women*) Score 3 or more per area to be treated. 2. Medical treatments have been tried for at least one year and failed. 3. Patients with a BMI of>30 should be in a weight reduction programme and should have lost at least 5% body weight. All cases will be subject to individual approval by the IFR Team and must be accompanied by an opinion from a secondary care consultant (i.e. endocrinologist). Photographs will also be required to allow the CCG's to visibly asses the severity equitably. Funded for 6 treatments only at an NHS commissioned premises. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	The CCG will fund this treatment if the patient meets the following criteria: • Has undergone reconstructive surgery leading to abnormally located hair-bearing skin **OR** • Is undergoing treatment for pilonidal sinuses to reduce recurrence This means **(for patients who DO NOT meet the above criteria)** 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.	*There is some difference between the current and the new criteria. The criteria around an existing endocrine medical condition and severe facial hirsutism has been removed.* *Proposed policy no longer includes: 'Ferryman Gallwey (A method of evaluating and quantifying hirsutism in women) Score 3 or more per area to be treated.* *Medical treatments have been tried for at least one year and failed.* *Patients with a BMI of>30 should be in a weight reduction programme and should have lost at least 5% body weight.* *All cases will be subject to individual approval by the IFR Team and must be accompanied by an opinion from a secondary care consultant (i.e. endocrinologist).* *Photographs will also be required to allow the CCG's to visibly asses the severity equitably.* *Funded for 6 treatments only at an NHS commissioned premises.'* *Proposed policy does not refer to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.* *Layout has been simplified and criteria are now clearer*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Surgical Revision of Scars	Funding of treatment will be considered only for scars which interfere with function following burns, trauma, treatments for keloid, or post-surgical scarring. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	The CCG will fund this treatment if the patient meets the following criteria: • For severe post burn cases or severe traumatic scarring **OR** • Revision surgery for scars following complications of surgery, keloid formation or other hypertrophic scar formation will only be commissioned where they are significantly functionally disabling or to restore normal function This means **(for patients who DO NOT meet the above criteria)** 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.	*There is some difference between the current and the proposed criteria. The criteria has been tightened to include 'severe' post-burn or 'severe' traumatic scarring.* *Layout has been simplified and criteria are now clearer*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Cataracts policy	Referral for cataract surgery should be based on symptomatic deterioration of vision e.g. difficulty reading, seeing TV, driving or visual disturbance e.g. glare/dazzle with bright sunlight or oncoming headlights. An example of a referral template for use by optometrists is given in appendix 1. There is good evidence that bilateral cataract replacement is beneficial **Appendix 1 Cataract Referral Guide** Referrals for cataract should only be made in the following context:- Questions / Responses: A / B / C How well can patient see objects in the distance? — without difficulty / with slight difficulty / with great difficulty How well can patient read writing on the TV and/or road signs? — without difficulty / with slight difficulty / with great difficulty How well can patient recognise people on the street? — without difficulty / with slight difficulty / with great difficulty How well can patient read from newspapers/books? — without difficulty / with slight difficulty / with great difficulty How often does patient suffer from glare at night? — never / occasionally / frequently **1) ASSESSMENT OF VISION AND QUALITY OF LIFE** **Interpretation** • If answer to question 4 is b or c, this is often an indication of macular problems rather than cataract. If this is the only problem, referral for cataract surgery is inappropriate. However, referral for an opinion on maculopathy might be required. • If answers to questions 1 to 3 are mainly (c), this is probably cataract-related and referral may be appropriate. • If glare is the ONLY problem (question 5), the referrer (after discussion with the patient) will need to make a judgment as to the potential impact of cataract removal before deciding whether surgery is appropriate. **2) FITNESS FOR SURGERY** Is the patient medically fit for surgery? **3) RISKS AND CONSENT** Has the potential to benefit been explained? Have details of the procedure and risks been explained to patient? Is patient still willing to proceed? **The referrer should be satisfied that the criteria outlined in (1) to (3) have all been met before referring**	Referral of patients to ophthalmologists for cataract surgery should be based on the following indications: 1. The patient has sufficient cataract to account for visual symptoms. It is strongly recommended that only those cases with **best corrected visual acuity of 6/9** (Snellen) **or +0.2** (Logmar**) or worse** in the poorer eye be referred. However, exception may be made where the impact of symptoms is such that the patient's quality of life is significantly impaired. A description of the impact on quality of life must be documented and accompany the referral information for all cases. Examples of the Impact on quality of life may include any of the following factors, although this is not an exhaustive list: a. the patient is at significant risk of falls b. the impact of the visual symptoms is affecting the patient's ability to access their chosen mode of transport including driving c. the impact of symptoms is compromising the patient's independence d. the impact of the visual symptoms is affecting the patient's ability to continue their employment or undertake caring responsibilities e. the impact of the visual symptoms is substantially affecting the patient's ability to undertake daily activities such as reading, watching television, leaving the house or recognising faces. f. the patient is experiencing disabling glare. **AND** 2. Where the referral has been initiated by an optometrist, there has been a discussion on the risks and benefits of cataract surgery based around the Patient Decision Aid For Cataract. http://sdm.rightcare.nhs.uk/pda/cataracts/ 3. The patient has understood what a cataract surgical procedure involves and wishes to have surgery **Guidance for second eye surgery in patients with bilateral cataracts** **The second eye criteria is** • As for the first eye, i.e. the impact of visual symptoms is sufficiently impairing the patient's quality of life despite one eye having been operated upon	*There are a number of differences between the current and the proposed criteria.* *In the revised criteria it is strongly recommended that only those cases with **best corrected visual acuity of 6/9** (Snellen) **or +0.2** (Logmar**) or worse** in the poorer eye be referred. However, exception may be made where the impact of symptoms is such that the patient's quality of life is significantly impaired.* *In addition a description of the impact on quality of life must be documented and accompany the referral criteria, with a number of examples of impacts on the quality of life given.* *The proposed criteria no longer includes an example referral template* *The proposed criteria now draws out the criteria for second eye referral*

Suite 2 Red rated Policies

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Removal and/or Replacement of Silicone Implants - **Revision of Breast Augmentation**	Revisional surgery will ONLY be considered if the NHS commissioned the original surgery and complications arise which necessitates surgical intervention. If revisional surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them will be based upon the clinical need for replacement and whether the patient meets the policy for augmentation at the time of revision. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	*Removal and/or replacement of silicone implants is not routinely commissioned.* *The removal of **ruptured** silicone implants will only be commissioned in the following circumstances:* *Where a patient has implants that have ruptured or failed, the patient should be referred back to the provider of the implants.* If the clinic no longer exists or refuses to remove the implants, the NHS will remove ruptured implants or implants that have failed only, but will **not** replace them.	*There is some change to the criteria here: the proposed policy now states that patients should be referred back to the original provider and only if the clinic no longer exists or refuses to remove the implants will they be removed by the NHS. In this instance the NHS will only remove the implants on rupture or failure and will **not** replace them.* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Male Breast Reduction Surgery for Gynaecomastia	Not routinely commissioned except on an exceptional basis where all of the following criteria are met: • True gynaecomastia not just adipose tissue. AND • Underlying endocrine or liver abnormality excluded. AND • Not due to recreational use of drugs such as steroids or cannabis or other supplements known to cause this. AND • Not due to prescribed drug use. AND • Has not responded to medical management for at least three months e.g. tamoxifen. AND • Post pubertal. AND • BMI <25kg/m2 and stable for at least 12 months. AND • Patient experiences persistent pain. AND • Experiences significant functional impairment. AND • In cases of idiopathic gynaecomastia in men under the age of 25 then a period of at least 2 years has been allowed for natural resolution. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	This procedure is not routinely commissioned.	*There is no change to this policy position.* *Additional information in the current criteria has been removed for clarity. The previous format of this criteria was misleading as it implied this was a criteria based policy. However the overall position remains the same.* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Laser Tattoo Removal	Only commissioned in any of the following circumstances: • Tattoo is result of trauma inflicted against the patient's will. • The patient was a child and not responsible for his/her actions at the time of tattooing. • Inflicted under duress. • During adolescence or disturbed periods (only in very exceptional circumstances where tattoo causes marked limitations of psycho-social function). An individual funding request will be required.	Removal of Tattoos is not routinely commissioned.	*There is no change to this policy position.* *Additional information in the current criteria has been removed for clarity. The previous format of this criteria was misleading as it implied this was a criteria based policy. However the overall position remains the same. Given the additional clarity, this has been rated as a red policy.*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Abdominoplasty/Apronectomy (sometimes called 'tummy tuck')	Not routinely commissioned other than if all of the following criteria are met: The flap hangs at or below the level of the symphysis pubis. Patients BMI is <25 and stable for at least 12 months. (Some allowance may be made for redundant tissue not amenable to further weight reduction). Bariatric surgery (if performed) was performed at least 3 years previously. AND any of the following: Causes significant problems with activities of daily life (e.g. ambulatory restrictions). Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics. Poorly-fitting stoma bag. (If the patient does not fulfil all of the required criteria, an IFR should be submitted detailing why exception should be made). IFR information ***must*** contain the following information:- • Date of bariatric surgery (where relevant). • Pre-operative or original weight and BMI with dates. • Series of weight and BMI readings demonstrating weight loss and stability achieved. • Date stable weight and BMI achieved. • Current weight/BMI. • Patient compliance with continuing nutritional supervision and management (if applicable). • Details of functional problems. Details of associated medical problems.	These procedures are not routinely commissioned.	*There is no change to this policy position.* *Additional information in the current criteria has been removed for clarity. The previous format of this criteria was misleading as it implied this was a criteria based policy. However the overall position remains the same. Given the additional clarity, this has been rated as a red policy.*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Other Skin Excisions/ Body Contouring Surgery e.g. Buttock Lift, Thigh Lift, Arm Lift (Brachioplasty)	Not routinely commissioned. If an IFR request for exceptionality is made, the patient must fulfil all of the following criteria before being considered. Patients BMI is <25 and stable for at least 12 months. (Some allowance may be made for redundant tissue not amenable to further weight reduction). Bariatric surgery (if performed) was performed at least 3 years previously. AND any of the following: Causes significant problems with activities of daily life (e.g. ambulatory restrictions). Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics. IFR information ***must*** contain the following information; • Date of bariatric surgery (where relevant). • Pre-operative or original weight and BMI with dates. • Series of weight and BMI readings demonstrating weight loss and stability achieved. • Date stable weight and BMI achieved. • Current weight/BMI. • Patient compliance with continuing nutritional supervision and management (if applicable). • Details of functional problems. • Details of associated medical problems. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	These procedures are not routinely commissioned.	*There is no change to this policy position.* *Additional information in the current criteria has been removed for clarity. The previous format of this criteria was misleading as it implied this was a criteria based policy. However the overall position remains the same. Given the additional clarity, this has been rated as a red policy.* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Surgical Treatments for hair Loss	**Treatments to Correct Hair Loss for Alopecia** Only commissioned in either of the following circumstances: • Result of previous surgery. • Result of trauma, including burns. Hair Intralace System is not commissioned. Dermatography is not commissioned. NHS wigs will be available according to NHS policy. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG **Hair Transplantation** Commissioned only in exceptional circumstance, e.g. reconstruction of the eyebrow following cancer or trauma. Dermatography may be an acceptable alternative in eyebrow reconstruction. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. **Treatments to Correct Male Pattern Baldness** This is not routinely commissioned	Surgical Treatment for Alopecia, hair transplantation, Male Pattern Baldness and hair intralace systems will not be routinely commissioned. The NHS has a policy for Wigs which may be an alternative option for patients: http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Wigsandfabricsupports.aspx The current cost is £67.75 for an acrylic wig with 2 allowed per year. There is no charge for chemotherapy patients.	*The differences in this policy are as follows:* • *the title of the policy has been clarified as 'Surgical Treatments for hair loss'* • *the proposed position for treatments to correct alopecia is that these are no longer commissioned* • *the proposed position for hair transplantation is that these are no longer commissioned* • *under the current commissioning policy, there are separate entries for Treatments to Correct Hair Loss for Alopecia, Hair Transplantation and Treatments to Correct Male Pattern Baldness so these have all been merged into one policy statement* • *clarity around access to wigs via the NHS has been included* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Rhytidectomy - Face or Brow Lift	This procedure is not available under the NHS on cosmetic grounds. Routinely commissioned in the following circumstances: Congenital facial abnormalities. Facial palsy. Treatment of specific conditions affecting the facial skin, e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis. • To correct consequences of trauma. • To correct deformity following surgery. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Rhytidectomy is restricted for non-cosmetic/other reasons. The CCG will fund this treatment if the patient meets the minimum eligibility criteria below. • Recognised diagnosis of Congenital (present from birth) facial abnormalities **OR** • Facial palsy (congenital or acquired paralysis) **OR** • As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis	*There are some differences between the current and the proposed criteria. The criteria has been laid out more clearly and the following criteria have been removed* • *To correct the consequences of trauma OR* • *For significant deformity following corrective surgery. However funding will not be approved to improve previous cosmetic surgery.* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Policy for male circumcision for medical reasons only	This not offered for social, cultural or religious reasons. However certain CCGs may have individual policies*. Indicated for the following condition; • Balantis xerotica obliterans. • Traumatic foreskin injury/scarring where it cannot be salvaged. • 3 or more episodes of balanitis/balanoposthitis. • Pathological phimosis. • Irreducible paraphimosis. • Recurrent proven Urinary Tract. Infections (UTIs) with an abnormal urinary tract.	Circumcision will be funded in the following medical circumstances: • Balantis xerotica obliterans. • Traumatic foreskin injury/scarring where it cannot be salvaged. • 3 or more episodes of balanitis/balanoposthitis. • Pathological phimosis. • Irreducible paraphimosis. • Recurrent proven Urinary Tract. Infections (UTIs) with an abnormal urinary tract. • Tight foreskin causing pain on arousal/ interfering with sexual function This is because if the patient does not meets the medical indications above non-medical circumcisions do not confer any health gain but do carry health risk. This procedure is not offered for social, cultural or religious reasons.	*There is some change to this policy:* • *The title has been clarified to now read 'Policy for male circumcision for medical reasons only'* • *the criteria now makes it clear that the procedure is not offered for social, cultural or religious reasons and* • *Congenital abnormalities are now provided for in the revised criteria.*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Pinnaplasty	May be commissioned in the following circumstances: Surgical "correction" of prominent ear(s) only when all of the following criteria are met: 1. Referral only for children aged 5 to 18 years at the time of referral. AND 2. With very significant ear deformity or asymmetry. Patients not meeting these criteria should not be routinely referred for surgery. Incisionless otoplasty is not commissioned.	Pinnaplasty is not routinely commissioned.	*This procedure is moving from a criteria based position to a not routinely commissioned position.*

Suite 1 Green rated Policies

Procedure	C&M Current Policy	Proposed Policy 2018/2019	
Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias and Surgical correction of Diastasis of the Recti	Surgery: not commissioned if no symptoms, easily reducible (i.e. can be 'pushed back in') and not at significant risk of complications. Surgical repair is not routinely commissioned.	Not routinely commissioned This means **(for patients who DO NOT meet the specified criteria)** 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.	*Policies are aligned*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Surgery for Asymptomatic Gallstones	N/A - This procedure is not routinely commissioned.	This procedure is not routinely commissioned.	*Policies are aligned*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Dilatation and Curettage	**Not routinely funded**	Not routinely commissioned. 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.	*Policies are aligned*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Policy for Private Mental Health Care- Non-NHS Commissioned Services: including Psychotherapy, adult eating disorders, general in-patient care, post-traumatic stress, adolescent mental health	This will not normally be funded. Most mental health conditions can be managed in the community with input from Community Mental Health teams. NHS England Specialist Commissioning provides specialist services for various conditions including PTSD, eating disorders and severe OCD. There is also a specialist NHS MH service provided for affective disorders. A request for private MH care should be initiated by a consultant psychiatrist and give full explanation as to why NHS care is inappropriate or unavailable.	Not routinely commissioned.	*Policies are aligned*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Policy for Hyaluronic Acid and Derivatives Injections for Peripheral joint pain	Hyaluronic Acid and Derivatives Injections are not commissioned for joint injection.	Not routinely commissioned.	*Policies are aligned*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Knee Replacement Surgery	Referral is based on local referral pathways. **Funding for <u>total or partial knee replacement</u> <u>surgery</u> is available if the following criteria are met** 1. Patients with BMI <40. AND 2. Patient complains of moderate joint pain AND moderate to severe functional limitations that has a substantial impact on quality of life, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. AND 3. Has radiological features of severe disease. OR 4. Has radiological features of moderate disease with limited mobility or instability of the knee joint.	Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant. **Funding for <u>total or partial knee replacement</u> <u>surgery</u> is available if the following criteria are met** 1. Patients with BMI <40. AND 2. Patient complains of moderate joint pain AND moderate to severe functional limitations that has a substantial impact on quality of life, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. AND 3. Has radiological features of severe disease. OR 4. Has radiological features of moderate disease with limited mobility or instability of the knee joint.	*Policies are aligned with additional guidance around referral via the appropriate local referral pathway* *Proposed policy has an expanded reference: 'Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant.'*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Hip Replacement Surgery	**Referral criteria for <u>Total Hip Replacements (THR)</u>** should be based on the level of pain and functional impairment suffered by the patient. Funding is available for patients who fulfil the following criteria; 1. Patient complains of severe joint pain. AND 2. Functional limitation, despite the use of non- surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. OR 3. Patient complains of mild to moderate joint pain AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. The CCGs will fund hip resurfacing for those who otherwise qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements as restricted by NICE Guidance Hip disease - metal on metal hip resurfacing (TA44).	Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant. **Referral criteria for <u>Total Hip Replacements (THR)</u>** should be based on the level of pain and functional impairment suffered by the patient. Funding is available for patients who fulfil the following criteria; 1. Patient complains of severe joint pain. AND 2. Functional limitation, despite the use of non- surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. OR 3. Patient complains of mild to moderate joint pain AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. The CCGs will fund hip resurfacing for those who otherwise qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements as restricted by NICE Guidance Hip disease - metal on metal hip resurfacing (TA44).	*Policies are aligned with additional guidance around referral via the appropriate local referral pathway.* *Proposed policy includes: 'Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant.'*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Surgical Removal of Ganglions	Aspiration and Surgery for ganglion (open or arthroscopic) are not routinely commissioned. Reassurance that no treatment is required should be given to the patient.	Aspiration and Surgery for ganglion (open or arthroscopic) are not routinely commissioned. Reassurance that no treatment is required should be given to the patient.	*Policies are aligned*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Adenoidectomy	Commissioned only in either of the following clinical situations. <u>In Children</u> For the treatment of obstructive sleep apnoea or upper airways resistance syndrome in combination with tonsillectomy. In conjunction with grommet insertion where there are significant nasal symptoms, in order to prevent repeat grommet insertion for the treatment of glue ear or recurrent otitis media. See 5.3 Adenoidectomy is not routinely commissioned as an isolated procedure.	Adenoidectomy will only be funded if Primary and Secondary Care clinicians undertake maximum medical therapy by following the Royal College of Surgeons High Value Care Pathway for Rhinosinusitis, with surgery reserved for recalcitrant cases, with a diagnosis confirmed by radiology, after an appropriate trial of treatment. **Or** Children or adults with sleep disordered breathing/apnoea confirmed with sleep studies undergo procedure in line with recognised management of these conditions. This means **(for patients who do not require tonsillectomy and/or grommets)** 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.	*There is some difference between the current and new criteria, with tightening of the proposed criteria to ensure: Primary and Secondary Care clinicians undertake maximum medical therapy by following the Royal College of Surgeons High Value Care Pathway for Rhinosinusitis, with surgery reserved for recalcitrant cases, with a diagnosis confirmed by radiology, after an appropriate trial of treatment.* *Proposed policy Includes adults with sleep disordered breathing/apnoea confirmed with sleep studies undergo procedure in line with recognised management of these conditions.* *Layout has been simplified and criteria are now clearer.*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Policy for Tonsillectomy for recurrent Tonsillitis (excluding peri-tonsillar abscess) Adults and Children	Tonsillectomy will only be commissioned where: • Seven or more well documented clinically significant adequately treated sore throats in the preceding year; OR • Five or more such episodes in each of the previous two years; OR • Three or more such episodes in each of the preceding three years. Is commissioned if appropriate following peri-tonsillar abscess. Tonsillectomy is not commissioned for tonsil stones or halitosis. Tonsillectomy may be appropriate for significant hypertrophy causing OSA. Tonsillectomy is recommended for severe recurrent sore throats in adults as above.	The CCG will fund this treatment if the patient meets one or more of the following criteria: • 7 or more documented clinically significant, adequately treated episodes in the preceding year; **OR** • 5 or more documented episodes in each of the preceding two years **OR** • 3 or more documented episodes in each of the preceding three years. **AND** • If symptoms are disabling and prevent normal functioning Each episode of tonsillitis should be documented in the patient's medical records and characterised by at least one of the following: • Aural temperature of at least 38.3°C • Tender anterior cervical lymph nodes • Tonsillar exudates • Tonsillar enlargement giving rise to symptoms of upper airways obstruction **Note:** Walk in Centre or Out of Hours documented episodes that are communicated in writing to GP Practices are included in the episode count. There are a small proportion of patients with specific clinical conditions or syndromes, who require tonsillectomy as part of their on-going management strategy, and who will not necessarily meet the SIGN guidance below (e.g. those presenting with psoriasis, nephritis, Periodic fever, aphthous stomatitis, pharyngitis and adenitis (PFAPA) syndrome. Children or adults with sleep disordered breathing/apnoea confirmed with sleep studies undergo procedure in line with recognised management of these conditions. **Note:** When in doubt, implement a six month period of clinical watchful waiting. (Watchful waiting involves carefully monitoring your symptoms to see whether they improve or get worse.) This means **(for patients who DO NOT meet the specified criteria)** 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.	*There is some difference between the current and new criteria, with tightening of the proposed criteria to ensure that episodes are documented.* *There is no longer any reference to peri-tonsillar abscess, tonsil stones. Halitosis or significant hypertrophy causing OSA* *Proposed policy includes: If symptoms are disabling and prevent normal functioning* *Proposed policy includes: Each episode of tonsillitis should be documented in the patient's medical records and characterised by at least one of the following:* • *Aural temperature of at least 38.3°C* • *Tender anterior cervical lymph nodes* • *Tonsillar exudates* • *Tonsillar enlargement giving rise to symptoms of upper airways obstruction* *Layout has been simplified and criteria are now clearer.*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Hysterectomy for Heavy Menstrual Bleeding	Hysterectomy not commissioned unless all of the following requirements have been met: • An unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena) unless medically contra-indicated or the woman has made an informed choice not to use this treatment. • The following treatments have failed, are not appropriate or are contra-indicated in line with NICE guidance. o Tranexamic acid or nonsteroidal anti-inflammatory drugs or combined oral contraceptives. o Norethisterone (15mg) daily from days 5 to 26 of the menstrual cycle, or injected long-acting progestogens. Endometrial ablation has been tried (unless patient has fibroids >3cm)	Hysterectomy not commissioned unless all of the following criteria have been met: • The following treatments have failed, are not appropriate or are medically contra-indicated: o An unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena) o Tranexamic acid or nonsteroidal anti-inflammatory drugs or combined oral contraceptives. o Norethisterone 15 mg daily from days 5 to 26 of the menstrual cycle, or injected long-acting progestogens o Up to 4 courses of ulipristal acetate 5mg for women with heavy menstrual bleeding and fibroids of 3cm or more in diameter. o Endometrial ablation has been tried (unless patient has fibroids >3cm) The procedure should not be offered where a patient wishes to cease menstruation.	*There is some difference between the current and new criteria, with the addition of specific criteria around the use of ulipristal acetate 5mg.* *Criteria has also been tightened to state that the procedure should not be offered as an option to cease menstruation - proposed policy no longer includes: 'the woman has made an informed choice not to use this treatment.'*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Varicose Veins Treatments	Treatment of varicose veins is not commissioned except in the following circumstances: • Ulcers/history of ulcers secondary to superficial venous disease. • Liposclerosis. • Varicose eczema. • History of phlebitis.	Treatment of varicose veins is only commissioned in the following circumstances: • Varicose veins which have bled and are at risk of bleeding again (immediate referral recommended). ***OR*** • A history of varicose ulceration ***OR*** • Signs of prolonged venous hypertension (haemasiderin pigmentation, eczema, induration lipodermatosclerosis), or significant oedema associated with skin changes ***OR*** • Superficial thrombophlebitis in association with varicose veins **Note:** compression hosiery should not be offered to treat varicose veins **unless** interventional treatment is unsuitable. This means **(for patients who DO NOT meet the specified criteria)** 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.	*Policies are aligned.* *Proposed policy includes: 'Varicose veins which have bled and are at risk of bleeding again (immediate referral recommended).'* *Proposed policy describes 'signs of prolonged venous hypertension' more clearly.* *Proposed policy includes: 'Superficial thrombophlebitis in association with varicose veins.'* *Proposed policy includes: '**Note:** compression hosiery should not be offered to treat varicose veins **unless** interventional treatment is unsuitable.'*

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Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Reduction Mammoplasty - Female Breast Reduction	Commissioned only if all of the following circumstances are met: • Musculo-skeletal symptoms are not due to other causes. AND • There is at least a two year history of attending the GP with the problem. AND • Other approaches such as analgesia and physiotherapy have been tried. AND • The patient is suffering from functional symptoms as a result of the size of her breasts (e.g. candidal intertrigo; backache). AND • The wearing of a professionally fitted brassiere has not helped. AND • Patients BMI is <25 and stable for at least twelve months. AND • The patients breast is a cup size H or larger. AND • There is a proposed reduction of at least a three cup sizes. AND • Aged over 18 years old. AND • It is envisaged there are no future planned pregnancies. Unilateral breast reduction is considered for asymmetric breasts of three or more cup size difference as measured by a specialist. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.	The CCG will fund this treatment if the patient meets ALL of the following criteria • Musculo-skeletal symptoms are not due to other causes. AND • There is at least a two year history of attending the GP with the problem. AND • Other approaches such as analgesia and physiotherapy have been tried. AND • The patient is suffering from functional symptoms as a result of the size of her breasts (e.g. candidal intertrigo; backache). AND • The wearing of a professionally fitted brassiere has not helped. AND • Patients BMI is <25 and stable for at least twelve months. AND • The patients breast is a cup size H or larger. AND • There is a proposed reduction of at least a three cup sizes. AND • Aged over 18 years old. AND • It is envisaged there are no future planned pregnancies. Unilateral breast reduction is considered for asymmetric breasts of three or more cup size difference as measured by a specialist – see the Breast Augmentation policy.	*Policies are aligned* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Augmentation Mammoplasty - Breast Enlargement	Only commissioned in the following circumstances: In all cases: • The BMI is <25 and stable for at least twelve months. AND • There is congenital absence of breast tissue unilaterally of three or more cup size difference as measured by a specialist. OR • Congenital absence i.e. no obvious breast tissue. In special circumstances reconstructive surgery may be appropriate for tubular breast abnormality. All non-surgical options must have been explored e.g. padded bra. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.	Augmentation Mammoplasty will be funded if the patient meets ALL of the following criteria: • There is congenital absence of breast tissue unilaterally of three or more cup size difference as measured by a specialist. AND • The patient's BMI is under 25 and has been stable for at least 12 months AND • Aged over 18 years old.	*Policies are aligned* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Mastopexy - Breast Lift	Not routinely commissioned. May be considered as part of other breast surgery to achieve an appropriate cosmetic result subject to prior approval. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	This procedure is not routinely commissioned.	*There is no change to this policy position.* *Additional information in the current criteria has been removed for clarity.* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Surgical Correction of Nipple Inversion	This is not routinely commissioned. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	This procedure is not routinely commissioned.	*There is no change to this policy position.* *Additional information in the current criteria has been removed for clarity.* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Surgical Treatment for Pigeon Chest	This procedure is not routinely commissioned by the NHS on cosmetic grounds	This procedure is not routinely commissioned.	*There is no change to this policy position.*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Labiaplasty, Vaginoplasty and Hymenorrhaphy	This is not routinely commissioned.	These procedures are not routinely commissioned.	*There is no change to this policy position.*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Liposuction	Liposuction is sometimes an adjunct to other surgical procedures e.g. thinning of a transplanted flap. Not commissioned simply to correct fat distribution. May be commissioned as part of the management of true lipodystrophies or non-excisable clinically significant lipomata. An individual funding request will be required. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Liposuction is not routinely commissioned.	*There is no change to this policy position.* *Additional information in the current criteria has been removed for clarity. The previous format of this criteria was misleading as it implied this was a criteria based policy. However the overall position remains the same.* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Policy for Diagnostic Interventions and Treatments for Early Management of Back Pain	The following treatments should not be offered for the early management of persistent non-specific low back pain. • Selective serotonin re-uptake inhibitors (**SSRIs**) for treating pain. • Injections of therapeutic substances into the back. • Laser therapy. • Interferential therapy. • Therapeutic ultrasound. • Transcutaneous electrical nerve stimulation (**TENS**). • Lumbar supports Traction.	**Policy for non-invasive interventions for low Back pain and sciatica** **Acupuncture** Acupuncture for low back pain and sciatica is **not routinely commissioned** **Manual Therapy** The following procedures are **not routinely commissioned**: • Lumbar traction • Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS) • Manual therapy (spinal mobilisation, manipulation, soft tissue techniques and massage) in isolation. Note: Consider manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy. **Orthotics** The following are **not routinely commissioned**: • Foot orthotics • Rocker shoes • Belts and corsets **Electrotherapy** The following are **not routinely commissioned:** • Transcutaneous electrical nerve stimulation (TENS) • Percutaneous electrical nerve stimulation (PENS) • Ultrasound • Interferential • Laser therapy The CCG **does not routinely commission** the following in the treatment of low back pain without Neuropathic pain: • Paracetamol used alone • Selective serotonin re-uptake inhibitors (**SSRIs**) • Serotonin– norepinephrine reuptake inhibitors • Tricyclic antidepressants • Anti-convulsants • Opioids for the management of acute back pain (if NSAIDs are contraindicated, ineffective or not tolerated then weak opioids may be given +/- paracetamol) Patients with neuropathic pain should be managed in line with NICE CG 173: • Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia) • 1.1.9 If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated. • 1.1.10 Consider tramadol only if acute rescue therapy is needed (see recommendation 1.1.12 about long-term use).	*There is some difference between the current and proposed policy. The proposed policy is aligned with NG59.* *Treatment options have been clearly broken down in the proposed policy into 5 headings:* • *Acupuncture* • *Manual therapy* • *Orthotics* • *Electrotherapy* • *Pharmacology* *These make reference to specific treatments under these areas, all of which are not routinely commissioned.*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
		• 1.1.11 Consider capsaicin cream[4] for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments. *Treatments that should not be used* 1.1.12 Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so: • cannabis sativa extract • capsaicin patch • lacosamide • lamotrigine • levetiracetam • morphine • oxcarbazepine • topiramate • tramadol (this is referring to long-term use; see recommendation 1.1.10 for short-term use) • venlafaxine.	

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
X rays and MRI scans as diagnostic tools for back related problems	There is no specific C&M policy around X rays and MRI scans, however it is noted in the comments section of 16.1 that *'X Rays and MRI scans should not be offered unless in a context of referral for surgery.'*	**Imaging for patients presenting with back pain.** Imaging is commissioned in AED only where patients present with red flags or concerns of serious underlying pathology (cancer, infection etc.) and requires urgent management. X rays, MRI and CT scans are NOT routinely commissioned in non-specialist settings. Imaging for patients with non-urgent presentations should not be offered imaging in AED and is not routinely commissioned. Consider imaging in specialist musculoskeletal settings for people with low back pain with or without sciatica only if the result is likely to change management i.e. prior to surgery.	*The proposed criteria provide a clear position that indicates imaging for patients presenting with back pain is not routinely commissioned in non-specialist settings.* *Imagining should only be considered in specialist musculoskeletal settings for patients with low back pain, with or without sciatica only if the result is likely to change management.* *Imaging is commissioned in AED only where patients present with red flags or concerns of serious underlying pathology and requires urgent management.*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Facet Joint - Non Specific Back Pain Over 12 Months including radio frequency ablation	Non specific back pain over 12 months – Not routinely commissioned. May have a role as a diagnostic procedure when considering radio frequency ablation. This would require an individual funding request.	**Injections for back pain** Therapeutic Facet Joint injection, therapeutic medial branch block, prolotherapy, Botulinum Toxin and Trigger Point Injections are Not routinely commissioned **<u>Epidural</u>** Single shot epidural steroid is of short-term benefit in acute and severe sciatica and may enable normal activity to resume. Benefits and risks should be discussed with the patient. Epidural injections should be targeted at the affected nerve root(s) and under image guidance where required. Only one injection should be offered and this should only be offered where: • symptoms are acute AND • The patient is experiencing severe sciatica. Epidural Injection for Non-specific Low Back Pain of greater than 12 months, is not routinely commissioned. Epidural injection for neurogenic claudication in patients with central stenosis is not routinely commissioned. **Radiofrequency Facet Joint Denervation** Treatments for low back pain will only be commissioned in line with NICE guidance NG59 'Low back pain and sciatica in over 16s: assessment and management' (November 2016) The CCG will fund a single procedure of radiofrequency denervation for people with chronic low back pain when: • comprehensive conservative treatment approach has not • worked for them	*There is some difference between the current and the proposed policy. The proposed policy is clear that Therapeutic Facet Joint injection, therapeutic medial branch block, prolotherapy, Botulinum Toxin and Trigger Point Injections are Not routinely commissioned.* *The proposed policy covers multiple injection options within one policy rather than having separate policies.* *The proposed policy states that for epidural injections, these should be offered only where symptoms are acute and the patient is experiencing severe sciatica and that only one injection should be offered.* *Epidural Injection for Non-specific Low Back Pain of greater than 12 months and Epidural injection for neurogenic claudication in patients with central stenosis is not routinely commissioned.* *The proposed policy now outlines 6 specific criteria a patient must meet in order for one procedure of radiofrequency denervation.*
Epidural Injection	Radicular Pain – Single injection may be of benefit to enable normal activity to resume in prolapsed disc & spinal stenosis where surgery is not desirable.' 'Non Specific Back Pain – Not routinely commissioned'.		
Radiofrequency Facet Joint Denervation Intra Discal Electro Thermal Annuloplasty (IDET) Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT) Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS)	The following should not be offered for the early management of persistent non-specific low back pain. Radiofrequency facet joint denervation. Intra Discal Electro Thermal Annuloplasty (**IDET**)Percutaneous intradiscal radiofrequency thermocoagulation (**PIRFT**),		

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
		AND • the main source of pain is thought to come from structures supplied by the medial branch nerve AND • The clinical presentation is consistent with symptoms arising from the facet joint: o Increased pain unilaterally or bilaterally on lumbar paraspinal palpation o Increased back pain on 1 or more of the following: o extension (more than flexion); rotation; extension/side flexion; extension/rotation o No radicular symptoms o No sacroiliac joint pain elicited using a provocation test AND • they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral AND • low back pain is chronic in nature AND • The patient has significant short term pain relief to a diagnostic medial branch block. Do not offer imaging for people with low back pain with specific facet join pain as a prerequisite for radiofrequency denervation. Providers who offer radiofrequency denervation will be expected to submit patient outcome data to the UK National Spinal RF Registry http://cl1.n3-dendrite.com/csp/spinalrf/FrontPages/index.html	*IDET and PIRFT have now been grouped with the disc and decompression procedures, however these remain not routinely commissioned*.

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Fusion	Not routinely commissioned. There is limited data on effectiveness and no data on superiority over other treatments. Fusion not commissioned unless the patient has completed an high intensity package of care, including a combined physical and psychological treatment programme. AND Still has severe non-specific low back pain for which they would consider surgery.	**Spinal Fusion** The following procedures are not routinely commissioned: • Fusion • Non-rigid stabilisation techniques • Lateral body fusion in the lumbar spine • Transaxial interbody lumbrosacral fusion • Anterior lumbar interbody fusion (ALIF) • Posterior lumbar interbody fusion (PLIF) • Or any other combination of approach where surgical fixation is performed	*There is no difference between the current and the proposed criteria for Non-rigid stabilisation techniques, Lateral body fusion in the lumbar spine, Transaxial interbody lumbrosacral fusion.* *For fusion, the current criteria stating Fusion not commissioned unless the patient has completed an high intensity package of care, including a combined physical and psychological treatment programme and still has severe non-specific low back pain for which they would consider surgery has been removed.* *The proposed criteria now makes clear that ALIF and PLIF and any other combination of approach where surgical fixation is performed is not routinely commissioned.*
Non-Rigid Stabilisation Techniques	This procedure is NOT routinely commissioned.		
Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine	This procedure is NOT routinely commissioned.		
Transaxial Interbody Lumbosacral Fusion	This procedure is NOT routinely commissioned.		

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Endoscopic Laser Foraminoplasty	This procedure is NOT routinely commissioned.	**Disc and Decompression procedures** Spinal decompression i.e. laminectomy, discectomy, facetectomy, foraminotomy, is commissioned where: • Patient presents with severe and acute sciatica AND • have failed to respond to conservative intervention AND • have imaging findings concordant with clinical presentation Patient outcome data must be entered onto the international registry database Spine Tango and providers are expected to regularly participate in the Cheshire and Mersey MDT Spinal Network. The following procedures are NOT routinely commissioned: • Endoscopic Laser Foraminoplasty • Endoscopic Lumbar Decompression • Percutaneous Disc Decompression using Coblation for Lower Back Pain • Percutaneous Intradiscal Laser Ablation in the Lumbar Spine • Automated Percutaneous Mechanical Lumbar Discectomy • Prosthetic Intervertebral Disc Replacement in the Lumbar Spine • Intradiscal Electro Thermal Annuloplasty (IDET) • Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)	*There is some difference between the current and the proposed policy.* *The proposed policy covers all types of disc and decompression procedures rather than having separate policies.* *Endoscopic Laser Foraminoplasty, Endoscopic Lumbar Decompression, Percutaneous Disc Decompression using Coblation for Lower Back Pain, Percutaneous Intradiscal Laser Ablation in the Lumbar Spine, Automated Percutaneous Mechanical Lumbar Discectomy, Prosthetic Intervertebral Disc Replacement in the Lumbar Spine, Intradiscal Electro Thermal Annuloplasty (IDET), and Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT) all remain not routinely commissioned.* *The proposed policy states that Spinal decompression i.e. laminectomy, discectomy, facetectomy, foraminotomy, is commissioned where:* • *Patient presents with severe and acute sciatica* *AND* • *have failed to respond to conservative intervention* *AND* • *have imaging findings concordant with clinical presentation*
Endoscopic Lumbar Decompression	This procedure is NOT routinely commissioned		
Percutaneous Disc Decompression using Coblation for Lower Back Pain	This procedure is NOT routinely commissioned.		
Percutaneous Intradiscal Laser Ablation in the Lumbar Spine	This procedure is NOT routinely commissioned.		
Automated Percutaneous Mechanical Lumbar Discectomy	This procedure is NOT routinely commissioned		
Prosthetic Intervertebral Disc Replacement in the Lumbar Spine	This procedure is NOT routinely commissioned		

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain	This procedure is NOT routinely commissioned.	This procedure is NOT routinely commissioned.	*There is no difference between the current and the proposed criteria*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Therapeutic Endoscopic Division of Epidural Adhesions	This procedure is NOT routinely commissioned.	This procedure is NOT routinely commissioned.	*There is no difference between the current and the proposed criteria*

Midlands and Lancashire Commissioning Support Unit

Policy Development Project Working Group Meeting 12 Minutes
Date: Tuesday 14th November 2017
Meeting time: 13:30 to 15:30
Dial in Details: 0800 917 1950 and use passcode 69175070 followed by

Agenda Item		
1	**Attendance**	**Apologies**
	Helen Pressage (HP) – *Warrington CCG* Zoe Graham (ZG) – *Warrington CCG* Moira Harrison (MH) – *South Sefton & Southport & Formby CCGs* Martin Stanley (MS) – *Halton CCG* David Marteau (DM) – *Halton CCG* Neil Meadowcroft (NM) – *Knowsley CCG* Craig Porter (CP) - *Knowsley CCG* Debbie Lowe (DL) – *MLCSU IFR Senior Manager* Anna Donaldson (AD) - *MLCSU Comms lead* Jennifer Mulloy (JM) – *MLCSU EIRA Business Partner* David Partington (JM) – *MLCSU EIRA Business Partner* Jane Wright (JW) – *MLCSU GP Lead* Michael O'Brien (MOB) – *MLCSU Policy Development Project Manager (Minutes)*	Ruth Hunter (RH) – *St Helens CCG* John Hampson (JHa) – *Public Health Specialist* Anne Henshaw (AH) – *MLCSU Medicines Management Team* Pam Hughes (PH) – *MLCSU Service Director* Judith Nielson (JN) – *Liverpool CCG* Jo Navin (JNa) – *MLCSU Comms Senior Manager* Harinder Sanghera (HS) – *MLCSU Senior IFR Development Lead*
2	**Welcome and Introductions**	
	DL welcomed all to the meeting and introductions were given.	
3	**Minutes of last meeting – Accuracy & Matters Arising**	
	MOB explained that roughly half of the actions that came out of the 31st October meeting have been completed, with the rest currently in progress. **Actions from the last Working Group meeting held in October 2017:**	

Action ID	Action	Update
1	MOB to update references in TOR to Public Health consultant/specialist	MOB advised that this has been completed
2	MOB to make final amendments to the Working Group Terms of Reference then circulate.	MOB advised that this has been completed and will be circulated shortly.
3	MOB to bring the November working Group forward so final decisions can be made against the red rated policies coming out of the EIRA and Engagement work.	MOB advised that this has been completed.
4	MOB to draft a letter to providers to give them notice that revised policies will be issued in January 2018 and to share this with Commissioning Leads.	MOB advised that this is in hand and will be completed shortly.
5	MOB Collate list of December and January Governing Body meetings to support planning for Governing body papers and issuing of policies.	MOB advised that this is ongoing as he is still waiting for dates from Halton and Knowsley CCGs

6	DP and MOB to liaise about ensuring copies of EIRAs for all Policies are made available to CCGs via the Governing Body papers that will be prepared in the coming weeks.	MOB advised that this has been completed.

4 Communications and Engagement update

AD gave an update for this item. She explained that the comms and engagement work for suite 1 and 2 has now been finalised and the report of findings has gone out. The next stage is to provide a summary for Governing Bodies so AD asked those in attendance what specific information they needed. It was noted that it would be useful to have a summary by area but CCGs will also need to see a Merseyside summary.

CP noted that Governing Bodies may wish to see a breakdown of local respondents to give their papers a local flavor. AD noted that this this has already been provided but that this needs to be in narrative form so this will be picked up and produced.

ACTION: JNa to begin production of local summary paragraphs.

ACTION FOR ALL: CCG Commissioning Leads to email JNa with an indication of what information they will need to submit to their Governing Bodies over the next 48 hours.

AD then explained that the comms and engagement plans for suite 3 have been circulated and that further comments and input would be welcome as there are differing levels of engagement for each CCG. It was noted that Knowsley CCG are not participating in phase 3. DL suggested that HK will liaise with CP to manage their transition out of the project in the coming weeks.

ACTION: HS to liaise with CP to manage the Knowsley CCG transition out of the project.

AD addressed the recent data breach with the CCGs. She noted we are working closely with our Information Governance Team and that there is a clear process to follow. Part of this process includes writing to those patients affected. The draft letter will be sent to CCGs later this week for sign off with the plan being to issue it to patients on Friday 17th November. AD explained that it has been made clear that this is an NHS to NHS data breach and that no patent details have been released into the public domain. AD explained that our Information Governance team is working closely with the ICO to ensure that the relevant assurances are put in place to mitigate against such issues in future and that we are embedding a more robust assurance process around use of patient data in the communications element of the project. It was noted that new staff need to receive full Information Governance Training and not just refresher training. The Comms team is taking proactive steps to address this issue and another call with the ICO is taking place later this week to agree next steps. AD explained that a logging system has been set up to capture any interactions with affected patients and these queries will be addressed by the MLCSU PALs team so patients will receive answers to any queries within 48 hours. AD advised CCGs to direct any patients that contact them, to the MLCSU PALs team.

ACTION: JNA to send the CCGs the logging system for their information.

CP stated that his colleague Jackie Johnson is communicating with MLCSU and that she has spoken to NHS England but wanted to know if there is a sole point of contact leading the process from MLCSU as that would be helpful for the CCG. CP also asked if there is a written process that can go to their Senior Team that assures them about the process we are following? AD explained that she is happy to answer any questions alongside Haley Gidman from the MLCSU IG team and we will write up the process and circulate it to CCGs by close of play on Thursday.

ACTION: AD/JNa to write up process for managing the data breach and circulate to CCGs by close of play

on Thursday 16th November.

MS explained that the SIRO for Halton CCG has recorded the incident on STEIS but because it does not need to be logged multiple times this will need to be addressed by CCGs.

5 Suite 1 and 2 Red policies: issues for Commissioning Leads to discuss and agree

MOB took the Working Group through this item. MOB explained that following a meeting of the Project team last week to identify the issues coming out of the EIRA and the engagement work, there are **two** issues that require Commissioning Lead discussion and decision to be reached today. The following minutes should be read in relation to the embedded document below:

Red Policy EIRA and Engagement issues fc

1. Increasing the age criteria on the Breast related policies from 18 to 21.

MOB explained that a proposed amendment to the policies for Breast Augmentation and Reduction was to change the age criteria from 18 to 21. The project team and public health and GP colleagues have been unable to find any evidence to support the suggestion that a womans physiological and hormonal development is more advanced at 21. MOB explained that the Project Team have worked to outline what we believe are the most realistic options for CCGs under this issue and these are:

Option 1	Option 2	Option 3
Keep the age criteria as they are (18+) No clinical evidence can be sourced that supports this criteria: **IMPACT OF IMPLEMENTING OPTION 1:** No impact will be seen here RISK AVOIDED	Implement the age change in criteria without evidence (21+) No clinical evidence can be sourced that supports this line: **IMPACT OF IMPLEMENTING OPTION 2:** Activity and costs are likely to reduce however, CCGs may be open to legal challenge given that there is no clinical evidence cited to support this change in criteria RISK ACCEPTED	Implement the age change in criteria without evidence but cite that this is the case, therefore suggesting the policies are reviewed for impact after 12 months, taking into account actual activity, complaints, FOIs, PALs, SARs requests etc No clinical evidence can be sourced that supports this line **IMPACT OF IMPLEMENTING OPTION 3:** Activity and costs are likely to reduce however; CCGs may be open to legal challenge given that there is no clinical evidence cited to support this change in criteria. If the impact seen is detrimental to patients and CCGs reputation, these policies can be reviewed at an earlier stage and rectified if required RISK EXPLOITED

JM noted that because there is no evidence to support this change, this can be viewed as direct discrimination between comparator groups. DL asked how exceptionality would apply here. Would an 18 year old be exceptional to another 18 year old? From an equality point of view, JM believes not and went on to explain that even when comparing an 18 to a 21 year old they would still be being treated differently for no justifiable reason. Overall, this is about objective justification and whether patients in these age brackets have a comparator. In this instance, it is felt that there would be direct comparators therefore there is significant risk here. JM also noted that under the Public Sector Equality Duty (PSED) if there is a case for challenge it puts CCGs at risk and unfortunately, even though other CCGs may have made similar changes in the past and seen no impact, this is still a risk.

CP said that he felt the proposed change from 18 to 21 should not have been taken forward and that given there is no evidence to justify the change option 1 is the most appropriate option - Keep the age criteria as they are (18+).

HP at this point also added that given that the numbers of these procedures being carried out on patients between the ages of 18 and 21 are so low, the impact on the activity and costs here of making the change to 21 are not sufficient to warrant the associated risk. MS also noted that good surgeons themselves will make an informed decision with the patient, taking their age into account. MS, HP and MH all agreed that option 1 was their chosen option.

DECISION: Halton, Knowsley, South Sefton, Southport and Formby and Warrington CCG colleagues all agree with option 1 – keep the age criteria for the Breast procedures at 18.

ACTION: JM to update the stage 2 EIAs to reflect the decision on the Breast procedures and age criteria and note this journey of change.

2. Removal of the children and psychological impact line from the introduction

MOB explained that for the second issue the suggestion had been to remove the following line from the introduction to the policy : *Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress.* MOB explained that the Project Team have worked to outline what we believe are the most realistic options for CCGs under this issue and these are:

Option 1	Option 2	Option 3
Keep the original line in the policy	Remove the line regardless of the potential impact	**There is a subsequent line in the policy that states:**
IMPACT OF IMPLEMENTING OPTION 1: No impact will be seen here	**IMPACT OF IMPLEMENTING OPTION 2:** Activity and costs are likely to reduce however; CCGs may be open to legal challenge given that there is no clinical evidence cited to support this change in criteria. Given that these changes affect children this is a particularly emotive issue and is likely to gain significant scrutiny. Mitigation here is around other options that would be available to support children from a psychological point of view.	*Psychological distress alone will not be accepted as a reason to fund surgery except where this policy explicitly provides otherwise. Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as a route into aesthetic surgery.* **Combining the lines will allow the overall policy to remain clear that psychological distress alone will not be accepted as a route to surgery, however it could also be made clear that children need to meet all the criteria, as well as being able to cite psychological distress as a factor in their application for treatments** **IMPACT OF IMPLEMENTING OPTION 3:** No impact will be seen here, and this will bring treatments for children more closely in line with the spirit of the review – to tighten up and strengthen the current criteria, whilst supporting CCGs duty of care towards patients, especially those more vulnerable in society.
RISK AVOIDED	**RISK ACCEPTED**	**RISK TRANSFERED**

JM noted that the argument for equalising patients by age by removing this line is open to debate because children are not the same as adults; they are less resilient to deal with physical and associated psychological issues so the eqaulisation argument is not sound from an equality perspective. The Royal College of Surgeons have said for example in relation to pinnaplasty that this procedure should be carried out in children of school age due to bullying, and lower psychological resilience. However, the counter argument we have seen here is that NHS resources should not be used to address children bullying other children. However if a child is being severely bullied, these

treatments may be effective in stopping the escalation into more serious mental health issues as well.

JM noted that there could be a challenge if the justification focuses on treating people of all ages exactly the same because age groups are different so this argument would not stand up.

DL asked the group, why would we not consider the circumstances from a clinical exceptionality point of view? JM asked that if you have a child who is distressed because of the shape of their ears, If they do not fit the criteria for the policy, what would make them fit under exceptionality? JW explained that usually, under IFR we would acknowledge bullying but the panel would be unlikely to make a decision based on this because it is not exceptional. JW also explained that for treatments such as minor skin lesions, these are purely cosmetic and are very often pushed for by parents, so the question for the panel becomes, is the risk of doing something worse than not doing something? Finally, JW noted that as we have discussed previously, psychological distress cannot be measured.

JM explained that she spoke to Andy Woods this morning and this issue was raised and that because psychological distress is difficult to measure, an alternative approach may be to have a statement in these policies that acknowledges lower psychological resilience in children, and states that if a patient has been undergoing treatment for psychological distress first, and this has not addressed the issue, then surgical options can be considered.

DL suggested that the correct approach would be for all patients regardless of age to have had psychological assessment and support, i.e. input from IAPT for adults and CAMHS for children before surgery is offered as an option. We therefore need a clear statement that says we expect an appropriate mental health service has been used, and that this would have to have been attempted before surgical options are considered.

To summarise, DL noted that Working Group members are in agreement to remove the above line from the introduction but that we need to have a clearer statement under the Psychological Distress section of the introduction stating what mental health services patients should have used before moving towards surgery. NM, CP and HP all agreed with this agree with this.

JW suggested that the statement needs to say surgical interventions will only be considered after ‘appropriate psychological interventions have been tried but found not to be appropriate’.

DECISION: Halton, Knowsley, South Sefton, Southport and Formby and Warrington CCG leads in attendance agreed that the removal of this statement is the correct approach and that the psychological distress section needs to be strengthened as per the above.

ACTION: MOB to circulate these minutes to Judith Nielson and Ruth Hunter for their decisions on these policies.

ACTION: MOB to update policies affected by these discussions for inclusion in CCG Governing Body papers

The final issue that has been raised applies to patients undergoing Gender Reassignment. This is not an issue that has affected our policy work to date, so no decision was required here, however it is important that this is shared with the group as it is an issue in the Lancashire project. The issue is around cosmetic treatments for patients going through the gender reassignment pathway and core and non-core treatments. Core treatments are funded by NHS England and non-core treatments are funded at the discretion of CCGs. An example was cited of a male patient transitioning to female and therefore requiring breast development. At present if the patients’ core treatment to develop breast tissue fails the GIC refer the patient to the CCG for further treatment. Lobby groups suggest that this is not appropriate because they suggest that these treatments are not cosmetic which is how they would be viewed under IFR – you are treating someone with Gender Dysphoria, not a cosmetic issue. JM noted that this has been recorded in the EIRA work as an area for CCGs to be aware of.

MS suggested that if a patient has hormone treatment and they end up with asymmetric breasts, the commissioning policy would apply if they have completed their transition, however if they are still within the pathway and not achieved what they wanted then it would not be appropriate to refer them to their CCG. All in attendance agree with this approach. JW noted that from an IFR perspective, we treat patients in the gender they identify with and apply the relevant criteria and that this is reflected by NHS England guidance. DL noted that in mitigation we

	need to look at this from an IFR perspective and reviewing these patients as a cohort. JM explained that their direct comparator would be other women under the GIC pathway who have had the same treatment. It was suggested that JM prepare some written guidance for the IFR Panel on how to manage cases where transgender patients are seeking non-core treatments. ***ACTION: JM to prepare written guidance for the IFR Panel on how to manage cases where transgender patients are seeking non-core treatments.***
6	**Any Other Business**
	No other business was raised.
8	**Date of next meeting**
	Date of next meeting: MOB noted that the date for the next meeting will be changed shortly and a new date circulated.

Actions:

Action ID	Action	Owner	By When
1	JNa to begin production of local summary paragraphs.	Jo Navin	
2	CCG Commissioning Leads to email JNa with an indication of what information they will need to submit to their Governing Bodies over the next 48 hours.	All CCG Leads	
3	HS to liaise with CP to manage the Knowsley CCG transition out of the project.	Harinder Sanghera	
4	JNa to send the CCGs the logging system for their information.	Jo Navin	
5	AD/JNa to write up process for managing the data breach and circulate to CCGs by close of play on Thursday 16th November.	Anna Donaldson/Jo Navin	
6	JM to update the stage 2 EIAs to reflect the decision on the Breast procedures and age criteria and note this journey of change.	Jenny Mulloy	
7	MOB to circulate these minutes to Judith Nielson and Ruth Hunter for their decisions on these policies.	Michael O'Brien	
8	MOB to update policies affected by these discussions for inclusion in CCG Governing Body papers	Michael O'Brien	
9	JM to prepare written guidance for the IFR Panel on how to manage cases where transgender patients are seeking non-core treatments.	Jenny Mulloy	

Midlands and Lancashire Commissioning Support Unit

NHS Halton Clinical Commissioning Group
NHS Knowsley Clinical Commissioning Group
NHS Liverpool Clinical Commissioning Group
NHS St Helens Clinical Commissioning Group
NHS South Sefton Clinical Commissioning Group
NHS Southport and Formby Clinical Commissioning Group
NHS Warrington Clinical Commissioning Group

Collaborative Policy Development Project: Governing Body paper seeking sign off of all policies reviewed to date, ahead of implementation with Providers

Appendix 4

Revised Introduction to the PLCP policy

December 2017

Introduction

Purpose and scope

CCGs are legally obliged to have in place and publish arrangements for making decisions and adopting policies on how particular healthcare interventions are to be accessed. This document is intended to be a statement of such arrangements made by the CCGs and will act as a guidance document for patients, clinicians and other referrers in primary and secondary care. It sets out the eligibility criteria under which CCGs will commission the service.

The purpose of this policy is to describe the eligibility criteria under which the CCGs listed below will commission treatments or interventions classified as 'Criteria Based Clinical Treatments' (CBCT). The term Criteria Based Clinical Treatments, refers to procedures and treatments that are of value, but only in the right clinical circumstances. Previously, they were referred to as Procedures of Low Clinical Priority (PLCP).

In making these arrangements, the CCGs have given regard to relevant legislation and NHS guidance, including their duties under the National Health Service Act 2006, the Health and Social Care Act 2012, Equality legislation – duties discharged under the Public Sector Equality Duty 2011, the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, the Joint Strategic Needs Assessment, relevant guidance issued by NHS England and the NHS Constitution.

Context

CCGs have been established under the National Health Service Act 2006 as the statutory bodies charged with the function of commissioning healthcare for patients for whom they are statutorily responsible. CCGs receive a fixed resource allocation from NHS England to enable them to fulfil their duties and have to decide how and where to allocate resources to best meet the healthcare needs of their population.

It is evident that the need and demand for healthcare is greater than the resources available to a society to meet it. Therefore, it will not be possible for CCGs to commission all the healthcare needs of the population they serve. As a result, CCGs need to prioritise their commissioning intentions to ensure their limited resources are allocated effectively and based on the needs of the local population.

The CCGs intention is always to ensure access to NHS resources is equal and fair, whilst considering the needs of the overall population.

Using the CBCT policies as presented in this document, the CCGs can prioritise their resources using evidence based information that determines what is clinically effective and therefore cost effective and likely to provide the greatest proven health gain for the whole of the CCG's population.

The main objective for having CBCT policies is to ensure that:

- Patients receive appropriate health treatments in the right place and at the right time;
- Treatments with no or a very limited clinical evidence base are not routinely undertaken; and
- Treatments with minimal health gain are restricted.

This also means that certain procedures will not be commissioned by CCGs unless patients meet all the criteria set out in relation to a procedure or treatment; or exceptional clinical circumstances can be demonstrated.

CCGs recognise there may be exceptional clinical circumstances where it may be clinically effective to fund any of the procedures listed in this policy for individual patients. Either where:

- The clinical threshold criteria as specified by this policy is not met; or
- The procedure is not routinely commissioned;

In accordance with each CCG's Individual Funding Request (IFR) process, the patient's circumstances as clinically evidenced in an application made by the patient's clinician will be considered on a case-by-case basis. This position is supported by each CCG's Ethical Framework which can be found on the respective CCG website.

Background

The following CCGs have worked collaboratively to develop this harmonised core set of commissioning criteria:

- Halton CCG;
- Knowsley CCG;
- Liverpool CCG;
- St Helens CCG;
- South Sefton CCG;
- Southport and Formby CCG;
- Warrington CCG;

This policy aims to improve consistency by bringing together one common set of criteria for treatments and procedures across the Merseyside and Warrington CCG footprints. This will help to reduce variation of 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.

Principles

Commissioning decisions by CCG Commissioners are made in accordance with the commissioning principles set out as follows:

- 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;

- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

Core eligibility criteria

However, there are a number of circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for the procedures and treatments listed within this policy, regardless of whether they meet the criteria; or the procedure or treatment is not routinely commissioned.

These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment;
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2 week rule;
  NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England;
- Reconstructive surgery post cancer or trauma including burns;
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures;
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis;
- For patients wishing to undergo Gender reassignment, this is the responsibility of NHS England and patients should be referred to a Gender Identity Clinic (GIC) as outlined in the *Interim NHS England Gender Dysphoria Protocol and Guideline 2013/14*.

Policy Categories

Each procedure/treatment is categorised as either 'not routinely funded' or 'restricted' and these are defined as follows:

- **Not routinely funded (NRF)** – This means the CCG does not routinely commission the treatment and will only commission this treatment for an individual patient where an IFR application in line with the CCG's IFR process, demonstrates clinical exceptionality;

- **Restricted –** This means the CCG will commission the treatment where the patient meets the specific criteria as set out within this Commissioning Policy. Where a patient does not meet the specific criteria specified the CCG will only commission this treatment for an individual patient where an IFR application in line with the CCG's IFR process, demonstrates clinical exceptionality;

Diagnostic Procedures

Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should **not** be carried out unless the eligibility criteria are met or approval has been given by the CCG or GP (as set out in the approval process of the patients responsible CCG) or as agreed by the IFR Panel as a clinically exceptional case.

Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

Psychological factors

Psychological distress alone will not be accepted as a reason to fund surgery. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient's psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention.

Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as a route into aesthetic surgery. Any application citing psychological distress will need to be considered as an IFR .

Lifestyle 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.

CBCT Referral/Treatment Listing Processes

Primary Care

Referrals for treatment should **not** be made unless the patient clearly meets the criteria as this can raise unrealistic expectations for the patient and lead to disappointment. If a General Practitioner/Optometrist/Dentist considers a patient might reasonably fulfil the eligibility criteria for a restricted procedure, as detailed in this document (i.e. they meet the specific criteria listed for each treatment) the General Practitioner/Optometrist/Dentist should follow the process for referral. NB. This may be via a referral management or prior approval team.

If in doubt over the local process, the referring clinician should contact the relevant CCG, IFR Team or Referral Management Team for guidance. Failure to comply with the local process may delay a decision being made.

Any referral letter should include specific information regarding the patient's potential eligibility. If the referral letter does not clearly outline how the patient meets the criteria, then the letter should be returned to the referrer for more information.

In cases where there may be an element of doubt the General Practitioner/Optometrist/Dentist should discuss the case with the IFR Team in the first instance.

Secondary Care

The secondary care consultant will also determine whether the procedure is clinically appropriate for a patient and whether the eligibility criteria for the procedure are fulfilled or not. The consultant may also request additional information before seeing the patient.

If a secondary care consultant considers a patient might reasonably fulfil the eligibility criteria for a restricted procedure, as detailed in this document (i.e. they meet the specific criteria listed for each treatment) the consultant should follow the listing process for treatment. NB. For some CCGs this will involve following a process of prior approval. If in doubt over the CCG requirements, the consultant should contact the relevant CCG or the IFR Team for guidance. Failure to comply with the CCGs' processes may delay a patient's treatment and/or release of funding resources.

Patients who fulfil the criteria may then be placed on a waiting list according to their clinical need. The patient's notes should clearly reflect exactly how the criteria were fulfilled including prior approval authorisation where relevant. This will allow for case note audit to support contract management.

Should the patient not meet the eligibility criteria this should be recorded in the patient's notes and the consultant should return the referral back to the General Practitioner/Optometrist/Dentist, explaining why the patient is not eligible for treatment.

IFR Applications/Clinical Exceptionality

Exceptionality is where a patient does not meet all of the criteria outlined for a specific procedure or treatment or, the procedure or treatment is not routinely commissioned.

In this scenario, should a patient not fulfil the clinical criteria but the referring clinician is willing to support the application as clinically exceptional, the case can be referred to the IFR Panel for consideration. The person who fills in the IFR can be a consultant or a GP.

In dealing with clinically exceptional requests for an intervention that is considered to be a poor use of NHS resources, the Merseyside CCGs have endorsed through the CCG Alliance the following description of exceptionality contained in a paper by the NW Medicines and Treatment Group:

- The patient has a clinical picture that is significantly different to the general population of patients with that condition; **and** as a result of that difference; the patient is likely to derive greater benefit from the intervention than might normally be expected for patients with that condition.

The CCGs are of the opinion that exceptionality should be defined solely in clinical terms. To consider social and other non-clinical factors automatically introduces inequality, implying that some patients have a higher intrinsic social worth than others with the same condition. It runs contrary to a basic tenet of the NHS, namely that people with equal need should be treated equally. Therefore, non-clinical factors will not be considered except where this policy explicitly provides otherwise.

The CCG must justify the grounds upon which it is choosing to fund treatment for a particular patient when the treatment is unavailable to others with the condition.

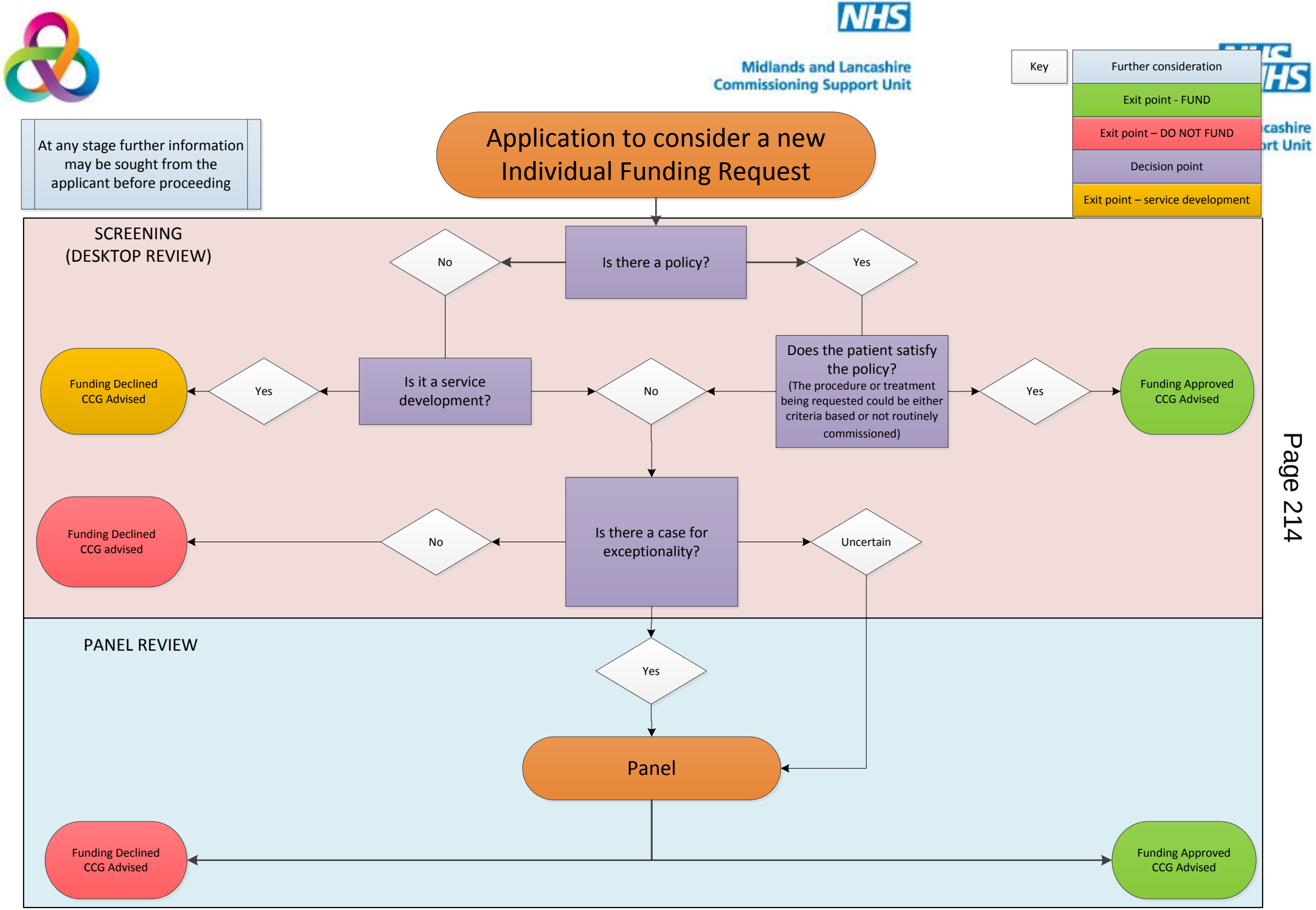
Individual Funding Requests should only be sent to the respective NHS.net accounts as below. Guidance regarding IFRs and an application form, can be found on the CCGs websites.

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

Individual Funding Request Case Manager
Midlands and Lancashire Commissioning Support Unit (MLCSU)
1829 Building
Countess of Chester Health Park
Liverpool Road
Chester
CH2 1HJ
Telephone: 01244 650 305

Email addresses for Individual Funding Request teams at CCGs:

CCG	Email Address
Halton CCG	IFR.manager@nhs.net
Knowsley CCG	
Liverpool CCG	
South Sefton CCG	
Southport & Formby CCG	
St Helens CCG	
Warrington CCG	Warringtonccg.IFR@nhs.net


Midlands and Lancashire Commissioning Support Unit
Key
Further consideration
Exit point - FUND
Exit point – DO NOT FUND
Decision point
Exit point – service development
At any stage further information may be sought from the applicant before proceeding
Application to consider a new Individual Funding Request
SCREENING (DESKTOP REVIEW)
Is there a policy?
No
Yes
Is it a service development?
Yes
Funding Declined CCG Advised
No
Does the patient satisfy the policy?
(The procedure or treatment being requested could be either criteria based or not routinely commissioned)
Yes
Funding Approved CCG Advised
Is there a case for exceptionality?
No
Funding Declined CCG advised
Uncertain
PANEL REVIEW
Yes
Panel
Funding Declined CCG Advised
Funding Approved CCG Advised

Medicines

Prior approval for treatment should always be sought from the responsible Medicine Management Team when using medicines as follows:

- Any new PbR excluded drug where the drug has not yet been approved/prioritised for use in agreement with the local CCG;
- Any existing PbR excluded drugs to be used outside of previously agreed clinical pathways/indication;
- Any PbR excluded drugs that are being used out with the parameters set by NICE both in terms of disease scores or drug use. It must not be assumed that a new drug in the same class as one already approved by NICE can be used, this must be subject to the process in Point 1;
- Any drug used out with NICE Guidance (where guidance is in existence);
- Any proposed new drug/new use of an existing drug (whether covered by NICE or PBR excluded or not) should first be approved by the relevant Area Medicines Management Committee, and funding (where needed) agreed in advance of its use by the relevant CCG;
- Any medicines that are classed by the CCG as being of limited clinical value;
- Any medicines that will be supplied via a homecare company agreement;

Clinical Trials

The CCGs do not expect to provide funding for patients to continue treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

Photographic evidence

Photographic evidence may be required in cases which are being considered for clinical exceptionality in line with the IFR processes. However, photographic evidence will not be accepted for consideration unless it is impossible to make the case in any other way.

The decision to submit photographic evidence remains with the patient and responsible clinician and must meet the CCGs criteria for submission as outlined by the CCGs IFR Policy.

If photographs are accepted for consideration in accordance with the CCGs criteria, they will be examined by clinical members of the IFR team. In the course of the work for the case the applicant should be aware that other members of the IFR Panel, IFR Process Reviews Panel or IFR team who prepare the papers may need to handle or see the photographs.

Personal data

In making referrals to the IFR Team, clinicians and other referrers in primary and secondary care should bear in mind their obligations under the Data Protection Act 1998 and their duty of confidence to patients. Where information about patients (including photographs) is sent to the IFR Team and is lost or inadvertently disclosed to a third party before it is safely received by the IFR Team, the referrer will be legally responsible for any breach of the Data Protection Act 1998 or the law of confidence.

Therefore, please consider taking the following precautions when using the Royal Mail to forward any information about patients including photographic evidence:

Clearly label the envelope to a named individual i.e. first name & surname, and job title.

Where your contact details are not on the items sent, include a compliment slip indicating the sender and their contact details in the event of damage to the envelope or package.

Use the Royal Mail Signed for 1st Class service, rather than the ordinary mail, to reduce the risk of the post going to the wrong place or getting lost.

Costs incurred will be the responsibility of the referrer, this includes photographic evidence.

OPCS Codes

OPCS codes have been recorded against procedures and treatments where possible, however these lists are not exhaustive and providers will have to satisfy themselves that procedures are coded correctly.

Copies of this policy

Electronic copies of this policy can be found on the websites of the respective CCGs. Alternatively; you may contact the CCG and ask for a copy of the Criteria Based Clinical Treatments 2017-18 policy document.

Monitoring and review

This policy will be 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;

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

From time to time, CCGs may need to make commissioning decisions that may suspend some treatments/criteria currently specified within this policy.

Evidence

At the time of publication the evidence presented per procedure/treatment was the most current available. Where reference is made to older publications these still represents the most up to date view.

Procedures of Lower Clinical Priorities – 'Reviewing Local Health Policies'

Supporting evidence

Provided by: Halton CCG, Knowsley CCG, Liverpool CCG, Southport and Formby CCG, South Sefton CCG, St Helens CCG, Warrington CCG

Contents

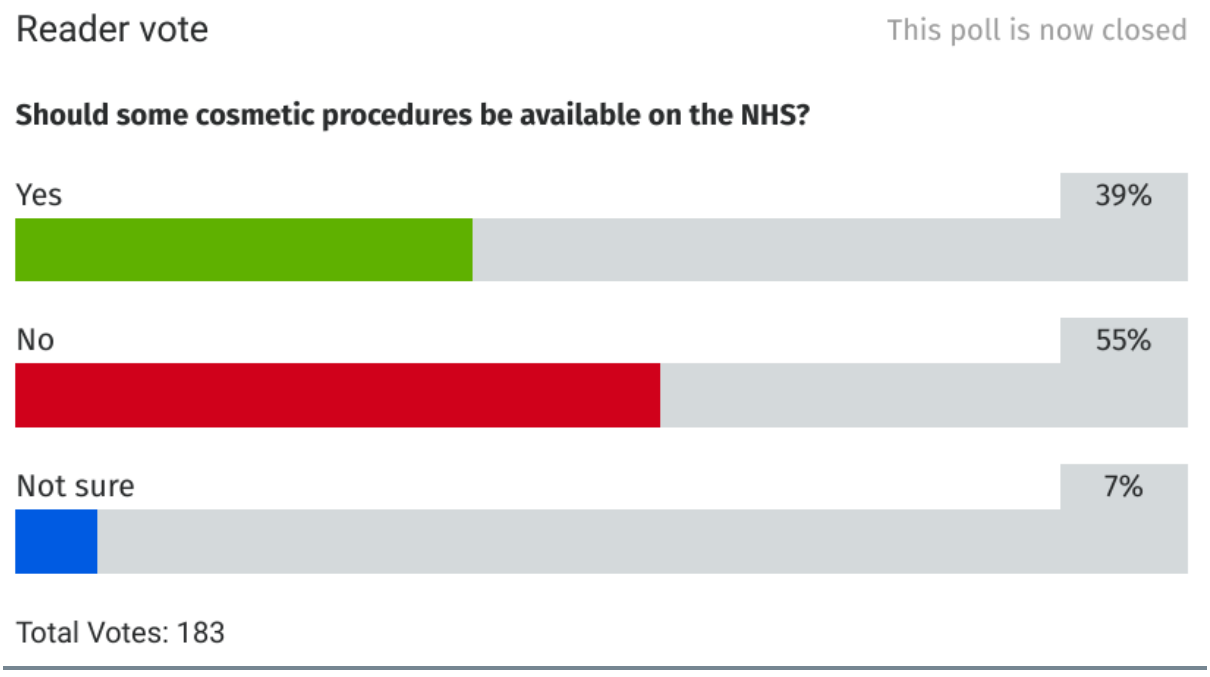
Media

A press release was issued both locally by the CCGs and regionally by the CSU to the following publications.

Publication	Local/Regional	Coverage
Liverpool Echo	Regional/Local (St Helens CCG)	The publication picked this up from a St Helens CCG perspective and tied the project to other headlines for the CCG including financial difficulties.
BBC North West Tonight	Regional	No coverage recorded
ITV Granada	Regional	'Shake up of NHS services in Merseyside & Cheshire' – 4th July 2017
Made in Liverpool	Regional	No coverage recorded
BBC Radio Merseyside	Regional	No coverage recorded
Global Radio	Regional	No coverage recorded
Baurer Radio	Regional	No coverage recorded
St Helens Star	Local - St Helens	No coverage recorded
Local Life	Local - St Helens	Coverage in summer edition including direction to website for review

Warrington Guardian	Local - Warrington	4th July - Treatments including nose jobs and tummy tucks may no longer be available on NHS for some residents. This article triggered 24 online comments. These have contributed towards to the comments themes below. Additionally, the media outlet carried out a poll on cosmetic surgery. Please see Figure 1.0 for results. 14th July - Health Chiefs review 100 NHS treatments and policies

Figure 1.0 - Warrington guardian online poll, 4th July 2017.



Media - online comments key themes

For full comments, please see Appendix 1

Key themes of online comments include the following;

- Reluctant to pay for cosmetic procedures as part of NHS funding.
- Work is potentially linked to NHS cuts and privatisation.
- Agreement that cosmetic procedures should be provided for ‘illness’ or ‘functional’ reasons and not purely cosmetic.

Stakeholder engagement

Clinical Engagement

All detailed clinical engagement for suite 1 and 2 policies has been documents within the appendix of this document.


Microsoft Word Document

Figure 1 Cataract and Botox feedback


Microsoft Word Document

Figure 2 Phase 2 policies feedback


Microsoft Word Document

Figure 3 Pinnaplasty feedback


Microsoft Word Document

Figure 4 Phase 1 policies GP and provider feedback


Microsoft Word Document

Figure 5 Back pain policies clinical feedback

Third Sector and Provider

Stakeholder	Action	Comments/follow up
4Wings	Email to organisations promoting the survey	
5 Borough Partnerships	3x email to share survey link and information with offer of a local meeting or focus group	Offer of meeting/focus group not taken up
ABCC (Anfield Breckside Community Council)	Email to organisations promoting the survey	
Al Ghazali	Email to organisations promoting the survey	
Alderhey Hospital	6x email to share survey link and information with offer of a local meeting or focus group	Offer of meeting/focus group not taken up
Alive Believers Centre	Email to organisations promoting the survey	
Alt Valley Community Trust	Email to organisations promoting the survey	
Amadudu Women and Children's Refuge	Email to organisations promoting the survey	
Asylum link	3x email to share survey link and information with offer of a local meeting or focus group	Offer of meeting/focus group not taken up
Beacon Counselling Trust	Email to organisations promoting the survey	
Bee Sparkling CIC	Email to organisations promoting the survey	
Big Love Sista CIC	Email to organisations promoting the survey	

Catalyst	Email to organisations promoting the survey	
Changing Faces	121 call with Head of Advocacy	Survey link shared via their channels and social media as well as the organisation themselves responding to the survey
Cobalt Housing	Email to organisations promoting the survey	
Cycling Projects	Email to organisations promoting the survey	
Elevate Potential	Email to organisations promoting the survey	
Emmanuel Westly Foundation	Email to organisations promoting the survey	
Everton in the Community	Email to organisations promoting the survey	
Faiths4Change	3x email to share survey link and information with offer of a local meeting or focus group	Offer of meeting/focus group not taken up
Gather in Circle	Email to organisations promoting the survey	
Greenbank	Email to organisations promoting the survey	
Halton and St Helens VCA	Face to face meeting to discuss policies and potential opportunities for promotion and support	
Healthwatch Halton	4 x emails including content for newsletters and social media to support promotion	
Healthwatch Knowsley	Face to face meeting	
Healthwatch Liverpool	4 x emails including content for newsletters and social media to	

	support promotion	
Healthwatch South Sefton	Face to face meeting	
Healthwatch Southport and Formby	4 x emails including content for newsletters and social media to support promotion	
Healthwatch St Helens	4 x emails including content for newsletters and social media to support promotion	
Healthwatch Warrington	4 x emails including content for newsletters and social media to support promotion	
Home Start Liverpool	Email to organisations promoting the survey	
HOTA	Email to organisations promoting the survey	
Kind	Email to organisations promoting the survey	
LCVS	Email to organisations promoting the survey	
Listening Ear	Email to organisations promoting the survey	
Little Angels Foundation	Email to organisations promoting the survey	
Live Wire	3x email to share survey link and information with offer of a local meeting or focus group	Offer of meeting/focus group not taken up
Liverpool Pride	Email to organisations promoting the survey	
MDI	Email to organisations promoting the survey	
Merseyside Council of Faiths	3x email to share survey link and information with offer of a local	Offer of meeting/focus group not taken up

	meeting or focus group	
Merseyside Domestic	Email to organisations promoting the survey	
Merseyside Polonia	Email to organisations promoting the survey	
Methodist Centre	Email to organisations promoting the survey	
Mpower People	Email to organisations promoting the survey	
MRANG	Email to organisations promoting the survey	
MYA	3x email to share survey link and information with offer of a local meeting or focus group	Offer of meeting/focus group not taken up
Pakistan Association Liverpool	Email to organisations promoting the survey	
Parks Option	Email to organisations promoting the survey	
Prosperity Hub	Email to organisations promoting the survey	
PSS ltd (UK)	Email to organisations promoting the survey	
Psychological Therapies Unit	Email to organisations promoting the survey	
Raise Ltd	Email to organisations promoting the survey	
Rialto Neighbourhood Council	Email to organisations promoting the survey	
RNIB	3x email to share survey link and information with offer of a local meeting or focus group	Offer of meeting/focus group not taken up

Rotunda Ltd	Email to organisations promoting the survey	
Sefton Health and Social Care Forum	Attendance at meeting to discuss project with representatives	Organisation sent link to survey with explanation to 181 contacts
Sefton in Mind	Attendance at meeting to discuss project with representatives	Organisation sent link to survey with explanation to 140 contacts
Sefton Park Day Centre	Email to organisations promoting the survey	
Self Injury Support (Warrington)	3x email to share survey link and information with offer of a local meeting or focus group	Offer of meeting/focus group not taken up
Shrewsbury House	Email to organisations promoting the survey	
Somali Women's Group	Email to organisations promoting the survey	
South Liverpool Domestic Abuse Services	Email to organisations promoting the survey	
SPARC	Email to organisations promoting the survey	
The Blackie	Email to organisations promoting the survey	
Tomorrow's People	Email to organisations promoting the survey	
Violence Services	Email to organisations promoting the survey	
Voice of Nations	Email to organisations promoting the survey	
Warrington ethnic community association	3x email to share survey link and information with offer of a local meeting or focus group	Offer of meeting/focus group not taken up
Women's Organisation	Email to organisations promoting the survey	

Writing on the Wall	Email to organisations promoting the survey	
YPAS	Focus group	Centred around young people and the children's access to services for psychological reasons

Online Activity

	Social media	Website
Knowsley CCG	NA	Dedicated webpage with link to materials and online survey
Liverpool CCG	Continuous promotions via social media platforms through 12 week period	Dedicated webpage with link to materials and online survey
St Helens CCG	Facebooks Ads to promote online survey for Age 18-21 Women and young people	Dedicated webpage with link to materials and online survey
Warrington CCG	Targetted Facebook for younger people and women aged 18-21	Dedicated webpage with link to materials and online survey
Halton CCG	Facebooks Ads to promote online survey for Age 18-21 Women and young people	Dedicated webpage with link to materials and online survey
Southport and Formby CCG	Continuous promotions via social media platforms through 12 week period	Dedicated webpage with link to materials and online survey
South Sefton CCG	Continuous promotions via social media platforms through 12 week period	Dedicated webpage with link to materials and online survey

Meetings and Events

Structure

The following structure was followed at each of the events and meetings attended for PLCP engagement.

At each event or meeting the following materials were provided;

- Hard copies of the survey, including freepost envelope
- Leaflet explaining the rationale for the project
- All attendees were encouraged to complete the surveys

Section	Summary
Introduction to project	Overview provided to the groups explaining that the review of these policies/policy is something which happens on a regular basis to ensure that the policies are in line with the latest medical guidance and the most appropriate for all. The CCGs taking part doing this together were outlined to provide context for the scale of the project. The batch review process was explained, telling groups that there are over 100 policies in total being reviewed. The first batch of policies included 36 which were reviewed and 18 of which have proposed amends or changes made to them. Some of the changes are merely wording updates and clarification and some changes may have a wider impact.
Approach to engagement outlined	Each of the policies has been reviewed and specific groups of people who may potentially be more affected identified in the Equality Impact Assessments. For each of these policies, there has been a mini plan developed for how these cohorts of people might be engaged with, including targeted online activity, face to face group engagement and sharing of the survey amongst third sector groups. The survey is available online, hardcopy and over the phone to ensure that accessibility standards for all are met.
Discussion on aims and objectives	The three main objectives were outlined; ● Making the most of NHS resources - this not only refers to the finances, but also staff time, operating theatre space, equipment etc. ● Make sure that treatments are provided based on up-to date guidelines and the latest methods and technology. ● Additionally, where possible, we would like to try and standardise policies and treatments available across the seven CCGs areas. All of this will help move towards patients having more equal access to healthcare.

	• The session is then opened up to the group to see if they both understand and agree with the aims.
Overview of policies included in batch one	The policies included in batch one are then run through and examples of the engagement is included.
Any specific policies highlighted for discussion by group	The group then have the opportunity to discuss or ask further questions on any of the specific policies and discuss their agreement or disagreement with the proposed changes. In some groups all policies were discussed and in other specific ones were chosen based on attendees interests.
Feedback noted by event/meeting attendee	Feedback is then summarised and agreed with the group to ensure that they are happy with the output and that their views have been heard.
Close	

Aims and Objectives

The following table demonstrated the general consensus reached at the following meetings where the aims and objectives of the project were discussed.

Strongly Agree = SA
Agree = A
Neither Agree nor Disagree = N
Disagree = D
Strongly Disagree = SD

	Aims and Objectives		
	Making the most of NHS resources - this not only refers to the finances, but also staff time, operating theatre	Make sure that treatments are provided based on up-to date guidelines and the latest	Where possible and appropriate, standardise policies and treatments

	space, equipment etc.	methods and technology.	available across the seven CCGs areas.
St Helens - PEIG x3	SA	SA	SA
St Helens- PPG	SA	SA	SA
Warrington - Health Forum	A	SA	SA
Southport and Formby SPOC	Mix of A&D	SA	SA
Healthwatch Knowsley – Focus group	SA	SA	SA
Halton - Peoples health forum	SA	SA	SA
Changing Faces - Call	SA	SA	SA
Healthwatch - South Sefton	50/50 Mix of A&D	SA	SA
South Sefton Consultation and Engagement review panel	SA	SA	SA
Halton PPG	SA	SA	SA

Southport and Formby Community Champions	SA	SA	SA
St Helens OSC	SA	SA	SA
South Sefton - Health and social care forum	SA	SA	SA
Liverpool CCG			
Knowsley PPG			
Halton PPG Plus	SA	SA	SA

Policies

The following table indicated where there have been agreements or disagreements to changes to policies in each meeting.

	Strongly Agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly Disagree**
St Helens - PEIG x3	Strongly agreed with all other policies			Children's statement 'Children under the age of 16 are able to access services for cosmetic and psychological reasons'	

St Helens-PPG/workshop		Abdominoplasty and apronectomy – Tummy tuck Cataract Face and Brow Lift Hemorrhoidectomy Laser tattoo removal Laser hair removal Male Circumcision Surgical body contouring Surgical correction of scars Surgical removal of lipoma (fatty tissue) Surgical removal of minor skin lesions Surgical treatment for hair loss – hair transplantation	Pinnaplasty and Rhino plasty- the group were split on this policy and the group did not achieve a consensus. This was predominantly down to some disagreement regarding the potential psychological impact. Removal of breast implants	Breast Enlargement Breast Reduction Male breast reduction - no disagreement with simplifying the policy, however disagree with the policy and would suggest an age bracket be entered.	

Warrington - Health Forum		All other policies		Removal of Children under 16 having access to treatments for psychological reasons statement	
Southport and Formby SPOC		All Policies			
Healthwatch Knowsley	All policies				
Halton - Peoples health forum	All Policies				
Changing Faces - Call					Removal of Children under 16 having access to treatments for psychological reasons statement
Healthwatch - South Sefton	Those at the meeting discussed, but shared views via completion of surveys individually, as well as sharing the survey via their channels.				
South Sefton Consultation and Engagement review	Those at the meeting discussed, but shared views via completion of surveys individually, as well as sharing the survey via their channels.				

panel					
Halton PPG	All Policies				
Southport and Formby Community Champions	Those at the meeting discussed, but shared views via completion of surveys individually, as well as sharing the survey via their channels.				
South Sefton - Health and social care forum		All policies			
Liverpool CCG					
Knowsley PPG					
Halton PPG Plus	All policies				
Sefton in Mind	Those at the meeting discussed, but shared views via completion of surveys individually, as well as sharing the survey via their channels.				
Southport and Formby and Southport and Seftons CCGs 'Big Chat' events	Those at the meeting discussed, but shared views via completion of surveys individually, as well as sharing the survey via their channels. Leaflets, hard copy surveys and freepost envelopes were available event.				
Sefton Council's Public	Those at the meeting discussed, but shared views via completion of surveys individually, as well as sharing the survey via their channels.				

Engagement and Consultation Panel	Leaflets, hard copy surveys and freepost envelopes were available event
CCGs' Engagement and Patient Experience Group (EPEG)	Those at the meeting discussed, but shared views via completion of surveys individually, as well as sharing the survey via their channels. Leaflets, hard copy surveys and freepost envelopes were available event

Reasons for agreeing

The following table highlights the key themes for agreement at meetings and events. These themes are in line with those highlighted in the survey also.

Policies	**Themes**					
	Making it simple for people to access	More clear wording and easier to understand	Improved quality of life	Positive Psychological Impact	Making access to treatments more fair	Using NHS resources in the best way possible
Cataract	X	X	X	X		
Surgical and laser treatment for minor skin lesions						X
Haemorrhoidectomy	X	X	X			
Surgical Treatment for Removal of Lipoma in Secondary Care						X
Rhinoplasty					X	X
Hair removal treatment including depilation and laser					X	X

treatment of electrolysis						
Pinnaplasty					X	X
Female reduction of mammoplasty	X				X	X
Removal of breast implants					X	X
Laser tattoo removal					X	X
Abdominoplasty and apronectomy	X	X				
Cosmetic surgery for body contouring	X	X				
Rhytidectomy	X	X				
Male Circumcision			X			X
Treatments for hairloss	X	X				

Reasons for disagreeing

The following table highlights the key themes for disagreement at meetings and events. These themes are in line with those highlighted in the survey also.

Policies	Themes			
	Concern over removal of clinicians power to make judgement	Negative Psychological impact	Concerns this is purely a cost cutting exercise	Concerns this might make waiting times longer
Cataract	X			X
Surgical and laser treatment for minor		X	X	

skin lesions				
Haemorrhoidectomy	X			
Surgical Treatment for Removal of Lipoma in Secondary Care	No disagreement			
Rhinoplasty		X		
Hair removal treatment including depilation and laser treatment of electrolysis	No disagreement			
Pinnaplasty		X	X	
Female reduction of mammoplasty		X		
Removal of breast implants	No disagreement			
Laser tattoo removal	No disagreement			
Abdominoplasty and apronectomy	No disagreement			
Cosmetic surgery for body contouring	No disagreement			
Rhytidectomy	No disagreement			
Male Circumcision	No disagreement			
Treatments for hairloss		X		

Appendix

Appendix 1 – Online media comments – Warrington Guardian

Good! I don't work full time and pay national insurance to pay for someone's cosmetic surgery!!!

Can't you see what you've just fallen for? Its misdirection and you've just been conned by this group and the Warrington Guardian. By positioning cosmetic surgery to the front this story, they've got you to nod along with them. Either that or you've been employed to set the narrative

Slowly but surely privatisation of the NHS is beginning to happen.

The NHS has been misused by some for years, it was only a matter of time before those costs became critical. Having said that NHS management also has a case to answer for allowing this situation to develop.

Too bad most people are still too blind to see it. Wastage is simply a ruse used by the vile Tory scum to fuel it's privatisation. The Tories have wasted billions on this venture that could have gone in to actually funding the NHS. The tendering process alone is a costly waste of money.

If people truly believe that the 'abusers' of the NHS are responsible for it's downfall, they are part of the problem. The NHS was running at a surplus in 2010. This deficit has been deliberately and whole engineered for their gain, at the expense of all of us.

Cosmetic surgery should not be an NHS treatment unless it has been due to an illness

You should ask the question what else is being axed and don't fall for this. You have only read what they want you to read

Should be done for people who have had accident or illness but not for vanity. I went to Warrington general for a problem with my eye. Got refused surgery but the doctor while on a NHS consultation said he could do it for 1,800 private!!!

Hopefully making cutbacks like this will prolong the NHS. Good move.

No it won't. Unless you've been asleep for the last 7 years, the Tories have gone all out to run the NHS into the ground and privatise many of the most 'profitable' services, while at the expense of other essential services that can't make a profit for these sub humans. The head of NHS England has spent his 7 years in his previous role within the American Health Insurance system, which by the way bankrupts over 600,000 Americans each year. These cut backs along with every other aspect of restructuring are nothing at all to do with prolonging the NHS, it is about preparing it for the great sell off. By that time, there will be no NHS left and we will all be paying astronomical amounts for treatment and insurance.

Absolutely spot on

What a ridiculous comment. It's a race to the bottom and you're happy to take part.

I can only agree with Warrington Wife....too much is wasted on totally unnecessary cosmetic surgery to pamper to vanity. If a procedure isn't medically necessary it shouldn't be carried out on

the NHS. Furthermore anybody without a NI no should not be treated unless an emergency and then billed a later date!

And I can only agree that you and Warrington Wife have been hoodwinked by the Tory propaganda machine. Far more is wasted on top down restructuring and contract tendering, but what ever daily **** rag you both read won't tell you that. All it will tell bigots like you is that vane people wanting cosmetic surgery and immigrants are responsible for all the ills of the NHS. Wake up for **** sake.

Too bad most people are still too blind to see that this NHS crisis has been deliberately engineered by the Tories. Wastage is simply a ruse used by the vile Tory scum to fuel it's privatisation. The Tories have wasted billions on this venture that could have gone in to actually funding the NHS. The tendering process alone is a costly waste of money.

If people truly believe that the 'abusers' of the NHS are responsible for it's downfall, they are part of the problem. The NHS was running at a surplus in 2010. This deficit has been deliberately and whole engineered for the Tory scum gain, at the expense of all of us.

The NHS should be for people who need treatment not who simply want stuff

Want stuff?? You mean like urgent treatment for the stroke they're having that is now unavailable in warrington?

cosmetic surgeries such as nose jobs, face and brow lifts, breast reductions and augmentations, tummy tucks, the removal of breast implants and surgery to remove moles and freckles, hair-loss cures, laser tattoo removals, surgical scar reductions. All not necessary.

Other procedures under review include cataract treatments, haemorrhoidectomies. I wouldn't consider these to be cosmetic. Why are they under review.

And penile implants? What are they? Cosmetic? Are the NHS making a rod for their own backs? They need to stiffen their resolve and cut-out cosmetic surgery on the NHS.

Cataract treatments, hemorrhoidectomies, should be available. Who wants hemorrhoids and be unable to see. The rich who avoid paying their taxes will just go privately.

Can understand that most would be deemed to be cosmetic but Cataracts - thought having them removed could save someone's sight - so would deem that to be a very needy and worthwhile procedure.

END

NHS
Midlands and Lancashire
Commissioning Support Unit

Criteria Based Clinical Treatments

Provided by:
NHS Halton CCG
NHS Liverpool CCG
NHS Southport and Formby CCG
NHS South Sefton CCG
NHS St Helens CCG
NHS Warrington CCG

Version control

Document version control			
Version	**Amendment**	**By who**	**Date amendment made**
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1.5	Title amended to remove reference to 2018-19	Michael O'Brien	22/02/2018
1.6	Amendment to CCG List	Michael O'Brien	22/02/2018

Proposed Review Date: April 2020

Contents

INTRODUCTION

Purpose and Scope

CCGs are legally obliged to have in place and publish arrangements for making decisions and adopting policies on how particular healthcare interventions are to be accessed. This document is intended to be a statement of such arrangements made by the CCGs and will act as a guidance document for patients, clinicians and other referrers in primary and secondary care. It sets out the eligibility criteria under which CCGs will commission the service.

This policy describes the eligibility criteria under which the CCGs listed below will commission treatments or interventions classified as 'Criteria Based Clinical Treatments' (CBCT). The term Criteria Based Clinical Treatments, refers to procedures and treatments that are of value, but only in the right clinical circumstances. Previously, they were referred to as Procedures of Low Clinical Priority (PLCP).

In making these arrangements, the CCGs have given regard to relevant legislation and NHS guidance, including their duties under the National Health Service Act 2006, the Health and Social Care Act 2012, Equality legislation – duties discharged under the Public Sector Equality Duty 2011, the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, the Joint Strategic Needs Assessment, relevant guidance issued by NHS England and the NHS Constitution.

Context

CCGs have been established under the National Health Service Act 2006 as the statutory bodies charged with the function of commissioning healthcare for patients for whom they are statutorily responsible. CCGs receive a fixed resource allocation from NHS England to enable them to fulfil their duties and have to decide how and where to allocate resources to best meet the healthcare needs of their population.

It is evident that the need and demand for healthcare is greater than the resources available to a society to meet it. Therefore, it will not be possible for CCGs to commission all the healthcare needs of the population they serve. As a result, CCGs need to prioritise their commissioning intentions to ensure their limited resources are allocated effectively and based on the needs of the local population.

The CCGs intention is always to ensure access to NHS resources is equal and fair, whilst considering the needs of the overall population.

Using the CBCT policies as presented in this document, the CCGs can prioritise their resources using evidence based information that determines what is clinically effective and therefore cost effective and likely to provide the greatest proven health gain for the whole of the CCG's population.

The main objective for having CBCT policies is to ensure that:

- Patients receive appropriate health treatments in the right place and at the right time;
- Treatments with no or a very limited clinical evidence base are not routinely undertaken; and
- Treatments with minimal health gain are restricted.

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This also means that certain procedures will not be commissioned by CCGs unless patients meet all the criteria set out in relation to a procedure or treatment; or exceptional clinical circumstances can be demonstrated.

CCGs recognise there may be exceptional clinical circumstances where it may be clinically effective to fund any of the procedures listed in this policy for individual patients. Either where:

- The clinical threshold criteria as specified by this policy is not met; or
- The procedure is not routinely commissioned;

In accordance with each CCG's Individual Funding Request (IFR) process, the patient's circumstances as clinically evidenced in an application made by the patient's clinician will be considered on a case-by-case basis. This position is supported by each CCG's Ethical Framework which can be found on the respective CCG website.

Background

The following CCGs have worked collaboratively to develop this harmonised core set of commissioning criteria:

- Halton CCG;
- Knowsley CCG;
- Liverpool CCG;
- St Helens CCG;
- South Sefton CCG;
- Southport and Formby CCG;
- Warrington CCG;

This policy aims to improve consistency by bringing together one common set of criteria for treatments and procedures across the Merseyside and Warrington CCG footprints. This will help to reduce variation of 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.

Principles

Commissioning decisions by CCG Commissioners are made in accordance with the commissioning principles set out as follows:

- 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;

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- Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered;
- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

Core eligibility criteria

However, there are a number of circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for the procedures and treatments listed within this policy, regardless of whether they meet the criteria; or the procedure or treatment is not routinely commissioned.

These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment;
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2 week rule;
  NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England;
- Reconstructive surgery post cancer or trauma including burns;
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures;
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis;
- For patients wishing to undergo Gender reassignment, this is the responsibility of NHS England and patients should be referred to a Gender Identity Clinic (GIC) as outlined in the Interim NHS England Gender Dysphoria Protocol and Guideline 2013/14.

Policy Categories

Each procedure/treatment is categorised as either 'not routinely funded' or 'restricted' and these are defined as follows:

- Not routinely funded (NRF) – This means the CCG does not routinely commission the treatment and will only commission this treatment for an individual patient where an IFR application in line with the CCG's IFR process, demonstrates clinical exceptionality;

- Restricted – This means the CCG will commission the treatment where the patient meets the specific criteria as set out within this Commissioning Policy. Where a patient does not meet the specific criteria specified the CCG will only commission this treatment for an individual patient where an IFR application in line with the CCG's IFR process, demonstrates clinical exceptionality;

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Diagnostic Procedures

Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met or approval has been given by the CCG or GP (as set out in the approval process of the patients responsible CCG) or as agreed by the IFR Panel as a clinically exceptional case.

Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

Psychological factors

Psychological distress alone will not be accepted as a reason to fund surgery. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient's psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention.

Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as a route into aesthetic surgery. Any application citing psychological distress will need to be considered as an IFR .

Lifestyle 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.

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CBCT Referral/Treatment Listing Processes

Primary Care

Referrals for treatment should not be made unless the patient clearly meets the criteria as this can raise unrealistic expectations for the patient and lead to disappointment. If a General Practitioner/Optometrist/Dentist considers a patient might reasonably fulfil the eligibility criteria for a restricted procedure, as detailed in this document (i.e. they meet the specific criteria listed for each treatment) the General Practitioner/Optometrist/Dentist should follow the process for referral. NB. This may be via a referral management or prior approval team.

If in doubt over the local process, the referring clinician should contact the relevant CCG, IFR Team or Referral Management Team for guidance. Failure to comply with the local process may delay a decision being made.

Any referral letter should include specific information regarding the patient's potential eligibility. If the referral letter does not clearly outline how the patient meets the criteria, then the letter should be returned to the referrer for more information.

In cases where there may be an element of doubt the General Practitioner/Optometrist/Dentist should discuss the case with the IFR Team in the first instance.

Secondary Care

The secondary care consultant will also determine whether the procedure is clinically appropriate for a patient and whether the eligibility criteria for the procedure are fulfilled or not. The consultant may also request additional information before seeing the patient.

If a secondary care consultant considers a patient might reasonably fulfil the eligibility criteria for a restricted procedure, as detailed in this document (i.e. they meet the specific criteria listed for each treatment) the consultant should follow the listing process for treatment. NB. For some CCGs this will involve following a process of prior approval. If in doubt over the CCG requirements, the consultant should contact the relevant CCG or the IFR Team for guidance. Failure to comply with the CCGs' processes may delay a patient's treatment and/or release of funding resources.

Patients who fulfil the criteria may then be placed on a waiting list according to their clinical need. The patient's notes should clearly reflect exactly how the criteria were fulfilled including prior approval authorisation where relevant. This will allow for case note audit to support contract management.

Should the patient not meet the eligibility criteria this should be recorded in the patient's notes and the consultant should return the referral back to the General Practitioner/Optometrist/Dentist, explaining why the patient is not eligible for treatment.

IFR Applications/Clinical Exceptionality

Exceptionality is where a patient does not meet all of the criteria outlined for a specific procedure or treatment or, the procedure or treatment is not routinely commissioned.

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In this scenario, should a patient not fulfil the clinical criteria but the referring clinician is willing to support the application as clinically exceptional, the case can be referred to the IFR Panel for consideration. The person who fills in the IFR can be a consultant or a GP.

In dealing with clinically exceptional requests for an intervention that is considered to be a poor use of NHS resources, the Merseyside CCGs have endorsed through the CCG Alliance the following description of exceptionality contained in a paper by the NW Medicines and Treatment Group:

- The patient has a clinical picture that is significantly different to the general population of patients with that condition; and as a result of that difference; the patient is likely to derive greater benefit from the intervention than might normally be expected for patients with that condition.

The CCGs are of the opinion that exceptionality should be defined solely in clinical terms. To consider social and other non-clinical factors automatically introduces inequality, implying that some patients have a higher intrinsic social worth than others with the same condition. It runs contrary to a basic tenet of the NHS, namely that people with equal need should be treated equally. Therefore, non-clinical factors will not be considered except where this policy explicitly provides otherwise.

The CCG must justify the grounds upon which it is choosing to fund treatment for a particular patient when the treatment is unavailable to others with the condition.

Individual Funding Requests should only be sent to the respective NHS.net accounts as below. Guidance regarding IFRs and an application form; can be found on the CCGs websites.

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

Individual Funding Request Case Manager
Midlands and Lancashire Commissioning Support Unit (MLCSU)
1829 Building
Countess of Chester Health Park
Liverpool Road
Chester
CH2 1HJ
Telephone: 01244 650 305

Email addresses for Individual Funding Request teams at CCGs:

CCG	Email Address
Halton CCG	IFR.manager@nhs.net
Knowsley CCG	
Liverpool CCG	
South Sefton CCG	
Southport & Formby CCG	
St Helens CCG	
Warrington CCG	Warringtonccg.IFR@nhs.net

Midlands and Lancashire Commissioning Support Unit

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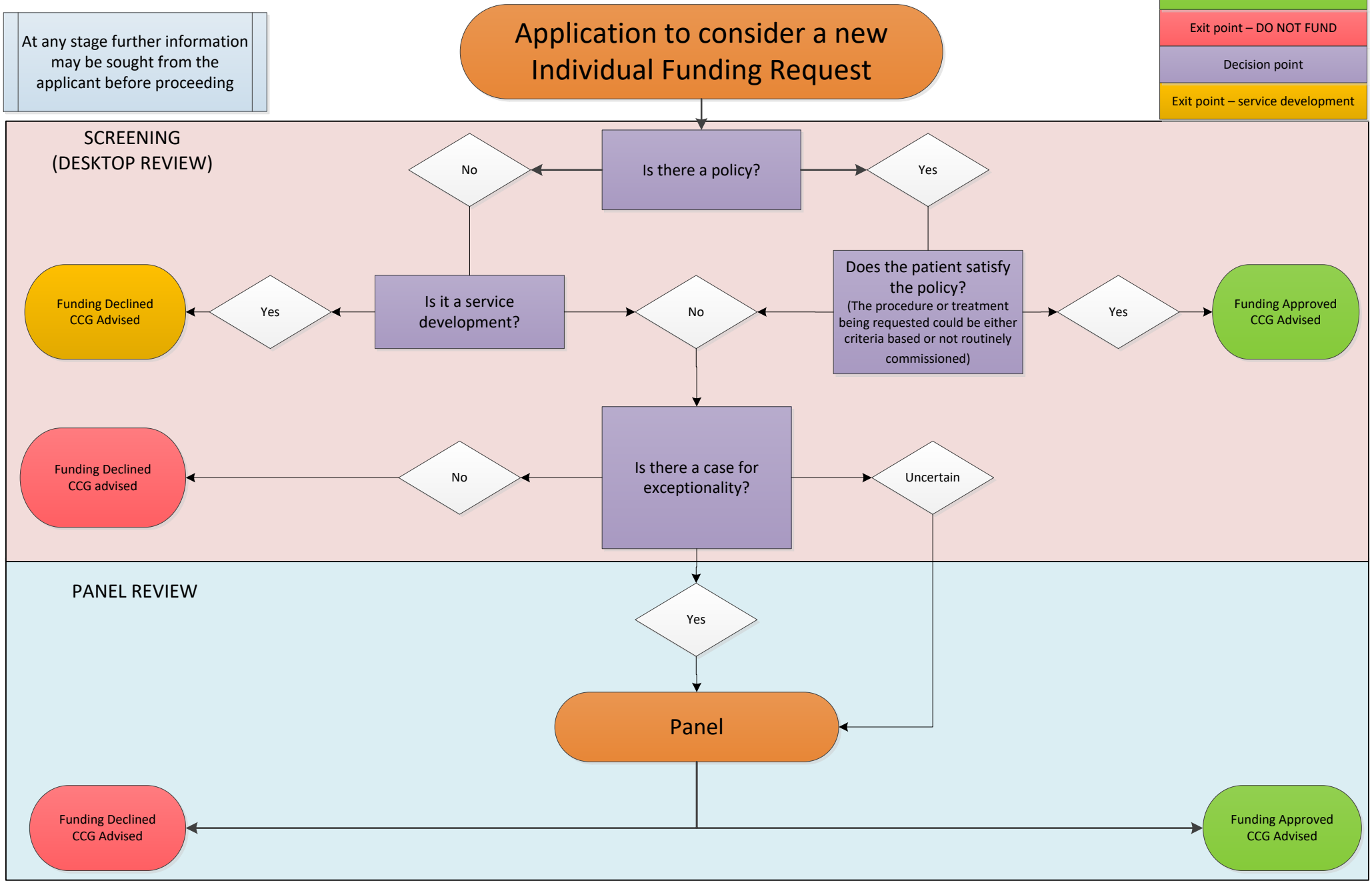
At any stage further information may be sought from the applicant before proceeding



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Medicines

Prior approval for treatment should always be sought from the responsible Medicine Management Team when using medicines as follows:

- Any new PbR excluded drug where the drug has not yet been approved/prioritised for use in agreement with the local CCG;
- Any existing PbR excluded drugs to be used outside of previously agreed clinical pathways/indication;
- Any PbR excluded drugs that are being used out with the parameters set by NICE both in terms of disease scores or drug use. It must not be assumed that a new drug in the same class as one already approved by NICE can be used, this must be subject to the process in Point 1;
- Any drug used out with NICE Guidance (where guidance is in existence);
- Any proposed new drug/new use of an existing drug (whether covered by NICE or PBR excluded or not) should first be approved by the relevant Area Medicines Management Committee, and funding (where needed) agreed in advance of its use by the relevant CCG;
- Any medicines that are classed by the CCG as being of limited clinical value;
- Any medicines that will be supplied via a homecare company agreement;

Clinical Trials

The CCGs do not expect to provide funding for patients to continue treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

Photographic evidence

Photographic evidence may be required in cases which are being considered for clinical exceptionality in line with the IFR processes. However, photographic evidence will not be accepted for consideration unless it is impossible to make the case in any other way.

The decision to submit photographic evidence remains with the patient and responsible clinician and must meet the CCGs criteria for submission as outlined by the CCGs IFR Policy.

If photographs are accepted for consideration in accordance with the CCGs criteria, they will be examined by clinical members of the IFR team. In the course of the work for the case the applicant should be aware that other members of the IFR Panel, IFR Process Reviews Panel or IFR team who prepare the papers may need to handle or see the photographs.

Personal data

In making referrals to the IFR Team, clinicians and other referrers in primary and secondary care should bear in mind their obligations under the Data Protection Act 1998 and their duty of confidence to patients. Where information about patients (including photographs) is sent to the IFR Team and is lost or inadvertently disclosed to a third party before it is safely received by the IFR Team, the referrer will be legally responsible for any breach of the Data Protection Act 1998 or the law of confidence.

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Therefore, please consider taking the following precautions when using the Royal Mail to forward any information about patients including photographic evidence:

Clearly label the envelope to a named individual i.e. first name & surname, and job title.

Where your contact details are not on the items sent, include a compliment slip indicating the sender and their contact details in the event of damage to the envelope or package.

Use the Royal Mail Signed for 1st Class service, rather than the ordinary mail, to reduce the risk of the post going to the wrong place or getting lost.

Costs incurred will be the responsibility of the referrer, this includes photographic evidence.

Copies of this policy

Electronic copies of this policy can be found on the websites of the respective CCGs. Alternatively; you may contact the CCG and ask for a copy of the Criteria Based Clinical Treatments 2017-18 policy document.

Monitoring and review

This policy will be 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;

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

From time to time, CCGs may need to make commissioning decisions that may suspend some treatments/criteria currently specified within this policy.

Evidence

At the time of publication the evidence presented per procedure/treatment was the most current available. Where reference is made to older publications these still represents the most up to date view.

GLOSSARY

Term	Meaning
Analgesics	Painkillers.
Asymptomatic	Without symptoms.
Augmentation	Increasing in size, for example breast augmentation.
Benign	Does not invade surrounding tissue or spread to other parts of the body; it is not a cancer.
Binocular vision	Vision in both eyes.
Body Mass Index (BMI)	Body Mass Index - a measure that adults can use to see if they are a healthy weight for their height.
CCG	Clinical Commissioning Group. CCGs are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.
Chronic	Persistent
Co-morbidities	Other risk factors alongside the primary problem.
Congenital	Present from birth
Conservative treatment	The management and care of a patient by less invasive means; these are usually non-surgical
DOH	Department of Health
Eligibility/Threshold	Whether someone qualifies. In this case, the minimum criteria to access a procedure.
Exceptional clinical circumstances	A patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients, with the same medical condition and at the same stage of progression as the patient.
Functional health problem/difficulty/impairment	Difficulty in performing, or requiring assistance from another to perform, one or more activities of daily living.
GP	General Practitioner.
Histology	The structure of cells or tissue under a microscope.
Individual Funding Request (IFR)	A request received from a provider or a patient with explicit support from a clinician, which seeks funding for a single identified patient for a specific treatment.
Irreducible	Unable to be reduced.
Malignant/malignancy	Harmful.
Monocular vision	Vision in one eye only.
Multi-disciplinary	Involving several professional specialisms for example in a Multi-disciplinary team (MDT).
NICE guidance	The guidance published by the National Institute for Health and Care Excellence.
Not routinely funded (a procedure)	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.
NSAIDS	Non-steroidal anti-inflammatory drugs – medication that reduces pain, fever and inflammation.
Paediatric(ian)	Medical care concerning infants, children and adolescents usually under 18.

GLOSSARY

Pathology/pathological	The way a disease or condition works or behaves. This may for example include examination of bodily fluids or tissue e.g. blood testing.
PCT	Primary Care Trust (PCTs were abolished on 31 March 2013, and replaced by Clinical Commissioning Groups).
PLCP	Procedures of Lower Clinical Priority; routine procedures that are of value, but only in the right circumstances.
Precipitates	Brings about/triggers.
Primary care	a patient's first point of interaction with NHS services e.g. a GP surgery.
Rationale	Explanation of the reason why.
Restricted (a procedure)	This means CCG will fund the treatment if the patient meets the stated clinical threshold for care.
Secondary care	Services provided by medical specialists, who generally do not have the first contact with a patient e.g. hospital services.
Stakeholders	Individuals, groups or organisations who are or will be affected by this consultation, e.g. patients who currently use the service, carers, specific patient groups, etc.
Symptomatic	Something causing or exhibiting symptoms.

A2. Dermatology

A2.2 Surgical Treatments for Minor Skin Lesions

The removal of benign skin lesions are not routinely commissioned for cosmetic reasons.

Intervention	Surgical Treatments for Minor Skin Lesions
Policy Statement	**Restricted** Please note the removal of benign skin lesions are not routinely commissioned for cosmetic reasons.
Minimum eligibility criteria	The CCG will only fund this treatment if the patient meets **ONE** of the following: • Suspected or proven malignancy (cancerous) (if suspected or proven malignancy refer via appropriate pathway) OR • Symptomatic e.g. ongoing pain or functional impairment. OR • Risk of infection. OR • Significant facial disfigurement. OR • All vascular lesions on the face except benign, acquired vascular lesions such as thread veins. For any of the above scenarios, referral for treatment should be made to a community provider
Rationale	This is because all removal of Benign (non-cancerous) or Congenital Skin Lesions that does not meet the criteria above is deemed to be cosmetic.
Evidence for inclusion and threshold	NHS Modernisation Agency - Information for commissioners of Plastic Surgery - referrals and guidelines in Plastic Surgery (Action on Plastic Surgery) (2005) Weblink: http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2

A2.3 Policy for Surgical removal of Lipoma

Lipoma are fat deposits underneath the skin. They are usually removed on cosmetic grounds, although patients with multiple subcutaneous lipoma may need a biopsy to exclude neurofibromatosis.

Removal of Lipoma in secondary care is restricted. The CCG will fund this treatment if the patient meets the minimum eligibility criteria below.

Intervention	Surgical removal of Lipoma
Policy Statement	**Restricted**
Minimum eligibility criteria	The CCG will fund this treatment if the patient meets the following criteria: • Lipoma is on the face or neck ***AND*** one of the following: • suspected malignancy **OR** • significant functional impairment caused by the lipoma **OR** • to provide histological evidence in conditions where there are multiple subcutaneous lesions This excludes lipomas unless they are on the face (including pinna) or the neck and they become infected or be symptomatic. Lipomas on other areas of the body should be referred back to primary care as agreed locally This means **(for patients who DO NOT meet the above criteria)** 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.
Rationale	This is because all removal of Lipoma that does not meet the criteria below is deemed to be cosmetic and does not meet the principles laid out in this policy.
Evidence for inclusion and threshold	NHS Modernisation Agency - Information for commissioners of Plastic Surgery - referrals and guidelines in Plastic Surgery (Action on Plastic Surgery) (2005) Weblink: http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2 NHS Choices – Lipoma Weblink: http://www.nhs.uk/Conditions/lipoma/Pages/Introduction.aspx

A4. ENT

A4.1 Policy for Adenoidectomy

An adenoidectomy is an operation to remove the adenoids – small lumps of tissue at the back of the nose, behind the palate.

Adenoids are part of the immune system, which helps fight infection and protects the body from bacteria and viruses. Adenoids are only present in children. They start to grow from birth and are biggest when your child is approximately three to five years old.

But by age seven to eight they start to shrink and by the late teens, are barely visible. By adulthood, the adenoids will have disappeared completely.

The adenoids disappear because – although they may be helpful in young children – they are not an essential part of an adult's immune system.

A good summary of adenoids and adenoidectomy is provided by NHS Choices.
Weblink:
http://www.nhs.uk/conditions/Adenoids-and-adenoidectomy/Pages/Introduction.aspx

Intervention	Adenoidectomy
Policy Statement	Restricted
Minimum eligibility criteria	Adenoidectomy will only be funded if Primary and Secondary Care clinicians undertake maximum medical therapy by following the Royal College of Surgeons High Value Care Pathway for Rhinosinusitis (see weblink below), with surgery reserved for recalcitrant cases, with a diagnosis confirmed by radiology, after an appropriate trial of treatment. Or Children or adults with sleep disordered breathing/apnoea confirmed with sleep studies undergo procedure in line with recognised management of these conditions. This means (for patients who do not require tonsillectomy and/or grommets) 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.
Evidence for inclusion and threshold	Royal College of Surgeons Commissioning Guide for Rhinosinusitis (2013): The Royal College of Surgeons of England and ENT UK (2013). Commissioning guide: Rhinosinusitis, Available from: https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/rhinosinusitis-commissioning-guide/ This guide has been prepared for commissioners by the Royal College of Surgeons following a review of the latest research evidence. Robb PJ et al (2009), Tonsillectomy and adenoidectomy in children with sleep-related breathing disorders: consensus statement of a UK multidisciplinary working

	party, Annals of the Royal College of Surgeons of England, 91, 371-373. Available from: http://europepmc.org/articles/PMC2758429;jsessionid=MVfPN7W1Ky1PN4EiKikL.52 https://www.nice.org.uk/guidance/cg60 *Adenoidectomy is not recommended* "Once a decision has been taken to offer surgical intervention for otitis media with effusion (OME) in children, insertion of ventilation tubes is recommended. Adjuvant adenoidectomy is not recommended in the absence of persistent and/or frequent upper respiratory tract symptoms." Scottish Intercollegiate Guidelines Network, NHS Quality Improvement Scotland. *Management of sore throat and indications for tonsillectomy 117.* April 2010. http://www.sign.ac.uk/pdf/qrg117.pdf

A4.2 Policy for Pinnaplasty

Ear correction surgery is cosmetic surgery to alter the size or shape of the ears, or pin them back if they stick out.
Pinning back the ears is known as an otoplasty, or pinnaplasty. It's usually carried out on children and young teenagers, although adults may wish to have it done, too.

An otoplasty isn't suitable for children younger than five as their ears will still be growing and developing.

Most people are happy with the results of an otoplasty, and generally it's a safe procedure. But it can be expensive and there are still risks to consider.
Weblink:
http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/ear-correction-surgery.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

Intervention	**Pinnaplasty**
Policy Statement	Not routinely commissioned
Minimum eligibility criteria	Pinnaplasty is not routinely commissioned.
Evidence for inclusion and threshold	Royal College of Surgeons and British Association of Plastic, Reconstructive and Aesthetic Surgeons – Pinnaplasty Commissioning Guide (2013) Weblink: http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/pinnaplasty/at_download/file

A4.4 Policy for Tonsillectomy for recurrent Tonsillitis (excluding peri-tonsillar abscess) Adults and Children

Tonsillitis is inflammation of the tonsils. It's usually caused by a viral infection or a bacterial infection.
This is a common type of infection in children, although it can sometimes affect adults.
The symptoms of tonsillitis include:
• sore throat that can feel worse when swallowing
• high temperature (fever) over 38C (100.4F)
• coughing
• headache

A good summary about treating Tonsillitis is provided by NHS Choices:
Weblink: http://www.nhs.uk/Conditions/Tonsillitis/Pages/Treatment.aspx

Intervention	Policy for Tonsillectomy for recurrent Tonsillitis (excluding peri-tonsillar abscess) Adults and Children
Policy Statement	**Restricted** **Note:** Tonsillectomy should **not** be carried out for tonsil stones and/or halitosis as there is no clinical evidence to suggest that this is an effective treatment for these conditions.
Minimum eligibility criteria	The CCG will fund this treatment if the patient meets one or more of the following criteria: • 7 or more documented clinically significant, adequately treated episodes of tonsillitis in the preceding year; **OR** • 5 or more documented episodes in each of the preceding two years **OR** • 3 or more documented episodes in each of the preceding three years. **AND** • If symptoms are disabling and prevent normal functioning Each episode of tonsillitis should be documented in the patient's medical records and characterised by at least one of the following: Aural temperature of at least 38.3°C Tender anterior cervical lymph nodes Tonsillar exudates Tonsillar enlargement giving rise to symptoms of upper airways obstruction **Note:** it is the referring clinician's responsibility to ensure all evidence pertaining to the minimum eligibility criteria above are

	provided as part of the referral. **Note:** Walk in Centre or Out of Hours documented episodes that are communicated in writing to GP Practices are included in the episode count. There are a small proportion of patients with specific clinical conditions or syndromes, who require tonsillectomy as part of their on-going management strategy, and who will not necessarily meet the SIGN guidance below (e.g. those presenting with psoriasis, nephritis, Periodic fever, aphthous stomatitis, pharyngitis and adenitis (PFAPA) syndrome. Children or adults with sleep disordered breathing/apnoea confirmed with sleep studies undergo procedure in line with recognised management of these conditions. **Note:** When in doubt, implement a six month period of clinical watchful waiting. (Watchful waiting involves carefully monitoring your symptoms to see whether they improve or get worse.) This means **(for patients who DO NOT meet the specified criteria)** 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.
Rationale	This is because of the Royal College of Surgeons recommendations for High Value Care Pathway for Tonsillectomy published in 2013 (see weblink below).
Evidence for inclusion and threshold	Royal College of Surgeons - Commissioning guide: Tonsillectomy (2013). Weblink: https://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/tonsillectomy SIGN - Management of sore throat and indications for tonsillectomy (2010). Weblink: http://www.sign.ac.uk/pdf/sign117.pdf NHS Choices - Tonsillitis http://www.nhs.uk/conditions/Tonsillitis/Pages/Introduction.aspx NHS Choices – Quinsy; Tonsillitis Weblink: http://www.nhs.uk/conditions/Quinsy/Pages/Introduction.aspx http://www.nhs.uk/conditions/tonsillitis/Pages/Introduction.aspx

A4.7 Policy for Rhinoplasty

Rhinoplasty, commonly known as a 'nose job', is a plastic surgery procedure for correcting and reconstructing the form, restoring the functions, and aesthetically enhancing the nose by resolving nasal trauma (blunt, penetrating, blast), congenital defect, respiratory impediment, or a failed primary rhinoplasty.

Intervention	Rhinoplasty
Policy Statement	**Restricted** a) Rhinoplasty is not routinely commissioned for cosmetic reasons. b) Rhinoplasty is restricted for non-cosmetic/other reasons e.g. a sepoplasty.
Minimum eligibility criteria	The CCG will fund this treatment if the patient meets the following criteria: • Documented medical breathing problems caused by obstruction of the nasal airway **OR** • Correction of complex congenital conditions e.g. Cleft lip and palate This means **(for patients who DO NOT meet the above criteria or require the procedure for cosmetic reasons)** 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.
Rationale	This is because if you have a blocked nose because your nasal bones are crooked or damaged, or the bone and cartilage between your nostrils is deviated (bent) a septoplasty can improve how you breathe.
Evidence for inclusion and threshold	Royal College of Surgeons – Rhinoplasty Guide Weblink: https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/nose-job/

A7. General Surgery

A7.1 Policy for Hemorrhoidectomy. Rectal surgery and removal of haemorrhoidal and anal skin tags

Symptoms range from temporary and mild, to persistent and painful. In many cases, piles are small and symptoms settle down without treatment. Surgical Haemorrhoidectomy can be used for third or fourth degree haemorrhoids.

A Haemorrhoidectomy is an operation to cut away the haemorrhoid(s) is an option to treat grade 3 or 4 piles, or for piles not successfully treated by banding or other methods. It is usually carried out under general anaesthetic, which means you will be asleep during the procedure and won't feel any pain while it is carried out.

Internal haemorrhoids are classified by their degree of prolapse, which helps determine management:

- 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)

A conventional haemorrhoidectomy involves gently opening the anus so the haemorrhoids can be cut out. You will need to take a week or so off work to recover.

You will probably experience significant pain after the operation, but you will be given painkillers. You may still have pain a few weeks after the procedure, which can also be controlled with painkillers. Seek medical advice if you have pain that continues for longer.

After having a haemorrhoidectomy, there is around a 1 in 20 chance of the haemorrhoids returning, which is lower than with non-surgical treatments. Adopting or continuing a high-fibre diet after surgery is recommended to reduce this risk.

Intervention	**Treatments for hemorrhoids. Rectal surgery and removal of haemorrhoidal and anal skin tags**
Policy Statement	**Restricted** This policy is to be used where conservative treatment of haemorrhoids has previously failed. Treatment of bleeding haemorrhoids depends on the degree of prolapse and severity of symptoms. In general, the treatment options vary by haemorrhoid severity or grade.

Minimum eligibility criteria	a) **Haemorrhoidectomy for grades 1 or 2** is not routinely commissioned. b) **Haemorrhoidectomy for grades 3 or 4** will be funded if the patient meets one or more of the following criteria: • Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding **OR** • Irreducible and large external haemorrhoids **Removal of skin tags is not routinely commissioned.** This means **(for patients who DO NOT meet the specified criteria)** that 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.
Rationale	**Haemorrhoidectomy for grades 1 or 2** is not routinely commissioned because Haemorrhoids can often be treated by simple measures such as eating more fibre or drinking more fluid or using standard topical measures. If these measures are unsuccessful, then haemorrhoids can usually be treated in a clinic setting providing local treatments including Rubber Band Ligation or Injecting the Haemorrhoids. **Haemorrhoidectomy for grades 3 or 4** will only be funded in the circumstances mentioned above is because Excisional Haemorrhoidectomy is more effective than rubber band ligation in the long term and is the treatment of choice for **recurrent** grade 2 and grade 3/4 haemorrhoids.
Evidence for inclusion and threshold	Royal College of Surgeons - Commissioning guide: Rectal Bleeding (2013) Weblink: https://www.rcseng.ac.uk/-/media/files/.../rectal-bleeding--commissioning-guide.pdf Royal College of Surgeons – haemorrhoidectomy pre-operation guide. Weblink: http://www.rcseng.ac.uk/members/resources/pre-op-leaflets/Colorectal/Haemorrhoidectomy.pdf/view NHS Choices - Piles (haemorrhoids) Weblink: http://www.nhs.uk/conditions/Haemorrhoids/Pages/What-is-it-page.aspx

A7.2 Policy for Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias and Surgical correction of Diastasis of the Recti

A hernia occurs when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall.

A hernia usually develops between your chest and hips. In many cases, it causes no or very few symptoms, although you may notice a swelling or lump in your tummy (abdomen) or groin.

The lump can often be pushed back in or disappears when you lie down. Coughing or straining may make the lump appear.

A good summary about treating hernias is provided by NHS Choices:
Weblink:
http://www.nhs.uk/conditions/hernia/Pages/Introduction.aspx

A good summary about Disatasis Recti is provided by NHS Choices:
Weblink:
http://www.nhs.uk/conditions/pregnancy-and-baby/pages/your-body-after-childbirth.aspx?tabname=pregnancy#separated

Intervention	Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias and Surgical correction of Diastasis of the Recti
Minimum eligibility criteria	**Not routinely commissioned** This means **(for patients who DO NOT meet the specified criteria)** 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.
Rationale	This is because these procedures highly specialised and techniques for treatment are not well developed making treatment complicated.
Evidence for inclusion and threshold	A systematic review on the outcomes of correction of diastasis of the recti Hernia, December 2011, Volume 15, Issue 6, pages 607-614, Hickey et al.

A7.3 Surgery for Asymptomatic Gallstones

Gallstones are small stones, usually made of cholesterol, that form in the gallbladder. In most cases they don't cause any symptoms and don't need to be treated.

However, if a gallstone becomes trapped in an opening (duct) inside the gallbladder, it can trigger a sudden, intense abdominal pain that usually lasts between one and five hours. This type of abdominal pain is known as biliary colic.

Some people with gallstones can also develop complications, such as inflammation of the gallbladder (cholecystitis), which can cause:

- persistent pain
- jaundice
- a fever

When gallstones cause symptoms or complications, it's known as gallstone disease or cholelithiasis.

A Good summary of Gallstones is provided by NHS Choices:
Weblink:
http://www.nhs.uk/conditions/gallstones/Pages/Introduction.aspx

Intervention	Surgery for Asymptomatic Gallstones
Minimum eligibility criteria	This procedure is not routinely commissioned.
Rationale	This is because the majority of people with gallbladder stones remain asymptomatic and require no treatment.
Evidence for inclusion and threshold	https://www.rcseng.ac.uk/-/media/files/rcs/.../gallstones--commissioning-guide.pdf Royal College of Surgeons (2016).

A8. Gynaecology

A8.1 Policy for Hysterectomy for Heavy Menstrual Bleeding

Heavy periods, also called menorrhagia, are when a woman loses an excessive amount of blood during consecutive periods. Menorrhagia can occur by itself or in combination with other symptoms, such as menstrual pain (dysmenorrhoea). Heavy bleeding does not necessarily mean there is anything seriously wrong, but it can affect a woman physically, emotionally and socially, and can cause disruption to everyday life.

Hysterectomy is one of the most frequently performed surgery on women, and can be performed vaginally as well as abdominally. Common indications include menorrhagia, fibroids, endometriosis, uterine prolapse and cancer of uterus and cervix.

Hysterectomy is one of a number of NICE recommended treatments of heavy menstrual bleeding (menorrhagia), but is associated with more complications compared to treatment with progestogens.

Therefore Hysterectomy is not routinely commissioned as a first-line treatment solely for HMB.
The NICE recommended treatments, including hysterectomy, are detailed below and Women should be given the following information on potentially unwanted outcomes.

A good summary of Hysterectomy is provided by NHS Choices:
Weblink:
http://www.nhs.uk/Conditions/hysterectomy/Pages/Introduction.aspx

Intervention	Hysterectomy for Heavy Menstrual Bleeding
Policy Statement	**Restricted**
Minimum eligibility criteria	Hysterectomy is not commissioned unless all of the following criteria have been met: • The following treatments have failed, are not appropriate or are medically contra-indicated: ○ An unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena) ○ Tranexamic acid or nonsteroidal anti-inflammatory drugs or combined oral contraceptives. ○ Norethisterone 15 mg daily from days 5 to 26 of the menstrual cycle, or injected long-acting progestogens ○ Up to 4 courses of ulipristal acetate 5mg for women with heavy menstrual bleeding and fibroids of 3cm or more in diameter. ○ Endometrial ablation has been tried (unless patient

	has fibroids >3cm) The procedure should not be offered where a patient wishes to cease menstruation.
Rationale	This is because NICE Clinical Guideline 44 recommends that: Hysterectomy should not be used as a first-line treatment solely for HMB. Hysterectomy should be considered only when: • other treatment options have failed, are contraindicated or are declined by the woman • there is a wish for amenorrhoea • the woman (who has been fully informed) requests it • the woman no longer wishes to retain her uterus and fertility Women offered hysterectomy should have a full discussion of the implication of the surgery before a decision is made. The discussion should include: sexual feelings, fertility impact, bladder function, need for further treatment, treatment complications, the woman's expectations, alternative surgery and psychological impact. Women offered hysterectomy should be informed about the increased risk of serious complications (such as intraoperative haemorrhage or damage to other abdominal organs) associated with hysterectomy when uterine fibroids are present. Women should be informed about the risk of possible loss of ovarian function and its consequences, even if their ovaries are retained during hysterectomy. Individual assessment is essential when deciding the route of hysterectomy. The following factors need to be taken into account: • presence of other gynaecological conditions or disease • uterine size • presence and size of uterine fibroids • mobility and descent of the uterus • size and shape of the vagina • history of previous surgery Taking into account the need for individual assessment, the route of hysterectomy should be considered in the following order: first line vaginal; second line abdominal. Under circumstances such as morbid obesity or the need for oophorectomy during vaginal hysterectomy, the laparoscopic

	approach should be considered, and appropriate expertise sought. When abdominal hysterectomy is decided upon then both the total method (removal of the uterus and the cervix) and subtotal method (removal of the uterus and preservation of the cervix) should be discussed with the woman.
Evidence for inclusion and threshold	NICE - Clinical guideline: Heavy menstrual bleeding CG44 (2007). Weblink: http://www.nice.org.uk/guidance/CG44 NHS Choices - Heavy periods (menorrhagia) Weblink: http://www.nhs.uk/conditions/Periods-heavy/Pages/Introduction.aspx Please note that the NICE website indicates that this clinical guideline is undergoing a full review, with expected date for the updated guidance to be published in November 2017:https://www.nice.org.uk/guidance/indevelopment/gid-ng10012. This policy will need to be reviewed again once the updated CG is published

A8.2 Policy for Dilatation and Curettage

Dilation and Curettage for Menorrhagia has been the traditional technique for obtaining samples of endometrium for pathological examination. However, 'blind' dilatation and curettage (D&C) has been shown to miss significant amounts of pathology.

D&C used to be commonly used to examine the womb and remove abnormal growths, but nowadays hysteroscopies are carried out instead.

A good summary of Hysteroscopy is provided by NHS Choices:
Weblink:
http://www.nhs.uk/conditions/hysteroscopy/Pages/Introduction.aspx

Intervention	Dilatation and Curettage
Minimum eligibility criteria	This procedure is not routinely commissioned
Rationale	This is because NICE Clinical Guideline 44 recommends that: Ultrasound is the first-line diagnostic tool for identifying structural abnormalities. Dilatation and curettage should not be used as a diagnostic tool. Dilatation and curettage should not be used as a therapeutic treatment**.**
Evidence for inclusion and threshold	NICE - Clinical guideline: Heavy menstrual bleeding CG44 (Last updated 2016). Weblink: http://www.nice.org.uk/guidance/CG44 National Collaborating Centre for Womens Health (2007) Heavy Menstrual Bleeding. Evidence Tables. https://www.nice.org.uk/guidance/cg44/evidence/evidence-tables-pdf195071294 NHS Choices - Hysteroscopy Weblink: http://www.nhs.uk/conditions/hysteroscopy/Pages/Introduction.aspx

A9. Mental Health

A9.4 Policy for Private Mental Health Care

Private Mental Health Care is not routinely commissioned because most mental health conditions can be managed in the community with input from Community Mental Health teams.

NHS England Specialist Commissioning provides NHS specialist services for various conditions including PTSD, eating disorders and severe OCD.

There is also a specialist NHS Mental Health service provided for affective disorders.

Intervention	Policy for Private Mental Health Care
Policy Statement	Not Routinely Commissioned

A11. Ophthalmology

A11.5 Policy for Cataract Surgery

A cataract exists when the lens of an eye becomes cloudy and may affect vision. Cataracts most commonly occur in older people and develop gradually. Cataracts can usually be treated with a routine day case operation where the cloudy lens is removed and is replaced with an artificial plastic lens (an Intraocular Implant).

The Royal College of Ophthalmologists' National Ophthalmology Database indicates that in 2006-2010 (before restrictions on access to cataract surgery based on visual acuity were commonplace), for eyes undergoing cataract surgery preoperative following percentages of cataract patients had visual acuities of better than or equal to:

- 6/6 Snellen (3% of cataract surgery patients)
- 6/9 Snellen (5% of cataract surgery patients)
- 6/12 Snellen (36% of cataract surgery patients)

So eyes with visual acuities of 6/9 or better, accounted for only about 10% of cataract surgery.

Intervention	**Cataract Surgery**
Policy Statement	The presence of a cataract in itself does not indicate a need for surgery. It is intended that all patients should be fully assessed and counselled as to the risks and benefits of surgery. This assessment will usually be undertaken by an accredited community optometrist prior to referral. Where both eyes are affected by cataract, the first eye referred for cataract surgery is usually expected to be the eye where cataract has caused the greatest reduction in visual acuity. This policy does not extend to cataract removal incidental to the management of other eye conditions.
Minimum eligibility criteria	Referral of patients to ophthalmologists for cataract surgery should be based on the following indications: 1. The patient has sufficient cataract to account for visual symptoms. It is strongly recommended that only those cases with **best corrected visual acuity of 6/9** (Snellen) **or +0.2** (Logmar**) or worse** in the poorer eye be referred. However, exception may be made where the impact of symptoms is such that the patient's quality of life is significantly impaired. A description of the impact on quality of life must be documented and accompany the referral information for all cases. Examples of the Impact on quality of life may include any

	of the following factors, although this is not an exhaustive list: a. the patient is at significant risk of falls b. the impact of the visual symptoms is affecting the patient's ability to access their chosen mode of transport including driving c. the impact of symptoms is compromising the patient's independence d. the impact of the visual symptoms is affecting the patient's ability to continue their employment or undertake caring responsibilities e. the impact of the visual symptoms is substantially affecting the patient's ability to undertake daily activities such as reading, watching television, leaving the house or recognising faces. f. the patient is experiencing disabling glare. **AND** 2. Where the referral has been initiated by an optometrist, there has been a discussion on the risks and benefits of cataract surgery based around the Patient Decision Aid For Cataract. http://sdm.rightcare.nhs.uk/pda/cataracts/ 3. The patient has understood what a cataract surgical procedure involves and wishes to have surgery **Guidance for second eye surgery in patients with bilateral cataracts** **The second eye criteria is** As for the first eye, i.e. the impact of visual symptoms is sufficiently impairing the patient's quality of life despite one eye having been operated upon
Guidance/evidence Atlas of Variation *Tacking Unwarranted Variation in Healthcare across the NHS* Public Health England, NHS Right Care and NHS England September 2015 *Evidence Review Cataract Surgery* –ChaMPs May 2014 Royal College of Ophthalmologists *Commissioning Guide for Cataract Surgery* February 2015 NHS Choices NHS Patient Decision Aids – Cataract	

A14. Plastic Surgery

A14.1 Reduction Mammoplasty - Female Breast Reduction

Breast Reduction Surgery
Breast reduction surgery can help women who are unhappy with the shape, weight or droop of their breasts by making them smaller and more lifted.

But if it's done to improve appearance rather than for health reasons, it's not normally available on the NHS. Instead, you'll need to pay for the procedure privately.

Weblink:
http://www.nhs.uk/Conditions/Breast-reduction/Pages/Introduction.aspx

Intervention	Reduction Mammoplasty - Female Breast Reduction
Minimum eligibility criteria	The CCG will fund this treatment if the patient meets ALL of the following criteria • Musculo-skeletal symptoms are not due to other causes. AND • There is at least a two year history of attending the GP with the problem. AND • Other approaches such as analgesia and physiotherapy have been tried. AND • The patient is suffering from functional symptoms as a result of the size of her breasts (e.g. candidal intertrigo; backache). AND • The wearing of a professionally fitted brassiere has not helped. AND • Patients BMI is <25 and stable for at least twelve months. AND • The patients breast is a cup size H or larger. AND • There is a proposed reduction of at least a three cup sizes. AND • Aged over 18 years old. AND • It is envisaged there are no future planned pregnancies. Unilateral breast reduction is considered for asymmetric breasts of three or more cup size difference as measured by a specialist – see the Breast Augmentation policy.

Evidence for inclusion and threshold	An investigation into the relationship between breast size, bra size and mechanical back pain British School of Osteopathy (2010). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities. Royal College of Surgeons – Breast Reduction Guide Weblink: https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/breast-reduction-guide/ NICE CG80 - Early and locally advanced breast cancer: diagnosis and treatment (2009). Weblink: https://www.nice.org.uk/guidance/cg80 NICE Quality Standard 12 – Breast Cancer (2016) Weblink: https://www.nice.org.uk/guidance/qs12 British Association of Plastic Reconstructive and Aesthetic Surgeons – Oncoplastic Breast Reconstruction Best Practice Guidelines (2012) Weblink: http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/final-oncoplastic-guidelines---healthcare-professionals.pdf?sfvrsn=0 Breast Cancer Care – Breast Reconstruction Weblink: https://www.breastcancercare.org.uk/information-support/facing-breast-cancer/going-through-treatment-breast-cancer/surgery/breast-reconstruction Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Health Commission Wales (2008). Greenbaum, a. R., Heslop, T., Morris, J., & Dunn, K. W. (2003). An investigation of the suitability of bra fit in women referred for reduction mammaplasty. *British Journal of Plastic Surgery*, *56*(3), 230–236. Wood, K., Cameron, M., & Fitzgerald, K. (2008). Breast size, bra fit and thoracic pain in young women: a correlational study. *Chiropractic & Osteopathy*, *16*(1), 1–7.

A14.2 Augmentation Mammoplasty - Breast Enlargement

Breast Enlargement
Breast Augmentation/enlargement involves inserting artificial implants behind the normal breast tissue to improve its size and shape.

Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

Intervention	Reduction Mammoplasty - Female Breast Reduction
Minimum eligibility criteria	Augmentation Mammoplasty will be funded if the patient meets ALL of the following criteria: • There is congenital absence of breast tissue unilaterally of three or more cup size difference as measured by a specialist. AND • The patient's BMI is under 25 and has been stable for at least 12 months AND • Aged over 18 years old.
Evidence for inclusion and threshold	NICE CG80 - Early and locally advanced breast cancer: diagnosis and treatment (2009). Weblink: https://www.nice.org.uk/guidance/cg80 NICE Quality Standard 12 – Breast Cancer (2016) Weblink: https://www.nice.org.uk/guidance/qs12 British Association of Plastic Reconstructive and Aesthetic Surgeons – Oncoplastic Breast Reconstruction Best Practice Guidelines (2012) Weblink: http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/final-oncoplastic-guidelines---healthcare-professionals.pdf?sfvrsn=0 Breast Cancer Care – Breast Reconstruction Weblink: https://www.breastcancercare.org.uk/information-support/facing-breast-cancer/going-through-treatment-breast-cancer/surgery/breast-reconstruction Dixon, J, et al, 1994, ABC of breast diseases: congenital problems and aberrations of normal breast development and involution, Br Med J, 309, 24 September, 797-800 Freitas, R, et al, 2007, Poland's Syndrome: different clinical presentations and surgical reconstructions in 18 cases, Aesthet Plast Surg, 31, 140-46.

	Heimberg, D, et al, 1996, The tuberous breast deformity: classification and treatment, Br J Plast Surg, 49, 339-45. Pacifico, M, et al, 2007, The tuberous breast revisited, J Plast Reconstruct Aesthet Surg, 60, 455-64. North Derbyshire, South Derbyshire and Bassetlaw Commissioning Consortium, 2007, Norcom commissioning policy – specialist plastic surgery procedures", 5-7. moderngov.rotherham.gov.uk/documents/s14201/Plastic%20Surgery%20report.pdf Sadove, C, et al, 2005, Congenital and acquired pediatric breast anomalies: a review of 20 years experience, Plast Reconstruct Surg, April, 115(4), 1039-1050. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service*

A14.3 Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation

COSMETIC SURGERY

Cosmetic surgery is often carried out to change a person's appearance in order to achieve what they perceive to be a more desirable look. Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely funded by the CCG Commissioner.

1. CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
2. CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment
3. The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor.
4. CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment
5. 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
6. CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance
7. Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered.

A good summary of Cosmetic Surgery is provided by NHS Choices.
Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

Intervention	Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation
Minimum eligibility criteria	Removal and/or replacement of silicone implants is not routinely commissioned. The removal of **ruptured** silicone implants will only be commissioned in the following circumstances: Where a patient has implants that have ruptured or failed, the patient should be referred back to the provider of the implants. If the clinic no longer exists or refuses to remove the implants, the NHS will remove ruptured implants or implants that have failed only, but will **not** replace them.
Evidence for inclusion and threshold	Poly Implant Prothèse (PIP) breast implants: final report of the Expert Group Department of Health (June 2012).

	NHS Choices: PIP breast implants http://www.nhs.uk/Conditions/PIP-implants/Pages/Introduction.aspx NHS Choices: Breast Enlargement http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/breast-enlargement.aspx Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service

A14.4 Mastopexy - Breast Lift

Mastopexy refers to the surgical correction of breasts that sag or droop. This can occur as part of the natural aging process, or pregnancy, lactation and substantial weight loss.
Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx

Intervention	Mastopexy - Breast Lift
Minimum eligibility criteria	This procedure is not routinely commissioned.
Evidence for inclusion and threshold	NICE Quality Standard 12 – Breast Cancer (2016) Weblink: https://www.nice.org.uk/guidance/qs12 British Association of Plastic Reconstructive and Aesthetic Surgeons – Oncoplastic Breast Reconstruction Best Practice Guidelines (2012) Weblink: http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/final-oncoplastic-guidelines---healthcare-professionals.pdf?sfvrsn=0 Breast Cancer Care – Breast Reconstruction Weblink: https://www.breastcancercare.org.uk/information-support/facing-breast-cancer/going-through-treatment-breast-cancer/surgery/breast-reconstruction NICE CG80 - Early and locally advanced breast cancer: diagnosis and treatment (2009). Weblink: https://www.nice.org.uk/guidance/cg80 Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service

A14.5 Surgical Correction of Nipple Inversion

Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded. This policy explicitly relates to correction of inverted nipples for cosmetic reasons.

Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx

Intervention	Surgical Correction of Nipple Inversion
Minimum eligibility criteria	This procedure is not routinely commissioned.
Evidence for inclusion and threshold	Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service

A14.6 Male Breast Reduction Surgery for Gynaecomastia

Gynaecomastia

Gynaecomastia is enlargement of the male breast tissue. It is defined as the presence of >2 cm of palpable, firm, subareolar gland and ductal breast tissue. It may occur at any time and there are a number of causes, some physiological and others pathological.

Pathological causes involve an imbalance between the activity of androgens and oestrogens - the former is decreased compared with the latter. Surgery
Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

Intervention	Male Breast Reduction Surgery for Gynaecomastia
Minimum eligibility criteria	This procedure is not routinely commissioned.
Evidence for inclusion and threshold	Dickson, G. (2012). Gynecomastia. *American Family Physician*, *85*(7), 716–722. Retrieved from: http://www.aafp.org/afp/2012/0401/p716.pdf NHS Choices: Breast Reduction (male) http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/breast-reduction-male.aspx Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service

A14.7 Policy for Policy for Hair Removal Treatments

Hair depilation can be used for excess hair (hirsutism) in a normal distribution pattern, or for abnormally placed hair. Permanent depilation may be achieved by electrolysis or laser therapy.

Hirsutism essentially means that an individual grows too much body or facial hair in a male pattern. Although hirsutism sometimes occurs in males, it is more difficult to detect because of the wide range of normal hair growth in men. Hirsutism affects approximately 10% of women in Western societies and is commoner in those of Mediterranean or Middle-Eastern descent.

A range of treatment options are available:

- Patients can self-fund options such as shaving, waxing, depilatories (hair removal creams) and bleaching creams. They can also self-fund the physical treatments listed below.
- Co-cyprindiol tablets (anti-androgen) may be prescribed. It should be noted however that eflornithine cream has Black status on the Pan Mersey formulary and is not recommended for prescribing.

Intervention	Policy for Policy for Hair Removal Treatments
Minimum eligibility criteria	The CCG will fund this treatment if the patient meets the following criteria: • Has undergone reconstructive surgery leading to abnormally located hair-bearing skin **OR** • Is undergoing treatment for pilonidal sinuses to reduce recurrence This means **(for patients who DO NOT meet the above criteria)** 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.
Evidence for inclusion and threshold	British Association of Dermatologists - hirsuitism patient information leaflet Weblink: http://www.bad.org.uk/shared/get-file.ashx?id=89&itemtype=document NHS Choices – Laser Hair Removal Weblink: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/laser-hair-removal.aspx Pan Mersey APC Guidance for Eflornithine: http://www.panmerseyapc.nhs.uk/recommendations/documents/PS158.pdf?UNLID=3067063562016122111329

A14.8 Surgical Treatment for Pigeon Chest - Pectus Anomaly

Pectus anomaly describes a deformity with the sternum (breastbone). The condition is the most common congenital wall deformity.
There are two main types of anomaly:

- **Pectus excavatum** (also known as “funnel chest”/”sunken chest”) in which the sternum is sunken inwards and the chest looks hollow
- **Pectus carinatum** (also known as “pigeon chest”) in which the sternum is raised and the chest pushed out. There may sometimes be a depression (dip) on one side and a protrusion (bulge) on the other.

There is also a rare third type of anomaly called **pectus arcuatum**. This is where there is a ridge high across the upper part of the sternum and so the rest of the chest falls away to a flatter shape.

Pectus anomalies occur in around four people in every 1,000 and are more common in men. Anomalies vary from mild to very marked.

Pectus anomalies are thought to be caused by poorly co-ordinated and possibly excessive growth of the costal (rib) cartilages. The anomaly occurs between the ribs and sternum (breast bone) before a child is born and can be excessive.

As the cartilagea grow longer, they “buckle” and push the sternum either inwards (pectus excavatum) or outwards (pectus carinatum).
Certain conditions are associated with pectus anomaly, such as:

- scoliosis – where the spine curves and becomes deformed
- Marfan’s syndrome – an inherited disorder of the connective tissue
- Poland’s syndrome – a rare inherited condition which involves the absence or underdevelopment of the chest muscles on one side of the body

A pectus anomaly is often seen at birth but usually becomes more obvious during early adolescence when growth is rapid. Once growth is complete the anomaly remains the same.

A good summary of Pectus deformities can be found here:
http://www.pectus.org/livingwith.htm

Intervention	Surgical Treatment for Pigeon Chest - Pectus Anomaly
Minimum eligibility criteria	This procedure is not routinely commissioned
Evidence for inclusion and threshold	nice.org.uk/guidance/IPG310 NICE (2009).

A14.9 Surgical Revision of Scars

The different types of scars include:

- **Flat, pale scars** – these are the most common type of scar and are due to the body's natural healing process. Initially, they may be red or dark and raised after the wound has healed, but will become paler and flatter naturally over time. This can take up to two years.
- **Hypertrophic scars** – red, raised scars that form along a wound and can remain this way for a number of years.
- **Keloid scars** – these are caused by an excess of scar tissue produced at the site of the wound, where the scar grows beyond the boundaries of the original wound, even after it has healed.
- **Pitted (atrophic or "ice-pick") scars** – these have a sunken appearance.
- **Contracture scars** – these are caused by the skin shrinking and tightening, usually after a burn, which can restrict movement.

Treating scars

Depending on the type and age of a scar, a variety of different treatments may help make them less visible and improve their appearance. Scars are unlikely to disappear completely, although most will gradually fade over time. If scarring is unsightly, uncomfortable or restrictive, treatment options may include:

- pressure dressings
- corticosteroid injections
- cosmetic camouflage (make-up)
- surgery

It is often the case that a combination of treatments can be used.

Intervention	Surgical Revision of Scars
Minimum eligibility criteria	The CCG will fund this treatment if the patient meets the following criteria: • For severe post burn cases or severe traumatic scarring **OR** • Revision surgery for scars following complications of surgery, keloid formation or other hypertrophic scar formation will only be commissioned where they are significantly functionally disabling or to restore normal function This means **(for patients who DO NOT meet the above criteria)** 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.
Evidence for inclusion and threshold	Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service

	NHS Choices – Scars - Treatment http://www.nhs.uk/Conditions/Scars/Pages/Treatment.aspx

A14.10 Laser Tattoo Removal

Tattoo fading involves using a laser to target tattoo ink in the skin. The laser heats the ink particles, so they break up and allow the body to absorb them. The amount of treatment needed varies, depending on the individual tattoo. However, it can take up to 12 sessions to treat a professional tattoo, which usually takes place once every eight weeks.
The results can vary, depending on the individual tattoo and the type or colour of ink used. Indian ink tattoos are usually easier to treat, and black and red inks tend to fade better. Some inks do not respond to treatment at all.

A good summary of Cosmetic Surgery is provided by NHS Choices.
Weblink:

http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

Intervention	Laser Tattoo Removal
Minimum eligibility criteria	Removal of Tattoos is not routinely commissioned.
Evidence for inclusion and threshold	Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Modernisation Agency's Action on Plastic Surgery 2005. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2 NHS Choices – The NHS Guide to cosmetic procedures Weblink: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/tattoo-removal.aspx

A14.11 Abdominoplasty/Apronectomy (sometimes called 'tummy tuck')

Abdominoplasty and apronectomy are surgical procedures performed to remove excess fat and skin from the mid and lower abdomen. Many people develop loose abdominal skin after pregnancy or substantial weight loss, whether it be due to surgical or dietary weight loss.

A good summary of Cosmetic Surgery is provided by NHS Choices.

Weblink: http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx
and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

Intervention	Abdominoplasty/Apronectomy (sometimes called 'tummy tuck')
Minimum eligibility criteria	These procedures are not routinely commissioned.
Evidence for inclusion and threshold	A systematic review of outcomes of abdominoplasty. Staalesen et al. Journal of Plastic Surgery and Hand Surgery, 09 2012, vol./is. 46/3-4(139-44). Royal College of Surgeons - Cosmetic Surgery Categorisation Weblink: https://www.rcseng.ac.uk/surgeons/surgical-standards/working-practices/cosmetic-surgery/documents/cosmetic-surgery-categorisation-and-requirements/at_download/file Royal College of Surgeons – Abdominplasty Guide Weblink: https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/tummy-tuck-abdominoplasty/ NHS Choices: Tummy Tuck (abdominoplasty http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/tummy-tuck.aspx Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service

A14.12 Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat

Thigh Lift, Buttock Lift and Arm Lift (Brachioplasty), Excision of Redundant Skin or Fat are surgical procedures performed to remove loose skin or excess fat to reshape body contours

A good summary of Cosmetic Surgery is provided by NHS Choices.

Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

Intervention	Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat
Minimum eligibility criteria	These procedures are not routinely commissioned.
Evidence for inclusion and threshold	Royal College of Surgeons (2013). https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/massive-weight-loss/ BAPRAS Commissioning Guide: Massive weight loss body contouring: http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/body-contouring-surgery-commissioning-guide-published.pdf?sfvrsn=0 Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service

A14.13 Surgical Treatments for hair Loss

Alopecia

Alopecia areata causes patches of baldness about the size of a large coin. They usually appear on the scalp but can occur anywhere on the body. It can occur at any age, but mostly affects teenagers and young adults.

In most cases of alopecia areata, hair will grow back in a few months. At first, hair may grow back fine and white, but over time it should thicken and regain its normal colour. Some people go on to develop a more severe form of hair loss, such as:

- Alopecia totalis (no scalp hair)
- Alopecia universalis (no hair on scalp or body)

Alopecia areata is caused by a problem with the immune system (the body's natural defence against infection and illness). It's more common among people with other autoimmune conditions, such as an overactive thyroid (hyperthyroidism), diabetes or Down's syndrome.

It's also believed some people's genes make them more susceptible to alopecia areata, as one in five people with the condition have a family history of the condition.

Alopecia areata can occur at any age, although it's more common in people aged 15-29. It affects one or two people in every 1,000 in the UK.

Further information can be found at following link:
http://www.alopeciaonline.org.uk/treatments-and-wigs.asp

Hair transplantation

A hair transplant is a procedure to move hair from an area unaffected by hair loss to an area of thinning or baldness. ,It is suitable for people with androgenetic alopecia (male- and female-pattern baldness) or scarring resulting from injury or burns. It is not usually appropriate for other types of hair loss, such as alopecia areata. A hair transplant isn't normally available on the NHS, as it is regarded as cosmetic surgery.

Male Pattern Baldness

Male-pattern baldness is the most common type of hair loss, affecting around half of all men by 50 years of age. It usually starts around the late twenties or early thirties and most men have some degree of hair loss by their late thirties.

It generally follows a pattern of a receding hairline, followed by thinning of the hair on the crown and temples, leaving a horseshoe shape around the back and sides of the head. Sometimes it can progress to complete baldness, although this is uncommon.

Male-pattern baldness is hereditary, which means it runs in families. It's thought to be caused by oversensitive hair follicles, linked to having too much of a certain male hormone

Intervention	Surgical Treatments for hair Loss
Minimum eligibility criteria	Surgical Treatment for Alopecia, hair transplantation, Male Pattern Baldness and hair intralace systems will not be routinely commissioned. The NHS has a policy for Wigs which may be an alternative option for patients: http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Wigsandfabricsupports.aspx The current cost is £67.75 for an acrylic wig with 2 allowed per year. There is no charge for chemotherapy patients.
Evidence for inclusion and threshold	British Association of Dermatologists - alopecia areata patient information leaflet Weblink: http://www.bad.org.uk/shared/get-file.ashx?id=1975&itemtype=document Interventions for alopecia areata – Cochrane Library 2008. http://www.bad.org.uk/library-media%5Cdocuments%5CAlopecia_areata_guidelines_2012.pdf Only one study which compared two topical corticosteroids showed significant short-term benefits. No studies showed long-term beneficial hair growth. None of the included studies asked participants to report their opinion of hair growth or whether their quality of life had improved with the treatment. No evidence of effective treatments for alopecia – Cochrane Pearls 2008. NICE Clinical Knowledge Summaries 2014. https://cks.nice.org.uk/alopecia-areata Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Modernisation Agency's Action on Plastic Surgery 2005. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2 NHS Choices – Guide to Hair Loss Treatment Weblink: http://www.nhs.uk/Conditions/Hair-loss/Pages/Treatment.aspx **Hair transplantation** *A trial on subcutaneous pedicle island flap for eyebrow reconstruction* – Mahmood & Mehri. Burns, 2010, Vol. 36(5), p692-697.

	Modernisation Agency's Action on Plastic Surgery 2005. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2

A14.16 Labiaplasty, Vaginoplasty and Hymenorrhaphy

Labiaplasty
A labiaplasty is a surgical procedure to reduce the size of the labia minora – the flaps of skin either side of the vaginal opening.

Vaginoplasty
Vaginoplasty is a reconstructive plastic surgery and cosmetic procedure for the vaginal canal and its mucous membrane, and of vulvo-vaginal structures that might be absent or damaged because of congenital disease (e.g., vaginal hypoplasia) or because of an acquired cause (e.g., childbirth physical trauma, cancer). The term vaginoplasty generally describes any such cosmetic reconstructive and corrective vaginal surgery, and the term neovaginoplasty specifically describes the procedures of either partial or total construction or reconstruction of the vulvo-vaginal complex.

Hyenorrhaphy
hymenorrhaphy or hymen reconstruction surgery, is a cosmetic procedure.

Weblink:
http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/labiaplasty.aspx

Intervention	Labiaplasty, Vaginoplasty and Hymenorrhaphy
Minimum eligibility criteria	These procedures are not routinely commissioned.
Evidence for inclusion and threshold	rcog.org.uk/globalassets/documents/guidelines/ethics-issues-and-resources/rcog-fgcs-ethical-opinion-paper.pdf (RCOG Statement 6). http://www.britspag.org/sites/default/files/downloads/Labiaplasty%20%20final%20Position%20Statement.pdf NHS Choices – Guide to Labiaplasty Weblink: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/labiaplasty.aspx Clinical characteristics of well women seeking labial reduction surgery: a prospective study. BJOG; 2011 Nov;118(12):1507-10. Liao, L-M; Michala, L; Creighton, SM. (2010). Labial Surgery for Well Women; a review of the literature. Goodman, M. P. (2009). Female Cosmetic Genital Surgery. *Obstetrics and Gynaecology; 113: 154-159*

	Bramwell R, Morland C, Garden A. (2007). Expectations and experience of labial reduction: a qualitative study. *BJOG* 2007; 114:1493-1499. Department for Education and Skills. (2004). *Local Authority Social Services Letter*. *LASSAL (2004)4,* London, DfES.

A14.17 Liposuction

Liposuction (also known as liposculpture) is a surgical procedure performed to improve body shape by removing unwanted fat from areas of the body such as abdomen, hips, thighs, calves, ankles, upper arms, chin, neck and back. Liposuction is sometimes done as an adjunct to other surgical procedures, such as cancer procedures.

A good summary of Cosmetic Surgery is provided by NHS Choices.
http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/liposuction.aspx

Intervention	Liposuction
Minimum eligibility criteria	Liposuction is not routinely commissioned.
Evidence for inclusion and threshold	Royal College of Surgeons – Liposuction: Weblink https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/liposuction/ NHS Choices: Liposuction http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/liposuction.aspx Liposuction for chronic lymphoedema NICE 2008. Modernisation Agency's Action on Plastic Surgery 2005. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2 Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service

A14.18 Rhytidectomy - Face or Brow Lift

A facelift (rhytidectomy) is cosmetic surgery to lift up and pull back the skin to make the face tighter and smoother. The procedure is designed to reduce flabby or sagging skin around the lower half of the face (mainly the jowls) and neck. If you're thinking of going ahead, be absolutely sure about your reasons for wanting a facelift and don't rush into it. The procedure can be expensive, the results can't be guaranteed, and there are risks to consider

Weblink:
http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/Facelift.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

Intervention	Face Lift or Brow Lift (Rhytidectomy)
Minimum eligibility criteria	Rhytidectomy is restricted for non-cosmetic/other reasons. The CCG will fund this treatment if the patient meets the minimum eligibility criteria below. Recognised diagnosis of Congenital (present from birth) facial abnormalities **OR** Facial palsy (congenital or acquired paralysis) **OR** As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis
Evidence for inclusion and threshold	Modernisation Agency's Action on Plastic Surgery 2005. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2 Royal College of Surgeons – Rhytidectomy Weblink https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/facelift/ NHS Choices: Facelift (Rhytidectomy) http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/Facelift.aspx

A16. Trauma and Orthopaedics

A16.1 Policy for non-invasive interventions for low Back pain and sciatica

Low back pain is soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs. Most people's low back pain is described as 'non-specific'. That means the pain is unlikely to be caused by an infection, a fracture or a disease like cancer.

Some people also get back symptoms radiating down one or both legs (radicular symptoms/sciatica). Radicular symptoms are caused, when the nerves from the back, are irritated causing pain, numbness or tingling down the leg. This pain, may vary from mild to severe, may be related to or triggered by a particular movement or action or it may be spontaneous. Most people will tend to suffer from back pain at some point in their lives and indeed it may recur. Most back pain usually improves enough within few days to few weeks, to be able to return to normal activities.

For such pain, it is best to continue with normal activities as much as possible, although you may need to return to them in stages, as the back pain steadily recovers. Getting back to work helps your recovery and employers will often arrange lighter duties to get you back sooner. Continuing with normal life as much as you can helps to take your mind off the pain and avoid you getting stiff and weak. Rest lying down, only when that's the only way to stop pain building up. Complete or prolonged bed rest is not advised at all as it is associated with delayed recovery.

If needed, simple analgesics (pain killers) help people with back pain or radicular pain keep active. Many of these are available over the counter. If advice is required then the local pharmacist or GP can help.

You should seek early advice from your GP if the low back pain does not respond to the measures described above, gets worse and certainly if it does not improve after six weeks. If you are on steroid medication, are at risk of osteoporosis or experience unsteadiness when you walk you should also contact your doctor.

Intervention	Policy for non-invasive interventions for low Back pain and sciatica
Policy Statement	Restricted
Minimum eligibility criteria	**Acupuncture** Acupuncture for low back pain and sciatica is **not routinely commissioned** **Manual Therapy** The following procedures are **not routinely commissioned**: • Lumbar traction • Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS) • Manual therapy (spinal mobilisation, manipulation, soft tissue

techniques and massage) in isolation.

Note: Consider manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy.

Orthotics

The following are **not routinely commissioned**:

- Foot orthotics
- Rocker shoes
- Belts and corsets

Electrotherapy

The following are **not routinely commissioned:**

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

Pharmacological interventions

The CCG **does not routinely commission** the following in the treatment of low back pain without Neuropathic pain:

- Paracetamol used alone
- Selective serotonin re-uptake inhibitors (**SSRIs**)
- Serotonin– norepinephrine reuptake inhibitors
- Tricyclic antidepressants
- Anti-convulsants
- Opioids for the management of acute back pain (if NSAIDs are contraindicated, ineffective or not tolerated then weak opioids may be given +/- paracetamol)

Patients with neuropathic pain should be managed in line with NICE CG 173:

- Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia)

1.1.9 If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated.

1.1.10 Consider tramadol only if acute rescue therapy is needed (see recommendation 1.1.12 about long-term use).

	1.1.11 Consider capsaicin cream[4] for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments. ***Treatments that should not be used*** 1.1.12 Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so: • cannabis sativa extract • capsaicin patch • lacosamide • lamotrigine • levetiracetam • morphine • oxcarbazepine • topiramate • tramadol (this is referring to long-term use; see recommendation 1.1.10 for short-term use) • venlafaxine.
Evidence for inclusion and threshold	Low back pain and sciatica in over 16s: assessment and management (November 2016) https://www.nice.org.uk/guidance/ng59 National Low Back and Radicular Pain Pathway 2017 http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf Osteoarthritis: the care and management of osteoarthritis in adults https://www.nice.org.uk/guidance/cg59 The effect of TAMARS treatments on chronic back pain, disability and quality of life - Lyndsey Mountain BSc Physiotherapy MCSP (Oct 2012) http://tamars.co.uk/wp/wp-content/uploads/2012/10/21stCenturyBackCare.pdf Final_TAMARS_report[1].pdf

A16.2 Imaging for patients presenting with low back pain

Imaging does not often change the initial management and outcomes of someone with back pain. This is because the reported imaging findings are usually common and not necessarily related to the person's symptoms. Many of the imaging findings (for example, disc and joint degeneration) are frequently found in asymptomatic people. Requests for imaging by non-specialist clinicians, where there is no suspicion of serious underlying pathology, can cause unnecessary distress and lead to further referrals for findings that are not clinically relevant.

Intervention	Imaging for patients presenting with low back pain.
Policy Statement	Restricted
Minimum eligibility criteria	X rays, MRI and CT scans are NOT routinely commissioned in non-specialist settings. For patients with non-urgent presentations consider imaging in specialist musculoskeletal settings for people with low back pain with or without sciatica only if the result is likely to change management i.e. prior to surgery. Imaging is only commissioned where patients present with red flags(see below) or concerns of serious underlying pathology (cancer, infection etc.) and requires urgent management. Emergency Spinal Referral • Suspected spinal cord neurology (gait disturbance, multilevel weakness in the legs and /or arms) • Impending Cauda Equina Syndrome (Acute urinary disturbance, altered perianal and/or genital sensation, (reduced anal tone and squeeze – if circumstances permit) • Major motor radiculopathy • Suspected Spinal Infection Priority Spine imaging (Protocol led MRI whole spine unless contraindicated) • Past history of cancer *(new onset spinal pain) • Recent unexplained weight loss • Objectively unwell with spinal pain • Raised inflammatory markers (relative to range anticipated for age) Plasma viscosity , CRP , ESR (according to local practice) • Possible immunosuppression with new spinal pain (IVDU, HIV, Chemotherapy, Steroids). • Prolonged steroid use * • Known osteoporosis, with new severe spinal pain

	Age <15, or >60 years new onset axial back pain *Statistically significant red flags. Although the others listed may not be
Evidence for inclusion and threshold	Low back pain and sciatica in over 16s: assessment and management (November 2016) https://www.nice.org.uk/guidance/ng59 Low back pain and sciatica in over 16s: assessment and management (November 2016) - Quality statement 2: Referrals for imaging https://www.nice.org.uk/guidance/qs155/chapter/Quality-statement-2-Referrals-for-imaging National Low Back and Radicular Pain Pathway 2017 http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173

A16.3 Injections for back pain

NICE 2016 recommend against repeated spinal injections for managing low back pain

Intervention	Injections for back pain
Policy Statement	Restricted
Minimum eligibility criteria	Therapeutic Facet Joint injection, therapeutic medial branch block, prolotherapy, Botulinum Toxin and Trigger Point Injections are Not routinely commissioned **<u>Epidural</u>** Single shot epidural steroid is of short-term benefit in acute and severe sciatica and may enable normal activity to resume. Benefits and risks should be discussed with the patient. Epidural injections should be targeted at the affected nerve root(s) and under image guidance where required. Only one injection should be offered and this should only be offered where: • symptoms are acute AND • The patient is experiencing severe sciatica. Epidural Injection for Non-specific Low Back Pain of greater than 12 months, is not routinely commissioned. Epidural injection for neurogenic claudication in patients with central stenosis is not routinely commissioned. **Radiofrequency Facet Joint Denervation** Treatments for low back pain will only be commissioned in line with NICE guidance NG59 'Low back pain and sciatica in over 16s: assessment and management' (November 2016) The CCG will fund a single procedure of radiofrequency denervation for people with chronic low back pain when: • comprehensive conservative treatment approach has not • worked for them AND • the main source of pain is thought to come from structures supplied by the medial branch nerve AND

	• The clinical presentation is consistent with symptoms arising from the facet joint:
	  ○ Increased pain unilaterally or bilaterally on lumbar paraspinal palpation
	  ○ Increased back pain on 1 or more of the following: o extension (more than flexion); rotation; extension/side flexion; extension/rotation
	  ○ No radicular symptoms
	  ○ No sacroiliac joint pain elicited using a provocation test
	AND
	• they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral
	AND
	• low back pain is chronic in nature
	AND
	• The patient has significant short term pain relief to a diagnostic medial branch block.
	
	Do not offer imaging for people with low back pain with specific facet join pain as a prerequisite for radiofrequency denervation.
	
	Providers who offer radiofrequency denervation will be expected to submit patient outcome data to the UK National Spinal RF Registry http://cl1.n3-dendrite.com/csp/spinalrf/FrontPages/index.html

Evidence for inclusion and threshold	Low back pain and sciatica in over 16s: assessment and management (November 2016) https://www.nice.org.uk/guidance/ng59 National Low Back and Radicular Pain Pathway 2017 http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173

A16.4 Spinal Fusion

Spinal fusion is used to join two or more vertebrae together by placing an additional section of bone in the space between them.

This helps to prevent excessive movements between two adjacent vertebrae, lowering the risk of further irritation or compression of the nearby nerves and reducing pain and related symptoms.

The additional section of bone can be taken from somewhere else in your body (usually the hip) or from a donated bone. More recently, synthetic (man-made) bone substitutes have been used.

To improve the chance of fusion being successful, some surgeons may use screws and connecting rods to secure the bones.

Afterwards, the surgeon will close the incision with stitches or surgical staples.

http://www.nhs.uk/Conditions/Lumbardecompressivesurgery/Pages/surgery.aspx

Intervention	**Spinal Fusion**
Minimum eligibility criteria	The following procedures are not routinely commissioned: • Fusion • Non-rigid stabilisation techniques • Lateral body fusion in the lumbar spine • Transaxial interbody lumbrosacral fusion • Anterior lumbar interbody fusion (ALIF) • Posterior lumbar interbody fusion (PLIF) • Or any other combination of approach where surgical fixation is performed
Evidence for inclusion and threshold	Low back pain and sciatica in over 16s: assessment and management (November 2016) https://www.nice.org.uk/guidance/ng59 National Low Back and Radicular Pain Pathway 2017 http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173 IPG 387: https://www.nice.org.uk/guidance/ipg387 Transaxial interbody lumbosacral fusion

A16.5 Disc and Decompression procedures

Lumbar decompression surgery is a type of surgery used to treat compressed nerves in the lower (lumbar) spine.

It's only recommended when non-surgical treatments haven't helped.

The surgery aims to improve symptoms such as persistent pain and numbness in the legs caused by pressure on the nerves in the spine.

Lumbar decompression surgery is often used to treat:
•spinal stenosis – narrowing of a section of the spinal column, which puts pressure on the nerves inside
•a slipped disc and sciatica – where a damaged spinal disc presses down on an underlying nerve
•spinal injuries – such as a fracture or the swelling of tissue
•metastatic spinal cord compression – where cancer in one part of the body, such as the lungs, spreads into the spine and presses on the spinal cord or nerves

Intervention	Disc and Decompression procedures
Policy Statement	Restricted
Minimum eligibility criteria	Spinal decompression i.e. laminectomy, discectomy, facetectomy, foraminotomy, is commissioned where: • Patient presents with severe and acute sciatica AND • have failed to respond to conservative intervention AND • have imaging findings concordant with clinical presentation Patient outcome data must be entered onto the international registry database Spine Tango and providers are expected to regularly participate in the Cheshire and Mersey MDT Spinal Network. The following procedures are NOT routinely commissioned: • Endoscopic Laser Foraminoplasty • Endoscopic Lumbar Decompression • Percutaneous Disc Decompression using Coblation for Lower Back Pain • Percutaneous Intradiscal Laser Ablation in the Lumbar Spine • Automated Percutaneous Mechanical Lumbar Discectomy • Prosthetic Intervertebral Disc Replacement in the Lumbar Spine • Intradiscal Electro Thermal Annuloplasty (IDET) • Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)

Evidence for inclusion and threshold	Low back pain and sciatica in over 16s: assessment and management (November 2016) https://www.nice.org.uk/guidance/ng59 National Low Back and Radicular Pain Pathway 2017 http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173 IPG31 Endoscopic laser foraminoplasty: guidance NICE 2003 (confirmed 2009) Reviewed October 2011 – Decision taken that this policy does not require update. IPG570: https://www.nice.org.uk/guidance/ipg570 Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica (December 2016) IPG543: https://www.nice.org.uk/guidance/ipg543 Percutaneous coblation of the intervertebral disc for low back pain and sciatica IPG:357 https://www.nice.org.uk/guidance/ipg357 Percutaneous intradiscal laser ablation in the lumbar spine IPG141: https://www.nice.org.uk/guidance/ipg141 Automated percutaneous mechanical lumbar discectomy IPG 306: Prosthetic intervertebral disc replacement in the lumbar spine NICE 2009.

A16.6 Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain

The lower back is commonly defined as the area between the bottom of the rib cage and the buttock creases. Chronic low back pain is tension, soreness and/or stiffness often worsened by movement lasting more than six weeks in the lower back region. Low back pain is a common disorder, affecting around one-third of the UK adult population each year. Peripheral nerve-field stimulation involves implanting electrodes in the back, connected to a neurostimulator under the skin. The aim is to mask the back pain by modulating the transmission of pain signals to the brain. The patient uses a remote control to deliver low voltage electrical stimulation to the subcutaneous tissue layers of the lower back. The stimulation causes a tingling sensation (paraesthesia) in the area of the body associated with the pain, easing the discomfort.

https://www.nice.org.uk/guidance/ipg451

Intervention	Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain
Minimum eligibility criteria	This procedure is not routinely commissioned.
Evidence for inclusion and threshold	NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173 IPG 451: Peripheral nerve-field stimulation (PNFS) for chronic low back pain NICE 2013. Current evidence on the efficacy of peripheral nerve-field stimulation (PNFS) for chronic low back pain is limited in both quantity and quality, and duration of follow-up is limited. Evidence on safety is also limited and there is a risk of complications from any implanted device

A16.7 Therapeutic endoscopic Division of epidural adhesions

Endoscopic epidural procedures are used to treat lower back pain, particularly when radiculopathy is present. The epidural space is examined with an endoscope and further interventions may then be performed, such as mobilising spinal adhesions or administering drugs to inflamed tissue.

Intervention	Therapeutic Endoscopic Division of Epidural Adhesions
Minimum eligibility criteria	This procedure is not routinely commissioned.
Evidence for inclusion and threshold	IPG333: https://www.nice.org.uk/guidance/ipg333 Therapeutic endoscopic division of epidural adhesions NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173 Current evidence on therapeutic endoscopic division of epidural adhesions is limited to some evidence of short-term efficacy, and there are significant safety concerns.

A16.19 Hyaluronic Acid and Derivatives Injections for Peripheral joint pain

Intervention	Policy for Hyaluronic Acid and Derivatives Injections for Peripheral joint pain
Minimum eligibility criteria	This procedure is not routinely commissioned.
Rationale	Hyaluronic Acid and Derivatives Injections are not commissioned for joint injections. **Do not offer intra-articular hyaluronan injections for the management of osteoarthritis**
Evidence for inclusion and threshold	**Do Not Do Recommendation** https://www.nice.org.uk/donotdo/do-not-offer-intraarticular-hyaluronan-injections-for-the-management-of-osteoarthritis

A16.23a Hip Replacement Surgery

A hip replacement is a common type of surgery where a damaged hip joint is replaced with an artificial one (known as a prosthesis). The hip joint is one of the largest joints in the human body and is what is known as a "ball and socket joint". In a healthy hip joint, the bones are connected to each other with bands of tissue known as ligaments. These ligaments are lubricated with fluid to reduce friction. Joints are also surrounded by a type of tissue called cartilage that is designed to help support the joints and prevent bones from rubbing against each other.

The main purpose of the hip joints is to support the upper body when a person is standing, walking and running, and to help with certain movements, such as bending and stretching.
Some common reasons why a hip joint can become damaged include:

- osteoarthritis – so-called "wear and tear arthritis", where the cartilage inside a hip joint becomes worn away, leading to the bones rubbing against each other
- rheumatoid arthritis – this is caused by the immune system (the body's defence against infection) mistakenly attacking the lining of the joint, resulting in pain and stiffness
- hip fracture – if a hip joint becomes severely damaged during a fall or similar accident it may be necessary to replace it

Many of the conditions treated with a hip replacement are age-related so hip replacements are usually carried out in older adults aged between 60 and 80. However, a hip replacement may occasionally be performed in younger people.
The purpose of a new hip joint is to:

- relieve pain
- improve the function of your hip
- improve your ability to move around
- improve your quality of life

Referral for elective hip surgery should be considered for people with osteoarthritis who experience the following joint symptoms-

- Pain
- Stiffness
- reduced function

Patients should be informed that the decision to have surgery can be a dynamic process and a decision to not undergo surgery now, does not exclude them from having surgery at a future point in time.

Intervention	Hip Replacement Surgery
Minimum eligibility criteria	Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant. **Referral criteria for Total Hip Replacements (THR)** should be based on the level of pain and functional impairment suffered by the

	patient. Funding is available for patients who fulfil the following criteria; 1. Patient complains of severe joint pain. AND 2. Functional limitation, despite the use of non- surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. OR 3. Patient complains of mild to moderate joint pain AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. The CCGs will fund hip resurfacing for those who otherwise qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements as restricted by NICE Guidance Hip disease - metal on metal hip resurfacing (TA44).

Guidance/evidence

Royal College of Surgeons – Painful Hip Commissioning Guide
https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/painful-hip-guide/

NICE – Clinical Guidance 177: Osteoarthritis: care and management (2014)
Weblink:
https://www.nice.org.uk/guidance/cg177

NHS Choices – Hip replacement
Weblink:
http://www.nhs.uk/Conditions/Hip-replacement/Pages/Introduction.aspx

A16.23b Policy for Knee Replacement Surgery

Knee replacement surgery (arthroplasty) involves replacing a damaged, worn or diseased knee with an artificial joint. It's a routine operation for knee pain most commonly caused by arthritis. More than 70,000 knee replacements are carried out in England and Wales each year, and the number is rising. Most people who have a total knee replacement are over 65 years old.

For most people, a replacement knee lasts over 20 years, especially if the new knee is cared for properly and not put under too much strain.

There are two main types of surgery, depending on the condition of the knee:

- total knee replacement (TKR) – both sides of your knee joint are replaced
- partial (half) knee replacement (PKR) – only one side of your joint is replaced in a smaller operation with a shorter hospital stay and recovery period

The most common reason for knee replacement surgery is osteoarthritis. Other conditions that cause knee damage include:

- rheumatoid arthritis
- haemophilia
- gout
- knee injury

A knee replacement is major surgery, so is normally only recommended if other treatments, such as physiotherapy or steroid injections, haven't helped reduce pain or improve mobility. You may be offered knee replacement surgery if:

- You have severe pain, swelling and stiffness in your knee joint and your mobility is reduced
- your knee pain is so severe that it interferes with your quality of life and sleep
- everyday tasks, such as shopping or getting out of the bath, are difficult or impossible
- you cannot work or have a normal social life

Referral for joint replacement surgery should be considered for people with osteoarthritis who experience all of the following joint symptoms;

- Pain
- Stiffness
- Reduced function

Intervention	Knee Replacement Surgery
Minimum eligibility criteria	Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant. **Funding for total or partial knee replacement surgery is available if the**

	following criteria are met 1. Patients with BMI <40. AND 2. Patient complains of moderate joint pain AND moderate to severe functional limitations that has a substantial impact on quality of life, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. AND 3. Has radiological features of severe disease. OR 4. Has radiological features of moderate disease with limited mobility or instability of the knee joint.

Guidance/evidence

Royal College of Surgeons - Commissioning Guide for Painful Osteoarthritis of the Knee (2017)
Weblink:
https://www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/commissioning/boa--painful-oa-knee-guide-final-2017.pdf?la=en

NICE – Clinical Guidance 177: Osteoarthritis: care and management (2014)
Weblink:
https://www.nice.org.uk/guidance/cg177

Journal of Arthroplasty, 2013, 28(5), p714-721, A workgroup of the American Association of Hip and, Obesity and total joint arthroplasty: a literature based review
Saif Salih* and Paul Sutton (2013). Obesity, knee osteoarthritis and knee arthroplasty: a review. BMC Sports Science, Medicine and Rehabilitation:5(25)
Weblink:
(http://www.biomedcentral.com/2052-1847/5/25)

NHS Choices – Knee replacement
Weblink:
http://www.nhs.uk/conditions/Knee-replacement/Pages/Kneereplacementexplained.aspx

A16.30 Surgical Removal of Ganglions

A ganglion is a non-cancerous fluid-filled lump which can occur near joints or tendons. It is most commonly found on the wrist or hands. The cyst can range from the size of a pea to the size of a golf ball. Ganglions can occur alongside any joint in the body, but are most common on the wrist (particularly the back of the wrist), and the hand and fingers.

Ganglions are harmless, but can sometimes be painful. If they do not cause any pain or discomfort, they can be left alone and may disappear without treatment, although this can take a number of years.

The two main treatment options for a ganglion cyst are:

- draining fluid out of the cyst with a needle and syringe – the medical term for this is aspiration
- cutting the cyst out using surgery

Intervention	Surgical Removal of Ganglions
Policy Statement	Aspiration and Surgery for ganglion (open or arthroscopic) is **not routinely commissioned.** Reassurance that no treatment is required should be given to the patient.
Rationale	This is because a ganglion will often disappear on its own after a year or two.
Evidence for inclusion and threshold	Ganglion Cysts – British Society for Surgery of the Hand http://www.bssh.ac.uk/patients/conditions/20/ganglion_cysts NHS Choices - Ganglion cyst Weblink: http://www.nhs.uk/conditions/Excisionofganglion/Pages/Introduction.aspx

A17. Urology

A17.1 Policy for Circumcision for medical reasons only

Male circumcision is the surgical removal of the foreskin.
The foreskin is the retractable fold of skin that covers the end of the penis. It's a continuation of the skin that covers the whole penis.

Further information can be found at:
http://www.nhs.uk/Conditions/Circumcision/Pages/Introduction.aspx

Intervention	Circumcision for medical reasons only
Minimum eligibility criteria	**Circumcision will be funded in the following medical circumstances**: • Balantis xerotica obliterans. • Traumatic foreskin injury/scarring where it cannot be salvaged. • 3 or more episodes of balanitis/balanoposthitis. • Pathological phimosis. • Irreducible paraphimosis. • Recurrent proven Urinary Tract. Infections (UTIs) with an abnormal urinary tract. • Tight foreskin causing pain on arousal/ interfering with sexual function This is because if the patient does not meets the medical indications above non-medical circumcisions do not confer any health gain but do carry health risk. This procedure is not offered for social, cultural or religious reasons.
Evidence for inclusion and threshold	2008 UK National Guideline on the Management of Balanoposthitis – Clinical Effectiveness Group British Association for Sexual Health and HIV (2008). Balanitis NICE Clinical Knowledge Summaries 2015 I don't know, let's try some canestan: an audit of non-specific balanitis treatment and outcomes Sexually Transmitted Infections 2012;88:A55-A56. Balanitis Patient.co.uk. https://www.rcseng.ac.uk/-/.../rcs/.../foreskin-conditions--

	commissioning-guide.pdf Foreskin Conditions: Royal College of Surgeons guidance (2013). NHS Choices – Circumcision Weblink: http://www.nhs.uk/Conditions/Circumcision/Pages/Introduction.aspx Male Circumcision: Guidance for Healthcare Practitioners Royal College of Surgeons, 2000 https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/male-circumcision/

A18. Vascular Surgery

A18.3 Policy for Varicose Veins Interventional Treatments e.g. endothermal ablation, foam sclerotherapy and surgery

Varicose veins are veins that have become wider than normal and are unable to transport blood properly so that blood collects in them. This can cause heaviness, aching, throbbing, itching, cramps and fatigue in the legs. In severe cases, patients may develop skin discoloration or inflammation and skin ulcers.

• Varicose veins are common affecting 15% to 30% of the adult population.

• They are tortuous distended bulging veins lying beneath the skin in the legs.

• They commonly arise from incompetence in the long and short saphenous veins and their branches, though they may be secondary varicosities with associated deep venous disease.

• They are not to be confused with intra-dermal spider veins or thread veins which lie within the skin.

• Complications from varicose veins include eczema, induration (lipodermatosclerosis), pigmentation, bleeding, thrombophlebitis and ulceration.

• Patients complain both of the appearance and report symptoms such as aching in the leg, pains in the leg, restlessness, cramps, itchiness, heaviness and swelling.

• Varicose eczema if severe or inflamed can be treated effectively with topical steroids.

• Thrombophlebitis usually responds to leg elevation, topical or systemic NSAID's and stockings. Antibiotics are occasionally required for secondary infection.

For most people, varicose veins do not present a serious health problem. They may have an unpleasant appearance, but should not affect circulation or cause long-term health problems. Most varicose veins do not require any treatment.

Before surgical treatment is necessary, your doctor may first provide advice on:

• weight loss (for guidance on weight management see Obesity [NICE clinical guideline 43]

• light to moderate physical activity

• avoiding factors that are known to make their symptoms worse if possible

• when and where to seek further medical help.

Intervention	Varicose Veins Interventional Treatments e.g. endothermal ablation, foam sclerotherapy and surgery
Minimum eligibility criteria	Treatment of varicose veins is only commissioned in the following circumstances: • Varicose veins which have bled and are at risk of bleeding again (immediate referral recommended). ***OR*** • A history of varicose ulceration ***OR*** • Signs of prolonged venous hypertension (haemasiderin pigmentation, eczema, induration lipodermatosclerosis), or

	significant oedema associated with skin changes ***OR*** • Documented episodes of superficial thrombophlebitis in association with varicose veins **Note:** compression hosiery should not be offered to treat varicose veins **unless** interventional treatment is inappropriate or declined. This means **(for patients who DO NOT meet the specified criteria)** 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.
Rationale	This is because if the above NICE and RCS criteria are met the Varicose Vein treatments detailed above are likely to reduce the likelihood of disease progression and improve quality of life by reducing symptoms
Evidence for inclusion and threshold	NICE - Clinical Guideline 168: Varicose veins in the legs: the diagnosis and management of varicose veins (2013): Weblink: http://guidance.nice.org.uk/CG168 Royal College of Surgeons - Commissioning guide: varicose veins (2013) Weblink: https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/varicose-veins-guide/ NHS Choices – Varicose veins Weblink: http://www.nhs.uk/conditions/Varicose-veins/Pages/Whatarevaricoseveins.aspx Tassie E, Scotland G, Brittenden J, et al., on behalf of the CLASS Study team. Cost-effectiveness of ultrasound guided foam sclerotherapy (UGFS), endovenous laser ablation (EVLA), and surgery as treatments for primary varicose veins: results based on the CLASS trial. Br J Surg. 2014;101(12):1532-40. Marsden, G; Perry, M; Bradbury, A; Hickey, N; Kelley, K; Trender, H; Wonderling, D; Davies, A H. A Cost-effectiveness Analysis of Surgery, Endothermal Ablation, Ultrasound-guided Foam Sclerotherapy and Compression Stockings for Symptomatic Varicose Veins. European journal of vascular and endovascular surgery : the official journal of the European Society for Vascular Surgery; Dec 2015; vol. 50 (no. 6); p. 794-801

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B1. Complementary Therapies			
B1.1 Complementary Therapies	Not routinely commissioned unless recommended by NICE guidance.	*Complementary and alternative medicine* – NHS Choices 2012. http://www.parliament.uk/business/committees/committees-a-z/commons-select/science-and-technology-committee/inquiries/homeopathy-/	Individual CCG addendums apply.
B2. Dermatology			
B2.1 Skin Resurfacing Techniques (including laser dermabrasion and chemical peels)	Only be commissioned in the following circumstances: Severe scarring following: Acne once the active disease is controlled. Chicken pox. OR Trauma (including post-surgical). Procedures will only be performed on the head and neck area. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Modernisation Agency's Action on Plastic Surgery 2005. Hædersdal, M., Togsverd-Bo, K., & Wulf, H. (2008). Evidence-based review of lasers, light sources and photodynamic therapy in the treatment of acne vulgaris. *Journal of the European Academy of Dermatology and Venereology*, *22*, 267–78. Department of Dermatology, Bispebjerg Hospital, University of Copenhagen, Copenhagen, Denmark. Collated on NHS evidence website suggests that short-term efficacy from optical treatments for acne vulgaris with the most consistent outcomes for PDT. www.evidence.nhs.uk Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B2.4 Treatments for Skin Pigment Disorders	NHS Cosmetic Camouflage is commissioned. This is provided by Changing Faces formerly the Red Cross.* Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	http://www.changingfaces.org.uk/Skin-Camouflage Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	Initially the recommended NHS suitable treatment for hypo – pigmentation is biopsy of suspicious lesions only. Access to a qualified camouflage beautician should be available on the NHS for Cosmetic Camouflage and other skin conditions requiring camouflage. *Access available for Wirral patients via Dermatology Department.
B2.5 Surgical/Laser Therapy for Viral Warts (excluding Genital Warts) from Secondary Care Providers	Will be commissioned in any of the following circumstances: Severe pain substantially interfering with functional abilities. Persistent and spreading after 2 years and refractive to at least 3 months of primary care or community treatment. Extensive warts (particularly in the immune-suppressed patient). Facial warts. Patients with the above exceptional symptoms may need specialist assessment, usually by a dermatologist.	Modernisation Agency's Action on Plastic Surgery 2005. Nongenital warts: recommended approaches to management Prescriber 2007 18(4) p33-44. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service patient.co.uk/doctor/viral-warts-excluding-verrucae http://www.patient.co.uk/doctor/verrucae	Most viral warts will clear spontaneously or following application of topical treatments. 65% are likely to disappear spontaneously within 2 years. There are numerous OTC preparations available. Community treatments such a cryosurgery, curettage, prescription only topical treatment should be considered before referral to secondary care.

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments

B3. Diabetes

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B3.1 Continuous Glucose Monitoring Systems for Continuous Glucose Monitoring in Type 1 Diabetes Mellitus	Not routinely commissioned and only considered if ALL of the following criteria are met; Type I diabetes. AND Currently on a sensor augmented continuous subcutaneous insulin pump in strict accordance with NICE appraisal TAG 151. AND HbA1c which is equal to or greater than 69 (8.5%) mmol/OR experiencing severe hypoglycaemic attacks which require intervention by a carer. AND Selected to use an approved sensor augmented pump system of high specification with a low Mean Absolute Relative Difference (MARD) value. AND Managed by a recognised centre of excellence in diabetes (currently using a minimum of 20 continuous infusion pumps per annum). AND Motivated to comply with the requirements. The device should be withdrawn from patients who fail to achieve clinically significant response after 6 months. All cases will be subject to individual approval by the IFR Team.	Continuous glucose monitoring systems for type 1 diabetes mellitus – Cochrane Database of Systematic Reviews, 2012. Beneficial effect of real-time continuous glucose monitoring system on glycaemic control in type 1 diabetic patients: systematic review and meta-analysis of randomized trials. – European Journal of Endocrinology. 2012 Apr; 166(4):567-74. Glycaemic control in type 1 diabetes during real time continuous glucose monitoring compared with self-monitoring of blood glucose: meta-analysis of randomised controlled trials using individual patient data - BMJ. 2011; 343: d3805. Continuous Glucose Monitoring for Patients with Diabetes – Ontario: Health Quality Ontario, 2011. Continuous glucose monitoring: consensus statement on the use of glucose sensing in outpatient clinical diabetes care - British Society for Paediatric Endocrinology and Diabetes, 2009. For further references please refer to Public Health Continuous Glucose Monitors Paper.	PH Continuous Glucose Monitors Pap PH Continuous Glucose Monitors Add

B4. ENT

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B4.3a Insertion of Grommets for Glue Ear (otitis media with effusion) - CHILDREN	CHILDREN The CCG will commission treatment with grommets/myringotomy for children with otitis media with effusion (OME) where: • There is a history of recurrent acute otitis media (RAOM) defined as 3 or more acute infections in 6 months or at least 4 in a year. OR • There has been a period of at least three months watchful waiting from the date of diagnosis of OME (by a GP/primary care referrer/ audiologist/ENT surgeon). AND • OME persists after three months. AND • The child (who must be over three years of age) suffers from persistent bilateral OME with a hearing level in the better ear of 25-30 dBHL (averaged at 0.5, 1, 2 and 4kHz) or worse confirmed over 3 months. OR • Persistent bilateral OME with hearing loss less than 25-30 dBHL (averaged at 0.5, 1, 2 and 4kHz) and with significant impact on the child's developmental, social or educational status. Children with Downs Syndrome are normally fitted with Hearing Aids. Management of children with cleft palate is under specialist supervision. Do not perform adenoidectomy at the same time unless evidence of significant upper respiratory tract symptoms see Section 5.1 Adenoidectomy.	http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/ome Royal College of Surgeons (2013). NICE Pathway – Surgical management of Otitis Media with effusion in children (2012). CG60 Surgical management of children with otitis media with effusion (OME) (February 2008). The advice in the NICE guideline covers: • The surgical management of OME in children younger than 12 years. • Guidance for managing OME in children with Down's syndrome and in children with all types of cleft palate. It does not specifically look at the management of OME in: •Children with other syndromes (for example, craniofacial dysmorphism or polysaccharide storage disease). •Children with multiple complex needs. *Grommets (ventilation tubes) for hearing loss associated with otitis media with effusion in children* - Cochrane Ear, Nose and Throat Disorders Group 2010. http://pathways.nice.org.uk/pathways/surgical-management-of-otitis-media-with-effusion-in-children - path=view%3A/pathways/surgical-management-of-otitis-media-with-effusion-in-children/assessment-and-treatment-for-children-with-otitis-media-with-effusion-without-downs-syndrome-or-cleft-palate.xml&content=view-node%3Anodes-surgical-interventions http://www.england.nhs.uk/wp-content/uploads/2013/11/N-SC015.pdf	

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B4.3b Insertion of Grommets for Glue Ear (otitis media with effusion) - ADULTS	ADULTS Grommets in adults with OME will be funded only in the following circumstances: • Significant negative middle ear pressure measured on two sequential appointments. AND • Significant ongoing associated pain. OR • Unilateral middle ear effusion where a post nasal space biopsy is required to exclude an underlying malignancy.	http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/ome Royal College of Surgeons (2013). http://www.england.nhs.uk/wp-content/uploads/2013/11/N-SC015.pdf	
B4.5 Surgical Remodelling of External Ear Lobe	This is not routinely commissioned.	Modernisation Agency's Action on Plastic Surgery 2005.	Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk.
B4.6 Use of Sinus X-ray	X-rays of sinuses are not routinely commissioned.	BSACI guidelines for the management of rhinosinusitis and nasal polyposis Clinical & Experimental Allergy Volume 38, Issue 2, Article first published online: 20 DEC 2007. NHS Choices Sinusitis http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/rhinosinusitus Royal College of Surgeons (2013).	

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B4.8 Surgery of Laser Treatment of Rhinophyma	Not routinely commissioned.	Nuances in the management of rhinophyma Facial Plastic Surgery, 2012 Apr;28(2):231-7. http://www.patient.co.uk/doctor/Rosacea-and-Rhinophyma.htm http://www.nhs.uk/Conditions/Rosacea/Pages/Treatment.aspx	The first-line treatment of this condition of the nasal skin is medical. However response is poor. Severe cases that do not respond to medical treatment may be considered for surgery or laser treatment in exceptional circumstances.
B5. Equipment			
B5.1 Use of Lycra Suits	Lycra Suits are not normally commissioned for postural management of cerebral palsy. Evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy.	What is the clinical and cost effectiveness of dynamic elastomeric fabric orthoses (DEFOs) for cerebral palsy? Health Improvement Scotland, May 2013. For further references please refer to Public Health Lycra Suits Paper.	Any application for exceptional funding should include a comprehensive assessment of the child's postural management needs with clear outcome goals and time frames. Public Health Recommendation: Current evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy. Lycra suit orthoses for cerebral palsy should be assigned low priority. Individual CCG addendums apply. PH Lycra Suits Paper.pdf

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B6. Fertility			
B6.1 Infertility Treatment for Subfertility e.g. medicines, surgical procedures and assisted conception. This also includes reversal of vasectomy or female sterilisation	See Cheshire & Merseyside Infertility Policy.	CG156 Fertility: Assessment and treatment for people with fertility problems – NICE 2013. Contraception – sterilization – NICE Clinical Knowledge Summaries 2012 http://cks.nice.org.uk/contraception-sterilization#!scenario	Individual CCG addendums apply.
B7. General Surgery			
B7.4 Lithotripsy for Gallstones	Lithotripsy not routinely commissioned.		Lithotripsy rarely performed as rate recurrence high.
B9. Mental Health			

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B9.1 Inpatient Care for Treatment of Chronic Fatigue Syndrome (CFS)	Inpatient care for Chronic Fatigue Syndrome is not routinely commissioned. If inpatient treatment is recommended an IFR referral will be required.	*Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management of CFS/ME in adults and children* – NICE 2007, CG53. *Cognitive behaviour therapy for chronic fatigue syndrome in adults* - Cochrane Depression, Anxiety and Neurosis Group 2008. *Adaptive pacing, cognitive behaviour therapy, Graded exercise, and specialist medical care for chronic fatigue syndrome: A cost-effectiveness analysis* - . PLoS ONE 7(8): e40808. doi:10.137. *Cost-effectiveness of counselling, graded-exercise and usual care for chronic fatigue: evidence from a randomised trial in primary care* - BMC Health Services Research 2012, 12:264.	Care of persons with CFS should take place in a community setting under the care of a specialist in CFS if necessary. NICE section 1.915 states: Most people with CFS will not need hospital admission. However, there may be circumstances when a planned admission should be considered. The decision to admit should be made with the person with CFS and their family, and be based on an informed consideration of the benefits and disadvantages. For example, a planned admission may be useful if assessment of a management plan and investigations would require frequent visits to the hospital.
B9.3 Non-NHS Drug and Alcohol Rehabilitation (non-NHS commissioned services)	This is not routinely commissioned.	Interventions to reduce substance misuse among vulnerable young people – NICE Public Health Guidance 4 (2007) Drug misuse: psychosocial interventions – NICE Clinical Guideline 51 (2007). Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence – NICE Clinical Guideline 115 (2011).	
B10. Neurology			

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B10.1 Bobath Therapy	Bobath Therapy is not routinely commissioned by the NHS. The evidence base is poor for both children and adults.	The Effectiveness of the Bobath Concept in Stroke Rehabilitation: What is the Evidence? Stroke, 2009; 40:e89-e97. Can physiotherapy after stroke based on the Bobath Concept result in improved quality of movement compared to the motor relearning programme Physiotherapy Research International Volume 16, Issue 2, pages 69–80, June 2011. Bobath Concept versus constraint-induced movement therapy to improve arm functional recovery in stroke patients: a randomized controlled trial Clinical Rehabilitation, 2012 Aug;26(8):705-15. http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/GB%20Meetings/2013/05%20March/Agenda%20Item%202.5a%20-%20Bobath%20Therapy%20for%20Cerebal%20Palsy.pdf Cambridge CCG (2013). A rapid review of the evidence for the effectiveness of Bobath therapy for children and adolescents with cerebral palsy National Public Health Service for Wales (2008).	
B10.2 Trophic Electrical Stimulation for Facial/Bells Palsy	Not routinely commissioned.	Physical therapy for Bell's palsy (idiopathic facial paralysis). Cochrane Database of Systematic Reviews. Issue 12 (2011).	

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B10.3 Functional Electrical Stimulation (FES)	Commissioned for foot drop of central neurological origin, such as stroke, MS, spinal cord injury. It is not routinely commissioned for lower motor neurone lesions. It is under review by NICE for dysphagia and muscle recovery chronic disease. Patients must have receptive cognitive abilities. Exclusion Criteria: • Fixed contractures of joints associated with muscles to be stimulated. Broken or poor condition of skin. • Chronic oedema at site of stimulation. • Diagnosis of deep vein thrombosis. • Receptive dysphasia (unable to understand instructions). • Complete peripheral nerve damage. • Pacemaker in situ. • Pregnancy or intention to become pregnant. • Active cancer. • Uncontrolled epilepsy. • Metal in region of stimulation e.g.: pin and plate. • Ataxic and polio patients are generally poor responders although there are exceptions.	Functional Electric Stimulation (FES) for Children with Cerebral Palsy: Clinical Effectiveness – CADTH Rapid Response Service, 2011. Children with cerebral palsy: a systematic review and meta-analysis on gait and electrical stimulation. Clinical Rehabilitation. 2010 Nov; 24(11):963-78. Interventions for dysphagia and nutritional support in acute and subacute stroke Cochrane Database of Systematic Reviews 2012, Issue 10. Functional electrical stimulation for drop foot of central neurological origin NICE, 2009. Functional electrical stimulation for rehabilitation following spinal cord injury Centre for Reviews and Dissemination, NIHR, 2011.	

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B11. Ophthalmology			
B11.1 Upper Lid Blepharoplasty - Surgery on the Upper Eyelid	Only commissioned in the following circumstances: • Eyelid function interferes with visual field.	Eyelid Surgery *The British Association of Aesthetic Plastic Surgeons 2011.* Modernisation Agency's Action on Plastic Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base London Health Observatory 2010.	Excess skin in the upper eyelids can accumulate due to the ageing and is thus normal. Hooded lids causing significant functional impaired vision confirmed by an appropriate specialist can warrant surgical treatment. Impairment to visual field to be documented.
B11.2 Lower Lid Blepharoplasty - Surgery on the Lower Eyelid.	Only commissioned in any of the following circumstances: • Correction of ectropion or entropion which threatens the health of the affected eye. • Removal of lesions of eyelid skin or lid margin. • Rehabilitative surgery for patients with thyroid eye disease.	*Eyelid Surgery* The British Association of Aesthetic Plastic Surgeons 2011. Local PCT consensus – review conducted 2007. Modernisation Agency's Action on Plastic Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.	Excessive skin in the lower lid may cause "eye bags" but does not affect function of the eyelid or vision and therefore does not need correction.

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments

B11.3 Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids)	Only commissioned for:
	• Larger legions which satisfy all of the following:
	  • Not responded to treatment for underlying familial lipoprotein lipase deficiency.
	  • Failed topical treatment.
	  • Causing significant disfigurement.
	  • Causing functional impairment.
	• Topical treatments may be available in a primary care or community setting.
		Local PCT consensus – review conducted 2007.
		
		DermNet NZ information resources
		updated Jan 2013.
		
		Commissioning Criteria – Plastic Surgery
		Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service
		Health Commission Wales (2008).
		
		http://www.patient.co.uk/doctor/xanthelasma
			The following treatments should be considered for patients with xanthelasma: Topical trichloroacetic acid (TCA) or cryotherapy.
			
			Xanthelasma may be associated with abnormally high cholesterol levels and this should be tested for before referral to a specialist.
			
			Lesions are harmless.

B11.4 Surgery or Laser Treatment for Short Sightedness (myopia) or Long Sightedness (hypermetropia)	Surgery or Laser Treatment for Short Sightedness or long sightedness is routinely not commissioned.		
B11.6 Coloured (irlens) Filters for Treatment of Dyslexia	There is insufficient evidence of efficacy on this treatment. It is not routinely commissioned until such time when there is robust evidence.	Coloured filters for reading disability:A systematic review WMHTAC 2008	

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B11.7 Intra Ocular Telescope for Advanced Age-Related Macular Degeneration	This is not routinely commissioned as there is limited published evidence of effectiveness.	Implantation of miniature lens systems for advanced age-related macular degeneration NICE, 2008. Intraocular telescope by Vision Care ™ for age-related macular degeneration North East Treatment Advisory Group (2012).	
B11.8 Surgical Removal of Chalazion or Meibomian Cysts	Referral to secondary care will only be considered when all of the following are met: • Present for six months or more. • Conservative treatment has failed. • Sited on upper eyelid. AND • Causes blurring or interference with vision. OR • Has required treatment with antibiotics due to infection at least twice in the preceding six months. In Children under 10 this is commissioned as visual development may be at risk.	Guidance for the management of referrals for Meibomian Cysts NHS Cornwall & Isles of Scilly Devon, Plymouth and Torbay (January 2013). http://www.kernowccg.nhs.uk/media/136633/chalazion__meibomian_cyst__guidance_16.01.2013.pdf NHS Cornwall & Isles of Scilly, Devon, Plymouth and Torbay	Individual CCG addendums apply.

B12. Oral Surgery

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B12.1 Surgical Replacement of the Temporo-Mandibular Joint, Temporo-Mandibular Joint Dysfunction Syndrome & Joint Replacement	Only commissioned in the following circumstances: Any or a combination of the following symptoms are present: • Restricted mouth opening <35mm). • Dietary score of< 5/10 (liquid scores 0, full diet scores 10). • Occlusal collapse (anterior open bite or retrusion). • Excessive condylar resorption and loss of height of vertical ramus. • Pain score > 5 out of 10 on visual analogue scale (and combined with any of the other symptoms). • Other significant quality of life issues. AND • Evidence that conservative treatments have been attempted and failed to adequately resolve symptoms and other TMJ modification surgery (if appropriate) has also been attempted and failed to resolve symptoms.	Surgical Replacement of the Temporo-mandibular Joint: Interim guidance for Merseyside and Wirral/Cheshire Commissioners when considering funding requests.  TMJ Replacement Guidance .pdf Total prosthetic replacement of the Temporomandibular joint (IPG329) NICE 2009 http://www.patient.co.uk/doctor/temporomandibular-joint-dysfunction-and-pain-syndromes	
B13. Paediatrics			
B13.1 Cranial Banding for Positional Plagiocephaly	Not routinely commissioned.	Nonsurgical treatment of deformational plagiocephaly: a systematic review Archives of Pediatrics and Adolescent Medicine, Volume 162, Issue 8, 2008, p 719-27. What is the role of helmet therapy in positional plagiocephaly? BestBETS 2008.	Most childrens head shapes will improve naturally in their own time.
B15. Respiratory			

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B15.1 Treatments for Snoring, Soft Palate Implants and Radiofrequency Ablation of the Soft Palate, Sodium Tetradecyl Sulfate (STS) Injection or 'snoreplasty', Uvulopalatoplasty and Uvulopalatopharyngoplasy	Not Routinely Commissioned.	Soft-palate implants for simple snoring. NICE interventional procedure guidance 240 (2007). Radiofrequency ablation of the soft palate for snoring. NICE interventional procedure guidance 124 (2005). Clinical Guideline 73: Management of obstructive sleep apnoea/ hypopnoea syndrome in Adults SIGN (2003). Surgery for obstructive sleep apnoea in adults Cochrane Database of Systematic Reviews (2005). Surgical procedures and non-surgical devices for the management of non-apnoeic snoring: a systematic review of clinical effects and associated treatment costs – Health Technology Assessment (2009). Effects and side-effects of surgery for snoring and obstructive sleep apnea : A systematic review – Sleep 2009 v.32(1) 27-36. The British Snoring & Sleep Apnoea Association	NICE concludes that soft palate implants for snoring can only be recommended in the context of research, and radiofrequency ablation should only be used providing special arrangements are in place for audit, consent and research. For both, there are no major safety concerns, but the evidence on efficacy and outcomes is uncertain. UPPP may compromise the patient's subsequent ability to use nasal CPAP. Research to date is exploratory and studies small and not randomised or blinded. The method of injecting a chemical into the soft palate known as 'Snoreplasty' is not well recognised in the UK as an effective method of treating snoring.

B16. Trauma & Orthopaedics

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B16.17 Bone Morphogenetic Proteins, Dibotermin Alfa, Eptotermin Alpha	Dibotermin alfa is commissioned in the following situation: • The treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation. • Eptotermin alfa is commissioned in line with its licensed indication: • Treatment of non-union of tibia of at least 9 month duration, secondary to trauma, in skeletally mature patients, in cases where previous treatment with autograft has failed or use of autograft is unfeasible.	Clinical effectiveness and cost-effectiveness of bone morphogenetic proteins in the non-healing of fractures and spinal fusion: a systematic review Health Technology Assessment NHS R&D HTA Programme, 2007. Clinical effectiveness and cost-effect... [Health Technol Assess. 2007] - PubMed - NCBI Annals of Internal Medicine | Safety and Effectiveness of Recombinant Human Bone Morphogenetic Protein-2 for Spinal Fusion: A Meta-analysis of Individual-Participant Data June 2013 BMPs: Options, indications, and effectiveness – Journal of Orthopaedic Trauma. 2010 Mar;24 Suppl 1:S9-16.	
B16.18 Surgery for Trigger Finger	Surgery not commissioned unless: • Conservative treatments, (including at least 1 corticosteroid injections) have failed or are contraindicated AND • Fixed flexion deformity that cannot be corrected easily is present.	Nimigan AS, Ross DC, Bing SG. Steroid injections in the management of trigger fingers. American Journal of Physical Medicine and Rehabilitation 2006; 85(1):36-43. BMJ review: Akhtar S, Bradley MJ, Quinton DN, Burke FD. Management and referral for trigger finder/thumb. BMJ 2005; 331(7507):30-33. NHS Oxfordshire, Interim Treatment Threshold Statement: Surgery for trigger finger (stenosing tenovaginosis) Corticosteroid injection for trigger finger in adults Cochrane Database of Systematic Reviews (2008). Trigger Finger Assessment Map of Medicine (2012) – for North Mersey Surgery versus ultrasound-guided steroid injections for trigger finger disease: protocol of a randomized controlled trial Danish Medical Journal 2013;60(5):A4633.	Conservative management (including splinting, steroid injections, NSAIDS) is adequate in the majority of cases. Local steroid injections should be the first line treatment unless the patient is diabetic (where surgery preferred).

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B16.20 Secondary Care Administered Steroid Joint Injections	Provision of joint injections for pain should only be undertaken in a primary care setting, unless ultrasound guidance is needed or as part of another procedure being undertaken in theatre.	Ultrasound-guided injections of joints of the extremities – University of York Centre for Research and Dissemination 2012.	
B16.21 Palmar Fasciectomy/Needle Faciotomy for Dupuytren's Disease	Requests for treatment will be considered when: • Metacarpophalangeal joint contracture of 30 degrees or more, (inability to place hand flat on table. OR • Any degree of proximal interphalangeal joint contracture. OR • Patients under 45 years of age with disease affecting 2 or more digits and loss of extension exceeding 100 or more. There should be significant functional impairment.	IPG043 Needle fasciotomy for Dupuyren's contracture - guidance – NICE 2004. Dupuytrens disease NICE Clinical Knowledge Summaries (2010). British society hand surgeons New guidelines awaited. NHS North West London commissioning policy – Dupuytren's Disease April 2013. Common Hand Conditions NHS Dorset Clinical Commissioning Group (2011).	

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B16.22 Radiotherapy Collagenase Injections for Dupytren's Disease	These procedures are not commissioned.	IPG368: Radiation therapy for early Dupuytren's disease NICE 2010.	Individual CCG addendums apply.
B16.24 Diagnostic Arthroscopy for Arthritis of the Knee	Routinely commissioned where there is strong clinical suspicion of a meniscal cartilage tear/s, ACL injuries, or other specific conditions, the benefits of knee arthroscopy is considered wholly appropriate. However it is not routinely commissioned for any of the following indications: • Investigation of knee pain. • Treatment of Osteo-Arthritis including Arthroscopic washout. • If there is diagnostic uncertainty despite a competent examination or if there are ''red flag'' symptoms then a Magnetic resonance imaging (MRI) scan may be indicated. If patients have had an inconclusive MRI scan and physiotherapy the procedure may be considered.	CG59 Osteoarthritis. Section 3.1 NICE 2008 Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis NICE 2007. Knee replacement: A guide to good practice British Orthopaedic Association, 2000. Commissioning Guide: Painful osteoarthritis of the knee Royal College of Surgeons (2013). http://guidance.nice.org.uk/CG177 CG177Osteoarthritis (NICE 2014)	
B16.25 Arthroscopic Lavage and Debridement for Osteoarthritis of the Knee	Arthroscopic lavage and debridement for knee osteoarthritis will not be commissioned, unless there is a clear history of mechanical locking (not gelling, 'giving way' or X-ray evidence of loose bodies).		

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B16.26 Patient Specific Unicompartmental Knee Replacement	This is not commissioned.	IPG317 Individually magnetic resonance imaging- designed unicompartmental interpositional implant insertion for osteoarthritis of the knee: guidance NICE, 2009	Referral should be made to specialist centres only.
B16.27 Patient Specific Total Knee Replacement	This is not commissioned.	EMERGING TECHNOLOGY Total Knee Replacement Using Patient-specific Templates ECRI Institute (2012) IPG 345: Mini-incision surgery for total knee replacement NICE 2010	

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B16.28 Surgical Treatment for Carpal Tunnel Syndrome	Conservative treatment in the community (local corticosteroid injection and splinting) may be appropriate for mild to moderate cases. Surgery for mild to moderate cases is not commissioned unless all of the following criteria are satisfied: • Patients have not responded to 3 months of conservative treatments, including: • 6 weeks of night-time use of wrist splints. Corticosteroid injection in appropriate patients. Conservative treatments contraindicated. Severe cases: • Carpal tunnel surgery (open or endoscopic) for severe symptoms (constant pins and needles, numbness and muscle wasting) will be commissioned following assessment. The following treatments are not commissioned for carpal tunnel syndrome: • Diuretics • NSAIDS • Vitamin B6 • Activity modification • Heat treatment • Botulinum toxin	Local corticosteroid injection for carpal tunnel syndrome Cochrane Database of Systematic Reviews, 2007. Clinical practice guideline on treatment of Carpal Tunnel Syndrome American Academy of Orthopaedic Surgeons, 2008. Interim Treatment Threshold Statement: Surgery for Carpal Tunnel Syndrome NHS Oxfordshire, 2009. Non-surgical treatment (other than steroid injection) for carpal tunnel syndrome - Cochrane Database of Systematic Reviews 2002. Surgical treatment options for carpal tunnel syndrome Cochrane Database of Systematic Reviews 2007. Surgical versus non-surgical treatment for carpal tunnel syndrome Cochrane Database of Systematic Reviews 2008. Is surgical intervention more effective than non-surgical treatment for carpal tunnel syndrome? a systematic review Journal of Orthopaedic Surgery & Research 2011, 6:17. Median Nerve Lesions and Carpal Tunnel Syndrome Patient.co.uk. Commissioning Guide: Painful tingling fingers Royal College of Surgeons (2013).	Mild cases often resolve spontaneously after 6 months.

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B16.29 Surgical Removal of Mucoid Cysts at Distal Inter Phalangeal Joint (DIP)	Only commissioned for mucoid cysts under the following circumstance: • Failure of conservative treatments including watchful waiting. AND any of the following: • Nail growth disturbed. • Discharging, ulcerated or infected. • Size interferes with normal hand function.	Digital Mucous Cyst Overview of condition – Medscape.	

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B16.31 Hip Arthroscopy for Femoro–Acetabular Impingement	CCGs routinely commission hip arthroscopy (from surgeons with specialist expertise in this type of surgery) in line with the requirements stipulated by NICE IPG 408, and only for patients who fulfil ALL of the following criteria: • A definite diagnosis of hip impingement syndrome/femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans. • An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist. • The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly compromised functioning for at least 6 months. • The symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy.	IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance – NICE, 2011. http://www.hullccg.nhs.uk/uploads/policy/file/22/hip-arthroscopy-hull-ccg.pdf NHS Hull Clinical Commissioning Group 2012. Vijay D Shetty, Richard N Villar. Hip arthroscopy: current concepts and review of literature. British Journal of Sports Medicine, 2007;41:64–68. Macfarlane RJ, Haddad FS The diagnosis and management of femoro-acetabular impingement. Annals of the Royal College of Surgeons of England, July 2010, vol/iss 92/5(363-7). Ng V Y et al.. Efficacy of Surgery for Femoro-acetabular Impingement: A Systematic Review. American Journal of Sports Medicine, November 2010,38 2337-2345. Commissioning Guide: Painful osteoarthritis of the hip Royal College of Surgeons (2013). IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance NICE, 2011	Current evidence on the efficacy of arthroscopic femoro–acetabular surgery for hip impingement syndrome is adequate in terms of symptom relief in the short and medium term. With regard to safety, there are well-recognised complications. Therefore this procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit with local review of outcomes.

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B16.32 Surgical Removal of Bunions/Surgery for Lesser Toe Deformity	Requests for the removal of bunions will only be considered where: • Conservative methods of management* have failed. AND • The patient suffers significant functional impairment** as a result of the bunions. AND • Radiographic evidence of joint damage (at point of referral). *Conservative measures include: Avoiding high heel shoes and wearing wide fitting leather shoes. Non-surgical treatments such as bunion pads, splints, insoles or shields or exercise where appropriate. **Significant functional impairment is defined as: The patient complains of moderate to severe joint pain not relieved by extended non-surgical management AND has severe impact on their ability to undertake activities of daily living. Treatment will not be commissioned for cosmetic appearance only.	Bunions NICE Clinical Knowledge Summaries (2012) IPG 332: Surgical correction of hallux valgus using minimal access techniques NICE (2010) Commissioning Guide: Painful deformed great toe in adults Royal College of Surgeons (2013)	

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B16.33 Surgical Treatment of Morton's Neuroma	Surgical Treatment is not routinely commissioned unless the patient has documented evidence that they are not responding to conservative treatments and the patient is experiencing significant pain or it is having a serious impact on their daily life and completed the following pathway. The patient should have had 3 months of conservative treatment in primary care such as footwear modification and metatarsal pads. Been referred to an orthotist or podiatrist for an assessment. Had a trial of local corticosteroid injection.	Therapeutic massage provides pain relief to a client with Morton's Neuroma: A case report - International Journal of Therapeutic Massage and Bodywork—Volume 5(2), June 2012. Clinical Inquiry. What is the best way to treat Morton's neuroma? - Journal of Family Practice 2011 v.60(3), p157-9. Morton's neuroma NICE Clinical Knowledge Summaries (2010).	

B16.34 Surgical Treatment of Plantar Fasciitis	Surgical Treatment is not routinely commissioned unless the following pathway has been followed:
	• Patient has documented evidence that they are not responding to conservative treatments
	• Patient is experiencing significant pain or it is having a serious impact on their daily life and has completed the following:
	  • Three months of conservative therapy such as footwear modification, stretching exercises, ice packs, weight loss
	  • Been referred to a podiatrist or physiotherapist
	  • Not responded to corticosteroid injections
		Heel pain--plantar fasciitis: clinical practice guidelines linked to the international classification of function, disability, and health from the orthopaedic section of the American Physical Therapy Association - Journal of Orthopaedic & Sports Physical Therapy. 2008:38(4):A1-A18.
		
		Plantar fasciitis
		NICE Clinical Knowledge Summaries (2009).
		
		Plantar fasciitis
		BMJ 2012;345:e6603.	

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B16.35 Treatment of Tendinopathies (Extracorporeal Shock Wave Therapy; Autologous Blood or Platelet Injection)	These treatments are not routinely commissioned for plantar fasciitis, achilles tendinopathy, refractory tennis elbow.	IPG 311: Extracorporeal shockwave therapy for refractory plantar fasciitis NICE 2009. IPG 312: Extracorporeal shockwave therapy for refractory Achilles NICE 2009. IPG 313: Extracorporeal shockwave therapy for refractory tennis elbow NICE 2009. IPG 437: Autologous blood injection for plantar fasciitis NICE 2013. IPG 438: Autologous blood injection for tendinopathy NICE 2013.	
B17. Urology			
B17.3 Reversal of Male Sterilisation	The NHS does not commission this service. Patients consenting to vasectomy should be made fully aware of this policy. Reversal will be only considered in exceptional circumstances such as the loss of a child.	CG156 Fertility: Assessment and treatment for people with fertility problems – NICE 2013. Contraception – sterilization – NICE Clinical Knowledge Summaries 2012 http://cks.nice.org.uk/contraception-sterilization#!scenario	

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B17.4 ESWT (extracorporeal shockwave therapy) for Prostadynia or Pelvic Floor Syndrome	This is not commissioned as there is limited clinical evidence of effectiveness.	Guidelines on chronic pelvic pain European Association of Urology (2012).	
B17.5 Hyperthermia Treatment for Prostadynia or Pelvic Floor Syndrome	This is not commissioned as there is limited evidence of effectiveness.	Guidelines on chronic pelvic pain European Association of Urology (2012). https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_41.pdf	
B17.6 Surgery for Prostatism	Only commissioned where there are sound clinical reasons and after failure of conservative treatments and in any of the following circumstances: • International prostate symptom score >7; dysuria; • Post voided residual volume >150ml; • Recurrent proven Urinary Tract Infections (UTI); • Deranged renal function; • Prostate-specific antigen (PSA) > age adjusted normal values.	CG97: Lower urinary tract symptoms: The management of lower urinary tract symptoms in men NICE 2010. LUTS in men, age-related (prostatism) NICE Clinical Knowledge Summaries (2010). http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/luts Royal College of Surgeons (2013).	No references to treatment thresholds found.
B18. Vascular			

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B18.1 Surgery for Extreme Sweating (Hyperhydrosis – all areas; Surgical Resection Endoscopic Thoracic Sympathectomy)	Treatment is medical. Treatment of hyperhidrosis with surgery is not routinely commissioned. Risk of compensatory hyperhidrosis elsewhere is very high.	Hyperhidrosis – NICE Clinical Knowledge Summaries (2013). Hyperhidrosis Patient.co.uk.	
B18.2 Chelation Therapy for Vascular Occlusions	This is not commissioned.	Diagnosis and management of Peripheral arterial disease: A national clinical guideline -SIGN, 2006. Effect of Disodium EDTA Chelation Regimenon Cardiovascular Events in Patients With Previous Myocardial Infarction The TACT Randomized Trial JAMA. 2013;309(12):1241-1250.	A recent trial has been published showing some modest benefit post MI but concluded evidence was not sufficient to support routine use post MI.

B19. Other

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
B19.1 Botulinum Toxin A & B Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migrane.	The use of botulinum toxin type A is commissioned in the following indications: • Anal fissures only following a minimum of two months with standard treatment (lifestyle and topical pharmaceutical products) for chronic anal fissures that have not resulted in fissure healing; and only a maximum of 2 courses of injections. • Blepharospasm and hemifacial spasm. • Probable contracture of joint in multiple sclerosis, in conjunction with prolonged stretching modalities (i.e. in line with NICE Clinical Guideline 8). http://guidance.nice.org.uk/CG8 • Focal dystonia, where other measures are inappropriate or ineffective. • Focal spasticity in patients with upper motor neurone syndrome, caused by cerebral palsy, stroke, acquired brain injury, multiple sclerosis, spinal cord injuries and neurodegenerative disease, where other measures are inappropriate or ineffective. • Idiopathic cervical dystonia (spasmodic torticollis). • Prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine) that has not responded to at least three prior pharmacological prophylaxis therapies, and whose condition is appropriately managed for medication overuse (i.e. in line with NICE Technology Appraisal 260). http://guidance.nice.org.uk/TA260 • Refractory detrusitor overactivity, only line with NICE Clinical Guideline 171 (women) http://guidance.nice.org.uk/CG171 and Clinical Guideline 97 (men) http://guidance.nice.org.uk/CG97 where conservative therapy and conventional drug treatment has failed to control symptoms. • Sialorrhoea (excessive salivary drooling), when all other treatments have failed.	NICE TA260 June 2012 – Migraine (chronic) botulinum toxin type A http://guidance.nice.org.uk/TA260 Idiopathic detrusor instability - only commissioned in accordance with NICE CG171 Sept 2013 - Urinary incontinence in women http://guidance.nice.org.uk/CG171 and only one course of injections. Diagnosis and management of hyperhidrosis British Medical Journal.	

Treatment/Procedure	Exceptionality – Prior Approval – Criteria	Evidence	Comments
	Botulinum toxin type A is not routinely commissioned in the following indications: • Canthal lines (crow's feet) and glabellar (frown) lines. • Hyperhidrosis. • Any other indication that is not listed above The use of Botulinum Type B is not routinely commissioned. Where the use of botulinum toxin is used to treat an indication outside of the manufacturer's marketing authorisation, clinicians and patients should be aware of the particular governance requirements, including consent (which must be documented) for using drugs outside of their licensed indications. For patients with conditions which are not routinely commissioned, as indicated above, requests will continue to be considered by Cheshire & Merseyside Clinical Commissioning Groups processes for individual funding requests, if there is evidence that the patient is considered to have clinically exceptional circumstances to any other patient experiencing the same condition within Cheshire & Merseyside. Requests to commission the use of botulinum toxin as an option to treat other indications, where a known cohort of patients can be identified, should be processed in accordance with the relevant CCG's defined processes. If a subsequent CCG approved policy supersedes the information above, this section will be reviewed and updated.		

REPORT TO: Health Policy & Performance Board

DATE: 19th June 2018

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health & Wellbeing

SUBJECT: Domiciliary Care & Care Homes – Quality Update

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update the Board and highlight key issues with respect to Domiciliary Care and Care Homes locally.

2.0 **RECOMMENDATION: That the Board:**

i) Note the contents of the report and its associated appendices.

3.0 **SUPPORTING INFORMATION**

3.1 It is a key priority for Halton Borough Council to ensure the provision of a range of good quality services to support Adults requiring commissioned care in the Borough. The Care Act 2014 has put this on a statutory footing through a choice of diverse high quality services that promote wellbeing.

3.2 The Care Quality Commission (CQC) is responsible for the registration, inspection and assessment of all registered providers. However, the Care Act 2014 places the duty of securing the quality of care in Halton on the Council itself.

3.3 The CQC assessment process enables all registered care providers to be classified into one of four categories following an appraisal which asks 5 key questions:

- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive?
- Is the service well led?

3.4 The four award categories are:

- Inadequate
- Requires Improvement
- Good
- Outstanding

The results of all CQC inspections are published, including the rating awarded.

3.5 CARE HOMES

The care home market in Halton consists of 26 registered care homes which provide 781 beds operated by 15 different providers. The capacity within the care homes ranges from independent to large providers, from care homes ranging from 4 beds to 66 beds.

3.6 24/26 care homes have now been rated by CQC. There is currently 1 home rated as Inadequate and 3 homes rated as requiring improvement, with the Council and owners working to address the issues.

2 care homes have not yet been inspected following a change of ownership from private ownership to Council owned. The remaining 20 homes have been assessed as good.

3.7 Some common themes across Care Homes have been identified as:

- Poor leadership, management and governance
- Low staffing levels and staff culture
- Poor quality assurance processes
- Medication management issues

3.8 The Council's Quality Assurance Team gathers intelligence and information on Providers via quality and contract performance monitoring; this includes "soft intelligence" from key stakeholders, review of the latest CQC report, business plans and financial accounts. This information is then used during regular monitoring visits.

3.9 The team also operate an early warning system, which includes; Provider self-assessment, Quality Dashboard and Electronic Call Monitoring (for Domiciliary Care).

3.10 LIVERPOOL CITY REGION CARE HOMES OVERVIEW

Location	Outstanding	Good	Requires improvement	Inadequate	% Inadequate or Requires Improvement
England	0.9%	63.7%	32.1%	3.3%	35%
North West	0.3%	58.4%	35.9%	5.3%	41%
Liverpool City Region	**0.4%**	**52.0%**	**40.6%**	**7.0%**	48%
Halton	0.0%	81.6%	17.0%	1.4%	18%
Knowsley	0.0%	77.8%	22.2%	0.0%	22%
Liverpool	1.4%	31.9%	58.5%	8.1%	67%
Sefton	0.0%	44.4%	38.8%	16.8%	56%
St. Helens	0.0%	85.6%	12.3%	2.1%	14%
Wirral	0.3%	46.9%	51.1%	1.7%	53%

The table above is a summary of percentage of care home beds in the Liverpool City Region, in relation to the rating of the homes (this is based on the latest overall rating by CQC under their new inspection methodology and only includes homes that have been inspected). What it indicates is that as a whole, the Liverpool City Region has a comparatively high volume of beds in care homes that are deemed as 'inadequate' or 'requires improvement'.

See Appendix 1 for Performance Data

3.11 DOMICILIARY CARE

The Council currently have 4 contracted provider agencies who work across patches that cover the area. These agencies provide approx. 700 people with supportive packages of care, delivering approx. 22,000 care hours per month.

3.12 3/4 Domiciliary Care providers have now been rated by CQC as good with the other not yet been inspected following a change of premises.

3.13 Some common pressures across the domiciliary care agencies:

- Difficulties in recruitment and retention
- Non-driving staff
- Rota management and continuity of care

The tender of domiciliary care gave a greater focus on the promotion of independence, reablement and a movement away from the traditional task based approach and is now being implemented with Dom Care 1 awarded the contract.

Dom Care 1 has sub-contracted with Dom Care 2 and Dom Care 3 in Halton.

See Appendix 2 for Performance Data

4.0 **POLICY IMPLICATIONS**

4.1 None identified

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None identified

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**

Safeguarding Adults Board (SAB) membership includes a Manager from Children and Enterprise Directorate, as a link to the Local Safeguarding Children Board. Halton Safeguarding Children Board membership includes adult social care representation. Joint protocols exist between Council services for adults and children.

The SAB chair and sub group chairs ensure a strong interface between, for example, Safeguarding Adults, Safeguarding Children, Domestic Abuse, Hate Crime, Community Safety, Personalisation, Mental Capacity & Deprivation of Liberty Safeguards.

6.2 **Employment, Learning & Skills in Halton**

None identified

6.3 **A Healthy Halton**

The safeguarding of adults whose circumstances make them vulnerable to abuse is fundamental to their health and wellbeing. People are likely to be more vulnerable when

they experience ill health.

6.4 **A Safer Halton**

None identified

6.5 **Halton's Urban Renewal**

None identified

7.0 **RISK ANALYSIS**

7.1 Failure to consider and address the statutory duty of the Local Authority could expose individuals to abuse and the Council as the Statutory Body vulnerable to complaint, criticism and potential litigation.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 It is essential that the Council addresses issues of equality, in particular those regarding age, disability, gender, sexuality, race, culture and religious belief, when considering its safeguarding policies and plans. Policies and procedures relating to safeguarding adults are impact assessed with regard to equality.

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

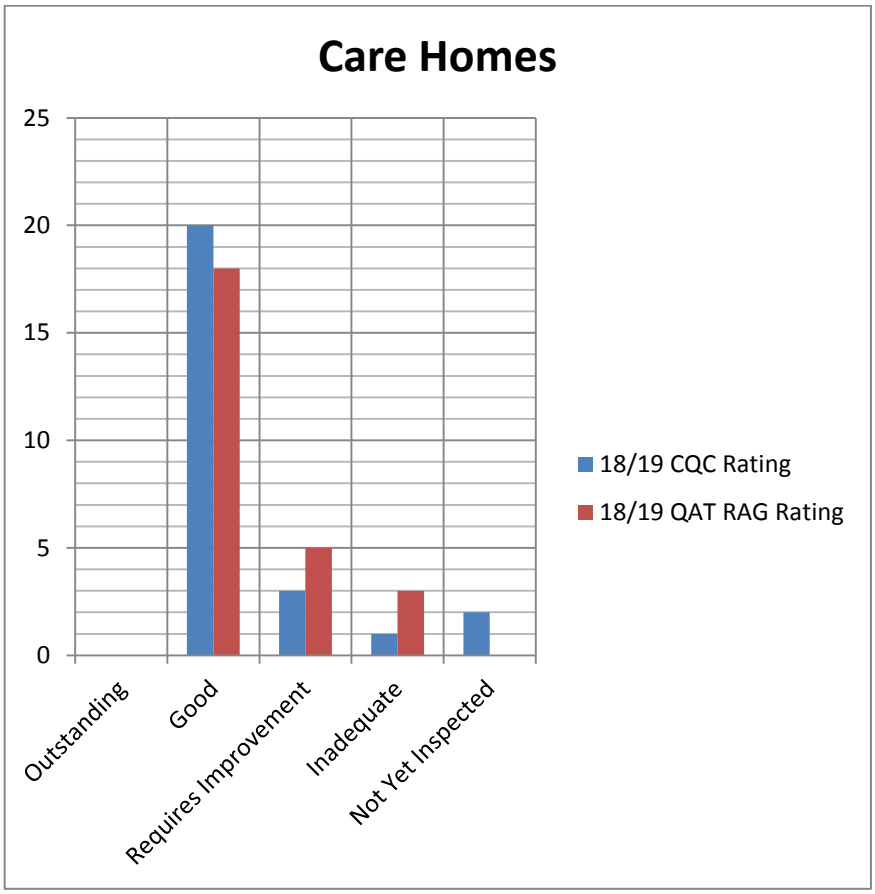
None under the meaning of the Act.

Appendix 1

Provider Name	Type of service	18/19 CQC Rating	18/19 QAT RAG Rating	Bed Capacity
Care Home 1	Care Home			6
Care Home 2	Care Home with Nursing			66
Care Home 3	Care Home			4
Care Home 4	Care Home			24
Care Home 5	Care Home			44
Care Home 6	Care Home with Nursing			58
Care Home 7	Care Home with Nursing			34
Care Home 8	Care Home with Nursing			12
Care Home 9	Care Home			64
Care Home 10	Care Home			6
Care Home 11	Care Home			23
Care Home 12	Care Home			8
Care Home 13	Care Home with Nursing			44
Care Home 14	Care Home			32
Care Home 15	Care Home			19
Care Home 16	Care Home			15
Care Home 17	Care Home			6
Care Home 18	Care Home			12
Care Home 19	Care Home			63
Care Home 20	Care Home			6
Care Home 21	Care Home with Nursing			56
Care Home 22	Care Home with Nursing			40
Care Home 23	Care Home			44
Care Home 24	Care Home			8
Care Home 25	Care Home			68
Care Home 26	Care Home			19
			Bed capacity	**781**

Overall

Care Homes	26	26
Outstanding	0	0
Good	20	18
Requires Improvement	3	5
Inadequate	1	3
Not Yet Inspected	2	0

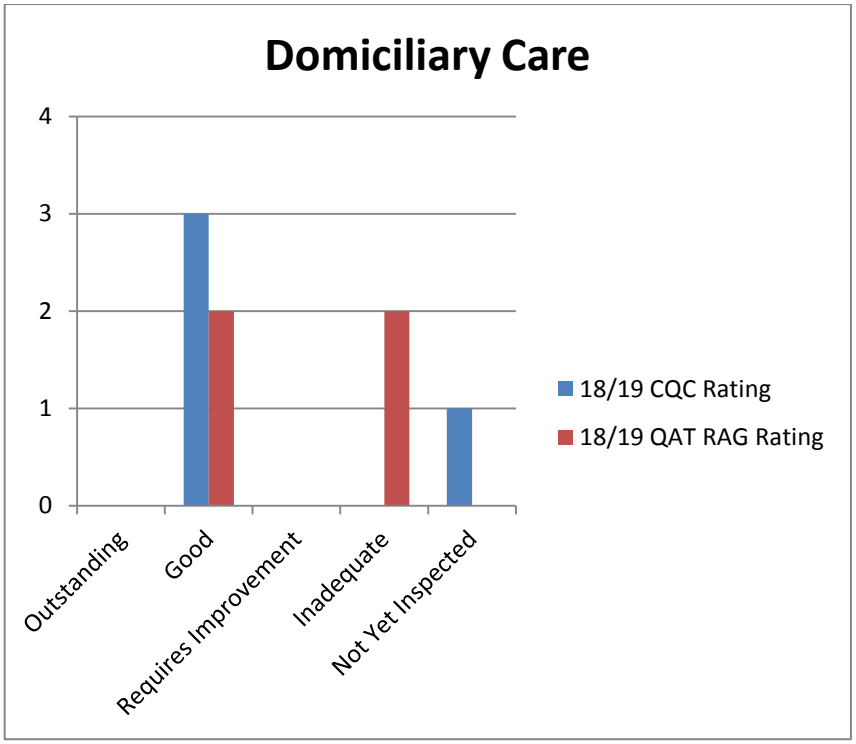

Care Homes
25
20
15
10
5
0
Outstanding
Good
Requires Improvement
Inadequate
Not Yet Inspected
18/19 CQC Rating
18/19 QAT RAG Rating

Appendix 2

Provider Name	Type of Service	18/19 CQC Rating	18/19 QAT RAG Rating	Hours
Dom Care 1	Homecare agencies			16,000
Dom Care 2	Homecare agencies			2,800
Dom Care 3	Homecare agencies			2,500
Dom Care 4	Homecare agencies			700
			Hours per month	22,000.00

Overall

Dom Care	4	4
Outstanding	0	0
Good	3	2
Requires Improvement	0	0
Inadequate	0	2
Not Yet Inspected	1	0



REPORT TO: Health Policy & Performance Board

DATE: 19th June 2018

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health & Wellbeing

SUBJECT: NHS Halton CCG Consultation & Engagement Programme for 2018/19

WARD(S) All

1.0 **PURPOSE OF THE REPORT**

1.1 To inform the board of NHS Halton CCG engagement and consultation requests regarding 3 GP practices to the CCG for the following estates:

Appleton Village Surgery, 2-6 Appleton Village. WA8 6DZ contractors have requested to relocate to a site off Lanark Gardens, Upton Rocks, Widnes.

Beeches Medical Centre, 20 Ditchfield Road, WA8 8QS has requested to relocate to Hough Green Health Park, 47-57 Hough Green Road. WA8 4NJ

Upton Rocks practice WA8 7NU has requested to close their Hale Village branch site, 6-7 Ivy Farm Court. L24 4AG

2.0 **RECOMMENDATION: That:**

a) A robust programme of consultation and engagement is undertaken with all relevant stakeholders.

b) Consideration of concerns to be answered regarding the Appleton Village new build.

c) A 12 week consultation is undertaken with Beeches Medical Centre patients to understand any patient concerns and aid the decision making process regarding the proposed relocation.

d) A 12 week consultation is undertaken with Upton Rocks Hale Village patients to understand any patient concerns and aid the decision making process regarding the proposed closure of Hale Village branch site.

3.0 **SUPPORTING INFORMATION**

3.1 **Appleton Village Surgery**

3.1.1 Appleton Village Surgery has 10,020 registered patients as at 1 April 2018.

3.1.2 Appleton Village Surgery has had a closed list to new patients since 1 December 2014 as there is not enough accessible space within the current building to enable an increased list size of patients to be seen. The proposed new building would be a modern fit for purpose building with 5 additional clinical rooms.

3.1.3 A business case for the Appleton Village Surgery Development was first submitted in January 2010 to the former NHS Halton and St Helens Primary Care Trust and was approved by the board on 21st September 2010. It detailed that a new build was the only option and provided the rationale for this as being:

- The surgery is not and could never be remodelled to be DDA (Disability Discrimination Act) compliant.
- The surgery is not and probably could never be remodelled to be compliant with other mandatory legislation.
- There is no disabled access
- There is no practice parking
- The surgery has a poor internal layout
- There is a heavy and increasing structural repair bill

3.1.4 When responsibility for premises moved to NHS England the Appleton Village Surgery Development business case was tested through a 2-stage assessment process by NHS England Merseyside Commissioning Directorate and NHS Property Services.

3.1.5 NHS Halton CCG took on the responsibility for delegated commissioning in 2015, including responsibility for decisions regarding primary care estates.

3.1.6 The practice re submitted its proposal to the CCG under the delegation rules. A 6 week consultation was undertaken from 22nd June 2017 to 7th August 2017 run by Midlands and Lancashire CSU on behalf of the CCG and the practice. Every Appleton Village patient aged over 18 was sent a letter that outlined the problems with the existing site, the benefits of the new site and how to get involved. Details of the relocation proposal including a slide deck

presentation were posted on to the surgery website including a link to the online survey. A drop-in event was held at the practice on Saturday 15 July from 10am – 2pm, posters advertising the drop-in event were displayed throughout the surgery. The event was attended by 146 people. The surgery used their automated Patient Text Message Service to contact patients every week during the consultation. They were encouraged to attend the patient event and complete the online survey. 1050 Appleton Village patients and 2 people who are not Appleton Village patients responded to the survey.

3.1.7 Respondents were asked to provide demographic profiling data (age, gender, ethnicity etc.). There was representation from all groups. Most respondents (71.77%) were very or fairly supportive of the move to Upton Rocks. Geographically those living in postcodes near to the existing surgery are unsupportive of the move whilst those living near to the new site are very supportive of the move. The reasons for the move and the expected benefits were recognised and supported by respondents.

3.1.8 For those who are unsupportive (19.46%) the key issues mentioned focused on transportation, travelling and access. All concerns discussed the time to travel to the site, the cost, modes of transport available for patients and specifically whether there is public transport. Following on from this respondents were concerned about how specific patient groups including the elderly, the disabled and those with long term conditions and other illnesses will be able to access the new site.

3.1.9 To mitigate against these concerns practice appointments will be offered to fit in with public transport times, and the option of telephone appointments will continue. Where appropriate the practice will undertake home visits. The practice Patient Participation Group actively engaged with Halton Community Transport who can support the patients with next day transport for those who are eligible for transport. The practice will change the on the day appointments system to enable next day appointments for patients utilising Halton Community Transport. Further engagement work will now be undertaken with groups that the consultation has indicated would have difficulty travelling to the proposed relocated site.

3.2 **Beeches Medical Centre**

3.2.1 Beeches Medical Centre has 8272 registered patients as at 1 April 2018.

3.2.2 Beeches Medical Centre has requested to relocate from their current building. The practice would like to move to a modern, fit for purpose building with potential for the practice to register more patients and offer more services at the practice site. Relocation would help the practice to maintain an open patient list that is able to accept new patients and improve parking facilities.

3.2.3 The practice has requested to locate on a site with another GP practices. The GP forward view highlights benefits for patients and practices of practices working at scale. Co-location with another practice will enable practices to offer a greater range of services on site, and to increase resilience. The nearest possible sites are Hough Green Health Park and the Health Care Resource Centre. The practice feels Hough Green Health Centre would be a better option for their practice. It is 1.1 miles from the Beeches current location.

3.2.4 The practice and CCG have engaged with the practice Patient Participation Group (PPG). The PPG felt relocation to Hough Green Health park would benefit patients that drive to the practice as parking at the proposed site would be better than at the current site. For those patients living near Liverpool Road the proposed site is on a direct bus line. The PPG felt patients would want reassurance that the practice is not merging with Hough Green Health Park practice and that patients will continue to be seen by the same staff.

3.2.5 The CCG proposes to undertake pre consultation work to understand if there are groups of patients that would be adversely impacted and ensure that there is opportunity to understand this within the consultation.

3.2.6 The CCG proposes to undertake a 12 week consultation from 2nd July to 17th September. The consultation will include a robust communications programme to ensure that all stakeholders including every Beeches Medical Centre patient to engage in the consultation. There would also be communications with Hough Green practice patients to reassure them that their GP practice will not be merging with Beeches Medical Centre.

3.3 **Hale Village branch Surgery**

3.3.1 Upton Rocks Surgery has 3617 registered patients as at 1 April 2018. Of these 313 patients reside in Hale Village.

3.3.2 Hale Village branch site is open for three hours a week (Wednesday 13.00-14.30 and Friday 12.30-14.00) and is located 3.5 miles from the main practice. The branch site is not DDA compliant and has

been classified as “condition C” estate within Halton Strategic Estates Plan 2015-2020 meaning that, “the property is operational but major repairs or replacement will be needed soon, for building and engineering elements.” The practice reports that it is difficult to staff the branch as locums refuse to travel and clinical staff prefer not to work in isolation. The practice also reports that there is under -utilisation of the appointments that are offered at Hale Village branch.

3.3.3 In line with the national Primary Medical Services (PMS) redistribution program to ensure equity of funding across practices, higher funded practices PMS funding is being gradually reduced over 4 years starting from 2015 and lower funded PMS practices funding is being increased. As Upton Rocks has historically received higher funding, its PMS funding is being reduced. The practice feel that the branch site is no longer viable and closure of the branch would help the practice to run more efficiently and offer more appointments to their patients at the main site. The practice will continue to offer home visits to appropriate patients.

3.3.4 The 8 nearest practices to Hale Village branch site are all located in Liverpool CCG boundary and range from 1.2 to 1.9 miles from the branch site. The nearest Widnes practices which have Hale in their practice boundary are: Hough Green, Newtown and West Bank branch Bevan Group practice and the main Upton Rocks site. All of these are approximately 3 miles from Hale Village branch surgery.

3.3.5 The practice and the CCG has engaged with the practice PPG to understand their concerns and issues that will need to be considered within the consultation. For those patients that would drive to both sites there is significantly more parking at Upton Rocks main branch site. The PPG expressed concerns around travel to the main site for those that cannot travel by car. There is a direct 82A Arriva bus from Hale Village to Upton Rocks. It is a 17 minute bus journey to Chestnut Lodge bus stop then a short (0.3 mile) walk from the bus stop to the practice.

3.3.6 There is a plan to build 1700 new homes in Halebank, and 94 new homes in Hale. It is likely that not all residents moving into these new homes would want to move from their current GP, or would choose to register at Upton Rocks practice. Hale Village branch is unlikely to be able to provide a single solution to providing a GP practice for the residents as the building would not have capacity to serve all of the additional patients from the proposed new homes.

3.3.7 At a meeting of the practice Patient Participation Group on 23rd March 2018 a petition was handed to CCG representatives objecting to the potential closure of the branch. The petition had 588 signatures (some of which were duplicates), of these 111 were Upton Rocks patients.

3.3.8 The CCG is proposing to run a 6 week consultation from 2nd July 2018 to 10th August 2018.

4.0 POLICY IMPLICATIONS

4.1 The National GP forward view recognises that GP estate need to be improved to increase the flexibility of facilities to accommodate: multi-disciplinary teams and their training, innovations in care for patients and the increasing use of technology, cater for population growth and enable patient access to a wider range of services. A key goal of the GP forward view is to ensure future sustainability and resilience of general practice.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The proposed relocations and branch closure will impact upon the amount of notional rent paid to the practices by the CCG. The CCG considers that the proposals would be affordable and supports the CCG's commitment to ensure that sustainable and resilient General Practice operates from fit for purpose buildings.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

6.2 Employment, Learning & Skills in Halton

It is increasingly difficult nationally for GP practices to recruit GPs and nurses to vacant posts and this situation has been reflected locally. It will be easier to recruit and retain GPs, GP trainees, nurses and administrative staff to work in modern, fit for purpose buildings where staff feel supported and do not work in isolation.

6.3 A Healthy Halton

The proposals will enable services to be provided more efficiently and provide greater opportunities for more services to be offered within the community and out of hospital.

6.4 A Safer Halton

The proposals to relocate Beeches Medical Centre and Appleton Village Surgery will enable more patients to park in dedicated practice parking and reduce potential parking hazards where there is less on-site parking.

The proposals will ensure that care is provided in fit for purpose Disability Building Regulations (Disability Discrimination Act) compliant buildings.

The proposal to close Hale Village branch surgery will improve safety for staff and patients working in isolation.

6.5 **Halton's Urban Renewal**

The relocation proposals would be in modern fit for purpose buildings, providing pleasant spaces where patients could access more services in the future, and would fit with the infrastructure development of Halton that residents are proud of.

7.0 RISK ANALYSIS

7.1 The CCG and practice pre engagement and consultation work seeks to identify any risks for patients of the proposals and if proposals are agreed to ensure the identified risks are mitigated.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Older patients, young families and some disabled patients have been identified as groups that may find a relocated practice more difficult to travel to. Consultation work will include representation from these groups to understand any concerns and ensure mitigations are in place. The midwifery service for pregnant women is not provided at the practice sites and is not affected by the proposed relocations and branch closure.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

9.1 None under the meaning of the Act.

REPORT TO: Health Policy and Performance Board

DATE: 19th June 2018

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health and Wellbeing

SUBJECT: Draft Topic Brief for Scrutiny Review of Care Homes – Future Sustainability

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present SMT with the draft Topic Brief for the Scrutiny Review of the Care Homes – Future Sustainability to go forward to the Health Policy and Performance Board for approval on 19th June.

2.0 **RECOMMENDATION: That the Board:**

i) Approve the draft Topic Brief for the Scrutiny Review of the Care Homes – Future Sustainability attached at the appendix; and

ii) Discuss membership of the Topic Group for this topic.

3.0 **SUPPORTING INFORMATION**

3.1 A meeting was held on 13th December 2017 with members of the Health Policy and Performance Board to discuss and agree priorities for Adult Social Care for 2018/19. Following the meeting, these priorities were agreed as:

- Care Homes – Future Sustainability;
- Supported Housing/Accommodation Review;
- Acute Trusts/Acute Mental Health – National pressures and how these translate into local pressures; and
- Accountable Care System.

3.2 At the Health PPB in February 2018, these priorities were discussed and Members chose the Care Home – Future Sustainability as the area for the scrutiny review during 2018/19.

3.3 The draft Topic Brief has been written, attached at the Appendix, for approval. The scrutiny will start in June 2018, with the final report and recommendations being presented at the Health PPB in February 2019.

4.0 **POLICY IMPLICATIONS**

4.1 None identified.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 Recommendations from the topic group will not have any financial cost to them.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**
None identified.

6.2 **Employment, Learning & Skills in Halton**
None identified.

6.3 **A Healthy Halton**
The Halton Care Home Model vision is of outstanding care for all individuals who live in our care homes. To enable us to achieve this vision we will need to:

- Provide excellent care every time to reinforce wellbeing and independence.
- Work with all partners to personalise services for the individual.
- We will have strong leadership across the system to ensure a quality driven and sustainable sector, grounded in our community and led by excellent staff.

6.4 **A Safer Halton**
None identified.

6.5 **Halton's Urban Renewal**
None identified.

7.0 **RISK ANALYSIS**

7.1 The role of scrutiny within Adult Social Care is a key function to ensure transparency, accountability and consistency within all areas and making sure the residents of Halton have the best outcomes possible.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified.

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

9.1 None identified.

TOPIC BRIEF

Topic Title:	Care Homes – Future Sustainability
Officer Lead:	Helen Moir, Divisional Manager, Independent Living Services
Planned start date:	June 2018
Target PPB Meeting:	March 2019

Topic Description and scope:
The Care Home sector nationally has highlighted a number of significant challenges, including capacity, quality and finances. This is replicated locally, and a number of work streams are in place to address these challenges. This topic focusses on the current approach in Halton, and will review future plans to address the local challenges.

Why this topic was chosen:
In Halton there are 15 providers of care homes, equating to a total of 674 beds, which includes 70% residential and 30% nursing. The demand on those beds is fairly high, and at any one time there is a vacancy rate of approximately 5%, compared to a national average of 10-15%.

Recently a number of concerns have been highlighted in relation to the future sustainability of this sector. The quality and financial challenge on the sector as a whole has resulted in some recent care home closures and the Local Authority has been able to support this by purchasing two care homes.

A new approach is being implemented to deliver on our vision to improve standards and sustainability in delivering outstanding care in Halton.

Key outputs and outcomes sought:

- Sustainability – gain an understanding of the Care Home sector in Halton, including how many homes, types of beds available, capacity, etc., for a clear picture of the sector;
- Consider the current pressures in Halton's Care Home sector and focus on plans currently being considered in relation to future sustainability.
- Funding – consider the current fee rate model, and potential options being considered for future funding and commissioning models, including the impact of "top ups";
- Consider Halton's position in relation to quality in comparison to our close neighbours to understand the potential impact on our local market.
- Consider any additional/alternative approaches to address the future sustainability of the market.

Which of Halton's 5 strategic priorities this topic addresses and the key objectives and improvement targets it will help to achieve:

A Healthy Halton

To improve the health and wellbeing of Halton people so they live longer, healthier and happier lives.

Nature of expected/desired PPB input:

Member led scrutiny review of the current approach to Market management of the care home sector in Halton.

Preferred mode of operation:

- Attend formal opening of Millbrow Care Home on 28th June that HBC have recently purchased;
- Focus group with internal adult social care staff – "how do we oversee the quality of care homes";
- Meetings with/presentations from relevant officers within the Council/Health Services and partner agencies to examine current practices regarding future sustainability;
- Benchmark against Halton's neighbouring Authorities and wider through the ADASS area to examine other commissioning models and how they compare to Halton's approach;
- Invite representative from the Local Care Home Owners to provide their perspective on the current approach in Halton;
- Undertake some site visits to homes in Halton; and
- Invite Local Care Quality Commission (CQC) to talk through their role and views on Halton Care Homes.

Agreed and signed by:

PPB chair …… **Officer ……**

Date …….. **Date …….**

REPORT TO: Health Policy & Performance Board

DATE: 19th June 2018

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health & Wellbeing

SUBJECT: Performance Management Reports, Quarter 4 2017/18

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This Report introduces, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to Health in Quarter 4 of 2017/18. This includes a description of factors which are affecting the service.

2.0 **RECOMMENDATION: That the Policy and Performance Board:**

i) Receive the Quarter 4 Priority Based report

ii) Consider the progress and performance information and raise any questions or points for clarification

iii) Highlight any areas of interest or concern for reporting at future meetings of the Board

3.0 **SUPPORTING INFORMATION**

3.1 The Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. Therefore, in line with the Council's performance framework, the Board has been provided with a thematic report which identifies the key issues in performance arising in Quarter 4, 2017/18.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications associated with this report.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 There are no other implications associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

There are no implications for Children and Young People arising from this report.

6.2 Employment, Learning & Skills in Halton

There are no implications for Employment, Learning and Skills arising from this report.

6.3 A Healthy Halton

The indicators presented in the thematic report relate specifically to the delivery of health outcomes in Halton.

6.4 A Safer Halton

There are no implications for a Safer Halton arising from this report.

6.5 Halton's Urban Renewal

There are no implications for Urban Renewal arising from this Report.

7.0 RISK ANALYSIS

7.1 Not applicable.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no Equality and Diversity issues relating to this Report.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None under the meaning of the Act.

Health Policy & Performance Board Priority Based Report

Reporting Period: Quarter 4: 1st January to 31st March 2018

1.0 Introduction

This report provides an overview of issues and progress against key service area objectives and milestones and performance targets, during the fourth quarter of 2017/18 for service areas within the remit of the Health Policy and Performance Board. These areas include:

- Adult Social Care (including housing operational areas)
- Public Health

2.0 Key Developments

There have been a number of developments within the fourth quarter which include:

Adult Social Care:

PBSS

The Team recently secured the Knowsley contract to provide Behaviour services to their residents. The contract is for 3 years and valued at £600k. This will provide security for the service and allow time to develop children's services and extend its expertise across the region.

Learning Disability Nurses

- The team are currently reviewing their eligibility and screening process, this is currently a joint process with our health colleagues from NWBH
- The LeDeR programme has been commissioned by NHS England to support the review of deaths of people with a Learning Disability, the aim of these reviews is to identify common themes and learning points, and Provide support to local areas in the development of action plans to take forward the lessons learned. The Learning Disability nursing team support this process and have 2 Nurses who participate in the reviews.
- The team have now completed an accredited course with the family planning association to enable them to deliver sexual health and relationships work. The team have now developed 8 sessions and delivered them following the training.
- There has recently been a meeting to discuss the Dynamic Risk Database as part of transforming care. This was to look at ways to improve working together and processes, such as joint risk assessments. The Nurses from the Learning Disability Team continue to be lead professionals for the Risk register.
- The team are changing the way we work with clients around Health Action Plans and we are currently trialling a new health questionnaire that is focussed on completion of the Learning Disability Health check.
- The team are liaising closely with generic services i.e., Hospitals to ensure reasonable adjustments are priority for our clients

- The team continue to support Nursing students from local universities and have recently supported a student Nurse from Edge Hill

Review of the North West Boroughs Acute Care Pathway and Later Life and Memory Services

This piece of work is now complete. The review took place in early 2017, and became known as the Tony Ryan report, after the name of the Report's author. This made a number of recommendations for change across the whole footprint of the North west Boroughs. Locally, this has resulted in a number of developments:

- The development of a new management structure within the North West Boroughs which relates more directly to local strategic and operational planning processes. This is already resulting in improved engagement at a local level in the way services are designed and delivered
- Mental health community services have been redesigned to focus more on the communities within Halton, and particularly Runcorn and Widnes. Large teams have been split and are now being relocated in both towns. This should provide for greater ease of access for local residents
- Care pathways have also been redesigned, to improve the throughput of work from specialist secondary care services, to a greater emphasis on support from within primary care services, and the private and voluntary sectors. The Council's Mental Health Outreach Team has been redesigned to focus more on short-term interventions for people with a range of mental health needs, and this is already showing promising signs of success. The new care pathways will also allow smoother and easier access to specialist secondary care services for those people that need it.

Developing the use of the Mental Health Resource Centre in Vine Street, Widnes

This resource was originally developed to provide an integrated hub to support people with a range of mental health problems in Halton, but for some years it was underused and not fully meeting this aim. Following the provision of capital allocations from the Borough Council, the North West Boroughs and NHS Halton Clinical Commissioning Group, the fabric of the building has been redesigned to support this original aim. Downstairs, the North West Boroughs Assessment and Home Treatment service will be based in the building, with clinic facilities and a small but important crisis resource which will help to divert people from needing admission to hospital when in mental health crisis. Upstairs remains occupied by the council's Mental Health Outreach Team and the Community Bridge Building Team, but the development within this area of flexible working facilities means that social workers from the Brooker Unit have been able to relocate to these premises. This interplay of NHS mental health services, council community mental health support services and council social work services will allow for much greater communication between the services, and for quick and simple referral pathways to be put in place for people with mental health problems.

Telehealth Service

The Telehealth Service have been looking at ways it can develop service delivery models that enable more people to be supported at home or in their local community to help manage the increasing demand. The service is looking at ways it can be more of a proactive and preventative service, looking to create better networks in the community, improve social isolation and keep people out of health and social care services for as long as possible.

The Telehealth Service is looking to double the number of connections over the next 4 years. The idea is to develop the service into one which better helps manage the demand on social care, reduces the number of referrals into mainstream services, the number of traditional care packages needed and the number of people being admitted into long-term care. The expectation is that the service can reduce the number of hospital admissions, calls to the ambulance service and help provide an improved discharge service.

Over the last 10 weeks Tunstall (our Telecare Provider) have worked closely with us to understand our 'As Is' processes so they can better assist us with transforming the service. The review identified that the service is generally reactive, and it does not implement preventative measures as standard. It was identified as part of the review that there is good practice where telecare is being utilised, however, Tunstall have made several recommendations and will continue to work with the service to realise its full potential.

Community Connectors

The two new local connector (LAC) posts. The 12 month pilot, has now started, this is a new role that focuses on building strong partnerships with communities, agencies and services to develop their capacity to meet people's needs and grow an evidence base in order to inform effective strategic and operational direction of local area connectors.

They will be committed to enhancing the lives of all people and fairness and equality in communities through empowering people to make their own decisions and committed to developing positive relationships. They shall act as a single, local point of contact in an agreed area and proactively seek out vulnerable people who may benefit from a local area connector approach.

They will provide advice, information and support in the community to people, families and their carers across service types

Building long term relationships with around 50-65 people/families enabling them to:

- Access information in a variety of ways
- Be heard, in control and make choices
- Identify their personal strengths and aspirations
- Find practices (non-service) ways of doing the things they want or need to do
- Develop and use personal and local networks
- Plan for the future
- Connect with, be part of and contribute to local community life
- Access support and services if required, at the right time

The Principal Social Worker continues to meet with all social workers in a "Social Work Matters" Forum on a quarterly basis, to promote good practice. We continue to look at developing models of good practice and an ongoing part of this work. In addition we have joined Ripfa which offers a research engine to promote evidence based practice and several training opportunities, a presentation was made to staff explaining the benefits. An event looking at risk assessment is planned for April, with social care staff facilitated by Ripfa.

Occupational Therapy

Following on from the endorsement of the Occupational Therapy, progression policy the team now have an advanced OT practitioner in place who is now working, looking at improvements in working practice. Work on implementing single-handed care is ongoing which promotes independence of service users, further work is underway to continue develop this area. A training programme was undertaken and HBC OTs are now undertaking manual handling assessments which had previously been commissioned externally, this should support better quality assessment for service users.

Autism Strategy

The One Halton, All Age Autism strategy 2018- 2021 and delivery plan has now been completed. The key aspects of this are the introduction of an Autism Action Alliance to drive forward the delivery plan, the establishment of a local autism group for adults with autism, scoping out existing services for people with autism and developing better links between commissioners in each area to develop better joined up

commissioning of services for people with autism. There will be an event to launch the new strategy in May 2018.

Transition Team

A Transition Team in Halton, was set up in February 2017 as a pilot. The team has now established with 3 social workers, which originate from Children and Adult services. The role of the team is to ensure the smooth transition of young people with disabilities, from 14 years old to 25 who are leaving children's service into Adult services. They have introduced the named social worker pilot.
The Team was working on as part of a government scheme to pilot "Named Social Workers", since September 2017, on an approach championed by Lyn Romeo Chief Social Worker. It is One-to-one intense Social Work intervention for 15 17/18 year olds with learning disabilities, autism and mental health conditions. Halton is one of 6 Local Authorities; chosen to be part of a £400,000 Government investment, with Halton Borough Council receiving £92,827 from the scheme, The extra investment, has been received positively by those who used the service and their families.
The pilot is now complete and has given a clear sense of the difference that a named social worker can make in transforming learning disability services.
The 6 months of the pilot, has now come to an end and Halton Borough Council, will aim to continue with this model, with people with these Severe Learning Disabilities, who are now given one primary point of contact to provide advice, work with family and carers and encourage patients to live more independently in the community

The Department has also funded the Innovation Unit – a social enterprise – and the Social Care Institute of Excellence to will continue to support Halton with the evaluation the scheme and how we can best support its roll out across the council.

Public Health:

A model and framework for prevention is being developed with the One Halton Board. Life expectancy has increased for women which is an improvement on previous years. The new 0-19 Healthy Child Programme will commence 1st April 2018. This programme has been awarded to Bridgewater Commuity Trust and will play a key role as part of the children's Early Help Strategy. The current action plan on helping pregnant women stop smoking is showing results with a significant increase in quitters.

3.0 Emerging Issues

3.1 A number of emerging issues have been identified during the fourth quarter that will impact upon the work of the Directorate including:

Adult Social Care:

Safeguarding

The Safeguarding Unit are working with the NW Safeguarding Leads Group to develop a NW policy for managing concerns around people in positions of trust with adults who have care and support needs. This policy will provide a framework and process for responding to allegations and concerns against people working with adults with care and support needs. This process will be replicated across all NW regions and will provide a cohesive response to allegations and concerns.

Community Deprivation of Liberty Safeguards

Following the 2014 Cheshire West ruling Local Authorities have been required to develop processes that will ensure that people based in the community who lack capacity and as a result of the nature of their support are considered as deprived of their liberty. This involves court of protection applications for this group of people. The focus of the recent work undertaken by a working group has been to develop processes, information and guidance for staff and the public to support a more effective approach to this work. To date approximately 50 people have been assessed and of these around 30 will need a court of protection application. The majority of this group have had the necessary paperwork completed and are awaiting review by manages and HBC legal team to progress to the next stage of the process (submission to the court of protection).

Public Health:

The review of the Ageing Well Programme should help us to identify why we are continuing to see high levels of falls in older people.

4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. As such Directorate Risk Registers were updated in tandem with the development of the suite of 2017/18 Directorate Business Plans.

5.0 Progress against high priority equality actions

There have been no high priority equality actions identified in the quarter.

6.0 Performance Overview

The following information provides a synopsis of progress for both milestones and performance indicators across the key business areas that have been identified by the Directorate. It should be noted that given the significant and unrelenting downward financial pressures faced by the Council there is a requirement for Departments to make continuous in-year adjustments to the allocation of resources in order to ensure that the Council maintains a balanced budget. Whilst every effort continues to be made to minimise any negative impact of such arrangements upon service delivery they may inevitably result in a delay in the delivery of some of the objectives and targets contained within this report. The way in which the Red, Amber and Green, (RAG), symbols have been used to reflect progress to date is explained at the end of this report.

"Rate per population" vs "Percentage" to express data

Four BCF KPIs are expressed as rates per population. "Rates per population" and "percentages" are both used to compare data but each expresses the same amount in a different way. A common guide used is that if a percent is less than 0.1 then a rate (e.g. per 100,000) is used. For example, permanent admissions to residential care expressed as a rate (50 admissions per or for every 100,000 people) makes more sense when comparing performance with other authorities rather than as a percentage (0.05%) which is quite a small number and could be somewhat confusing. More examples below:

Location	Rate per 100,000 population	Percent
Region A	338.0	0.34%
Region B	170.5	0.17%
Region C	225.6	0.23%

Adult Social Care

Key Objectives / milestones

Ref	Milestones	Q4 Progress
1A	Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target	✓
1B	Integrate social services with community health services	✓
1C	Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder.	✓
1D	Continue to implement the Local Dementia Strategy, to ensure effective services are in place.	✓
1E	Continue to work with the 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems.	✓
1F	The Homelessness strategy be kept under annual review to determine if any changes or updates are required.	✓
3A	Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Group, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place.	✓

Supporting Commentary

1a - Work continues to ensure the effective management of this budget.
End of year has seen a small overspend, discussions with the CCG continue to increase the allocation of funding for next year to ensure financial viability.

1b - Multi-disciplinary Team work is ongoing across primary care, community health care and social care

1c - A new All-Age Autism strategy has been developed with key stakeholders and people with autism and their carers. As part of the consultation, an event with key providers took place on 10th January, along with a number of different events with Children, young people and their parents/carers which were all used to develop the delivery plan. The strategy has been presented to Health PPB on 27th February and the Health and Wellbeing Board on 28th March.

1d - The Post Diagnosis Community Pathway has been extended for 1 year until 31.3.19. The Halton Dementia Action Alliance has planned a number of activities in support of National Dementia Action week (May 2018), including an event in conjunction with Halton Libraries to engage people with reminiscence therapy, promotion of local vol/com sector support services,

dementia awareness using HBC social media channels throughout the 'action week', Dementia Friends Awareness for members of the public and a Dementia Friends Awareness Session for HBC staff.

1e - This objective has been achieved. The pathways for people with acute mental health problems and for older people with mental health problems have been redesigned and are in place. Social care services have been redesigned to take this into account. Work continues to ensure that health and social care teams are co-located in both Widnes and Runcorn, to ensure the appropriate delivery of these pathways.

1f - The annual homelessness strategy review is underway and a consultation event with providers was conducted early March 2018, which proved very successful. The strategy and action plan is presently being reviewed and will be updated to reflect key priorities.
The homelessness strategy is due to be fully reviewed and a five year strategy document report will be completed for approval mid 2018. The strategy will include a five year action plan, which will determine the LA priorities and key objectives, to ensure it reflects economical and legislative changes.

3a - The work on developing the One Halton placed based commissioning and service delivery is ongoing.

Key Performance Indicators

Older People:						
Ref	**Measure**	**16/17 Actual**	**17/18 Target**	**Q4**	**Current Progress**	**Direction of travel**
ASC 01	Permanent Admissions to residential and nursing care homes per 100,000 population 65+ ***Better Care Fund performance metric***	515.3	635	623.3	✓	↓
ASC 02	Delayed transfers of care (delayed days) from hospital per 100,000 population. ***Better Care Fund performance metric***	519	TBC	458	✗	↑
ASC 03	Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population. ***Better Care Fund performance metric***	3381	13,289	3261	✓	↑
ASC 04	Hospital re-admissions (within 28 days) where original admission was due to a fall (aged 65+) (directly standardised rate per 100,000 population aged 65+) ***Better Care Fund performance metric***	N/A	N/A	N/A	N/A as no target	N/A
ASC 05	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital	62.12%	65%	78%	✓	↑

	into reablement/rehabilitation services (ASCOF 2B) ***Better Care Fund performance metric***					
Adults with Learning and/or Physical Disabilities:						
ASC 06	Percentage of items of equipment and adaptations delivered within 7 working days	93%	96%	94%	✗	↑
ASC 07	Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support – include brief definition) (Part 1)	74%	78%	76%	✗	N/A
ASC 08	Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support – include brief definition) (Part 2) DP	44%	44%	29%	✗	N/A
ASC 09	Proportion of adults with learning disabilities who live in their own home or with their family (ASCOF 1G)	86.90%	87%	88.84%	✓	↑
ASC 10	Proportion of adults with learning disabilities who are in Employment (ASCOF 1E)	6.9%	5%	5.30%	✓	↓
ASC 11	Out of Borough Placements – number of out of borough residential placements	32	30	NYA	NYA	NYA
People with a Mental Health Condition:						
ASC 12	Percentage of adults accessing Mental Health Services, who are in employment.	N/A	N/A	0.49%	N/A	N/A
ASC 13 (A)	Percentage of adults with a reported health condition of Dementia who are receipt of services.	52.86%	TBC	60.82%	N/A	N/A
ASC 13 (B)	Percentage of Carers who receive services, whose cared for person has a reported health condition of Dementia.	11.57%	TBC	14.38%	N/A	N/A
Homelessness:						
ASC 14	Homeless presentations made to the Local Authority for assistance In accordance with Homelessness Act 2002.	NA	500	117	✓	↑
ASC 15	Homeless Households dealt with under homelessness provisions of Housing Act 1996 and LA accepted	NA	100	**10**	✓	↑

	statutory duty					
ASC 16	Number of households living in Temporary Accommodation	1	17	6	✓	↑
ASC 17	Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number divided by the number of thousand households in the Borough)	6.62	6.00%	1.64	✓	↑
Safeguarding:						
ASC 18	Percentage of VAA Assessments completed within 28 days	83.5%	88%	74.49%	✗	↓
ASC 19	Percentage of existing HBC Adult Social Care staff that have received Adult Safeguarding Training, including e-learning, in the last 3-years (denominator front line staff only).	48%	56%	61%	✓	↑
ASC 20 (A)	DoLS – Urgent applications received, completed within 7 days.	73%	80%	N/A	N/A	N/A
ASC 20 (B)	DoLS – Standard applications received completed within 21 days.	77%	80%	N/A	N/A	N/A
ASC 21	The Proportion of People who use services who say that those services have made them feel safe and secure – Adult Social Care Survey (ASCOF 4B)	81.30%	82%	N/A	N/A	N/A
Carers:						
ASC 22	Proportion of Carers in receipt of Self Directed Support.	99.4	TBC	99.63%	N/A	↑
ASC 23	*Carer reported Quality of Life (ASCOF 1D, (this figure is based on combined responses of several questions to give an average value. A higher value shows good performance)*	8.10%	9	N/A	N/A	N/A
ASC 24	*Overall satisfaction of carers with social services (ASCOF 3B)*	48.90%	50	N/A	N/A	N/A
ASC 25	The proportion of carers who report that they have been included or consulted in discussions about the	78.80%	80	N/A	N/A	N/A

	person they care for (ASCOF 3C)					
ASC 26	Do care and support services help to have a better quality of life? (ASC survey Q 2b) ***Better Care Fund performance metric***	93.30%	93%	N/A	N/A	N/A

Supporting Commentary

Older People:

ASC 01 Figure provided is an estimate. Final year-end figures will not be known until completion of statutory returns in June 2018.

ASC 02 There were an average of 453 delayed days per month in the three months Dec-Feb, this is a rate of 458 per 100,000. Whilst the individual monthly target was achieved in January, it was missed in both December and February. The average number of delayed days is much reduced on the previous quarter average of 629 per month. Problems exist around capacity for care at home, patient/family choice in not accepting transitional beds and Trusts enforcing the home of choice policy.

ASC 03 There were 3261 non-elective admissions per 100,000 in the three months to Feb 18 against a target of 3340. This is below target and below the Q3 actual of 3404 per 100,000. Although the CCG is on target for Q4 for non-elective admissions, performance earlier in the year means that the CCG is currently 1.9% above the full year plan for non-elective admissions and is likely to have exceeded the target by the end of March.

ASC 04 Data not currently available due to data issues with the CSU.
No refresh on data is available beyond 2015/16.

ASC 05 Ongoing review of people in receipt of Intermediate Care has contributed to this increased performance

Adults with Learning and/or Physical Disabilities:

ASC 06 Figure provided is an estimate. Final year-end figures will not be known until completion of statutory returns in June 2018.

ASC 07 Figure provided is an estimate. Final year-end figures will not be known until completion of statutory returns June 2018.
There is no comparable data for the same period in 2016/17.

ASC 08 Figure provided is an estimate. Final year-end figures will not be known until completion of statutory returns June 2018.
There is no comparable data for the same period in 2016/17.

ASC 09 Figure provided is an estimate. Final year-end figures will not be known until completion of statutory returns June 2018.

ASC 10 Target achieved. At year-end there were 21 clients with a learning disability in employment.

ASC 11 There is currently no accurate data available for out of borough placements, we are

currently collating an up to date list of those services users who are placed out of borough.

People with a Mental Health Condition:

ASC 12 This is a new indicator for 2017/18, therefore no comparable data

ASC 13 (A) This is a new indicator for 2017/18, therefore no comparable data

ASC 13 (B) This is a new indicator for 2017/18, therefore no comparable data

Homelessness:

ASC 14 In accordance with the Homelessness legislation, all Local Authorities have a statutory duty to administer and address homelessness within the Borough. It must offer advice and assistance and give due consideration to all applications for housing assistance.

The Local Authority must have a reason to believe that an applicant may be homeless or threatened with homelessness, and make the necessary enquiries in accordance with the Homelessness Act 2002, to determine whether a duty is owed under Part 7 of the Housing Act 1996

The statutory homelessness figures identified for quarter three are low, however, this is consistent with the increased level of prevention activity administered by the Housing Solutions Team. The team fully utilise all prevention initiatives and financial resources available to reduce homelessness.

ASC 15 Part 7 of the Housing Act 1996 sets out the powers and statutory duties that all housing authorities are fully compliant. The LA must ensure that vulnerable clients who present as homelessness are offered advice and assistance.

The Local Authority has a statutory duty to provide both temporary and secure accommodation to clients accepted as statutory homeless. The figures are generally low, which is due to the high level of officer activity and initiatives to prevent homelessness

ASC 16 National and Local trends indicate a gradual Increase in homelessness, which will impact upon future service provision, including temporary accommodation placements.

The introduction of the Homelessness Reduction Act 2017 will have a big impact upon homelessness services, which will result in a vast increase in the use of the temporary accommodation.

ASC 17 The Housing Solutions Team promotes a community focused service, with emphasis placed upon homeless prevention.

The officers have a range of resources and options that are offered to vulnerable clients threatened with homelessness. The tea strives to improve service provision across the district. Due to the early intervention and proactive approach, the officers have continued to successfully reduce

homelessness within the district.

Safeguarding:

ASC 18	Figure provided is an estimate. Final year-end figures will not be known until completion of statutory returns June 2018.
ASC 19	Target achieved. The Adult Social Care Workforce Group will monitor to ensure this figure is continually improving.
ASC 20 (A)	Data not available due to reporting issues which are being investigated.
ASC 20 (B)	Data not available due to reporting issues which are being investigated.
ASC 21	Annual collection only to be reported in Q4.

Carers:

ASC 22	Figure provided is an estimate. Final year-end figures will not be known until completion of statutory returns June 2018.
ASC 23	Carer Survey. Annual collection only to be reported in Q4 in 2018/19.
ASC 24	Carer Survey. Annual collection only to be reported in Q4 in 2018/19.
ASC 25	Carer Survey. Annual collection only to be reported in Q4 in 2018/19.
ASC 26	For this survey this year we excluded voluntary questions to try to improve response rate, therefore there is no data available.

Public Health

Key Objectives / milestones

Ref	Milestones	Q4 Progress
PH 01a	Increase the uptake of smoking cessation services and successful quits among routine and manual workers and pregnant women	✓
PH 01b	Work with partners to increase uptake of the NHS cancer screening programmes (cervical, breast and bowel)	U
PH 01c	Ensure Referral to treatment targets are achieved and minimise all avoidable breaches. AND/ OR Increase awareness among the local population on the early signs and symptoms of cancer.	✗
PH 02a	Facilitate the Healthy child programme which focusses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, and health, well-being and parenting advice for ages 2½ years and 5 years.	U

PH 02b	Maintain the Family Nurse Partnership programme.	✓
PH 02c	Facilitate the implementation of the infant feeding strategy action plan	✓
PH 03a	Expansion of the Postural Stability Exercise Programme.	✓
PH 03b	Review and evaluate the performance of the integrated falls pathway.	✓
PH 04a	Work in partnership to reducing the number of young people (under 18) being admitted to hospital due to alcohol	U
PH 04b	Raise awareness within the local community of safe drinking recommendations and local alcohol support services through delivering alcohol awareness campaigns, alcohol health education events across the borough and ensuring key staff are trained in alcohol identification and brief advice (alcohol IBA	✓
PH 04c	Ensure those identified as having an alcohol misuse problem can access effective alcohol treatment services and recovery support	✓
PH 05a	Monitor and review the Mental Health Action plan under the Mental Health Governance structures (covering actions to promote mental health and wellbeing and the early detection and effective treatment of mental health conditions.	✓
PH 05b	Implementation of the Suicide Action Plan.	✓

Supporting Commentary

PH 01a Throughput of clients accessing smoking cessation services in Halton has remained the same during Q3 2017 (July-September) as compared to the same period in 2016. This goes against the national trend where most Stop Smoking Services are experiencing reductions in throughput.

Halton CCG has received £75,000 of funding from NHS England for use in this financial year (2017/18) to reduce maternal smoking rates. An action plan with focussed outcomes has been developed outlining joint proposals for the use of this funding for evidence based effective interventions to reduce maternal smoking. Home visits are offered to allow pregnant women referred into the service. During Quarter 3 a total of 31 pregnant women were referred into the Halton stop smoking service an increase from previous quarters.

PH 01b Halton are continuing to identify areas and opportunities to maximise uptake of screening. We are working in collaboration with many partners to explore opportunities to develop new initiatives to improve screening uptake and early detection messaging, we are currently working closely with the Cheshire and Merseyside Cancer Prevention Group to look at opportunities at scale for improving screening uptake, we are also working closely with the GP federations to explore targetted opportunities to increase screening uptake at more local levels, initially focussing on cervical screening.

PH 01c Halton is working with the Cheshire and Merseyside Prevention Group to explore opportunities for identifying and developing a early detection awareness campaign to try and maximise impact on local more resistent populations. With a new Trust cancer manager in place for Warrington and Halton NHSFT we are working more closely to explore root causes of local breaches.

PH 02a The new 0-19 service, which was awarded to Bridgewater community health care trust, is on track to commence in April 2018.
The Bridgewater health visitor service continues to deliver all the elements of the Healthy Child programme, however there has been a reduction in the coverage of some of the mandated checks. Assurance has been received that this is due to staff vaccancies that have been filled, and that coverage will improve. Performance will continue to be closely monitored

PH 02b Family Nurse Partnership was recommissioned as part of the integrated service. It continues to be fully operational with a full caseload and works intensively with first time, teenage mothers and their families.

In December FNP had its annual review and celebration event. The Halton FNP team maximum capacity is 100 clients, and they have delivered the programme to 123 clients since starting in November 2014. In 2017 the 4 nurses delivered 1495 home visits. The programme runs from early pregnancy to the child's second birthday, and Halton has now had 20 clients complete the whole programme and graduate to the Health Visiting service.

PH 02c The implementation of the infant feeding action plan is underway, with oversight from the Halton Health in the Early Years group. The infant feeding team continue to proactively contact all mothers on discharge from hospital to support with feeding, and have had cases of women wishing to initiate breastfeeding following discharge from hospital. The infant feeding work will be fed into the whole systems approach to tackling obesity.

PH 03a Health Improvement continues to provide the "Age Well programme" across the borough. A review of referral pathways is currently being undertaken to increase appropriate referrals for all partners into Falls prevention classes. A trail has taken place in a care home to pilot the Age well programme and also in an intermediate care hospital to improve service provision and reduce future demand on services. Older people's practice manager to work with community therapy team to expand on pilot and review rehab pathway for deteriorating clients. HIT Continue to deliver staff training to frontline professionals to raise awareness of falls prevention and the appropriate falls pathways.

PH 03b Work is being undertaken with intermediate care to review the post Falls recovery pathway. Links also being made with the new frailty unit at Warrington to develop referral pathway for Halton residents. The falls prevention strategy is to be circulated in draft for comment to wider partners with view to sign off by end of Qtr 2 2018. A comprehensive training programme is now being rolled out to raise confidence in the use of screening tools and to increase capacity in service via staff having the skills to work more effectively with patients to improve strength, balance and gait without referring for specialist services.

PH 04a Good progress has been made in recent years in reducing the number of young people being admitted to hospital due to alcohol. Key activity includes:

- Delivery of alcohol education within local school settings (Healthitude, Amy Winehouse Foundation, Cheshire Police).
- Delivery of community based alcohol education activity.
- Delivering early identification and brief advice (alcohol IBA) training and resources for staff who work with children and young people).
- Partnership work to reduce underage sales and associated antisocial behaviour.

More recent data has seen this downward trend level off. Therefore local partnership work needs to continue to be strengthened.

PH 04b Work continues to raise awareness among the local community of safe drinking recommendations and to train staff across the health, social care, criminal justice, community and voluntary sector in alcohol identification and brief advice (alcohol IBA).

PH 04c During Q3, CGL (Change, Grow, Live - Halton Integrated Substance Misuse Service) received 61 new referrals; 47 for alcohol only and 14 for alcohol and non-opiate problems. Local data suggests that by the end of Q3 92 individuals were engaged in structured treatment where alcohol was the primary concern, and 55 were involved in post treatment recovery support. A further 42 clients were in receipt of support for non-opiate and alcohol problems.

PH 05a Halton Health Improvement and Public heatlh continue to roll out a series of programmes and training activities around Mental health, with good partnership working on the delivery of action plans, raising awareness and provision of community based programmes and activities.

PH 05b The Suicide prevention action plan has been updated and continues to be implemented. The plan links closely with the Cheshire and Merseyside No More Suicides strategy. Champs are leading on an area-collaborative approach to gain Suicide Safer Community Status.
A real time surveillance intelligence flow has been set up which will enable faster identification of potential trends and clusters. Beginning to work more clsely with the mental health concordat to ensure a user focus is provided to the group.

Key Performance Indicators

Ref	Measure	16/17 Actual	17/18 Target	Q4	Current Progress	Direction of travel
PH LI 01	A good level of child development (% of eligible children achieving a good level of development at the end of reception)	61.9% (2015/16)	65.0% (2016/17)	60.9% (2016/17)	✗	↓
PH LI 02a	Adults achieving recommended levels of physical activity (% adults achieving 150+ minutes of physical activity)	48.5% (2015)	49.0% (2016)	60.8% (May 2016/17)	U	N/A
PH LI 02b	Alcohol-related admission episodes – narrow definition (Directly Standardised Rate per 100,000 population)	841.7 (2015/16)	841.7 (2016/17)	876.8 (Q2 2017/18) Provisional	U	⟷
PH LI 02c	Under-18 alcohol-specific admissions (crude rate per 100,000 population)	55.5 (2013/14-2015/16)	54.1 (2014/15-2016/17)	61.3 (2015/16-2017/18)Provisional	✗	↓
PH LI 03a	Smoking prevalence (% of adults who currently smoke)	16.6% (2016)	16.2% (2017)	Annual data only	U	N/A

PH LI 03b	Mortality from cardiovascular disease at ages under 75 (Directly Standardised Rate per 100,000 population) *Published data based on calendar year, please note year for targets*	92.0 (2016)	89.8 (2017)	96.9 (2017) Provisional		
PH LI 04a	Self-harm hospital admissions (Emergency admissions, all ages, directly standardised rate per 100,000 population)	341.5 (2015/16)	332.3 (2016/17)	336.7 (2016/17)		
PH LI 04b	Self-reported wellbeing: % of people with a low happiness score	12.7% (2015/16)	11.1% (2016/17)	Annual data only		N/A
PH LI 05	Mortality from all cancers at ages under 75 (Directly Standardised Rate, per 100,000 population) *Published data based on calendar year, please note year for targets*	177.2 (2016)	169.2 (2017)	173.7 (2017) Provisional		
PH LI 06ai	**Male** Life expectancy at age 65 (Average number of years a person would expect to live based on contemporary mortality rates) *Published data based on 3 calendar years, please note year for targets*	17.3 (2013-15)	17.6 (2014-16)	17.3 (2014-16)		
PH LI 06aii	**Female** Life expectancy at age 65 (Average number of years a person would expect to live based on	18.8 (2013-15)	19.1 (2014-16)	19.1 (2014-16)		

	contemporary mortality rates) *Published data based on 3 calendar years, please note year for targets*					
PH LI 06b	Falls and injuries in the over 65s (Directly Standardised Rate, per 100,000 population; PHOF definition)	3016. (2015/16)	3000.5 (2016/17)	3305.8 (2016/17)		
PH LI 06c	Flu vaccination at age 65+ (% of eligible adults aged 65+ who received the flu vaccine, GP registered population)	72.2% (2015/16)	75.0% (2016/17)	74.0% (2017/18) Provisional		

Supporting Commentary

PH LI 01 - No further update – data released annually

PH LI 02a - November 2015/16 figure including gardening in the list of activities; May 2016/17 figures exclude gardening from the list of activities included in being physically active.

PH LI 02b - We are above the target rate as of Q2 2017/18, however as we are only halfway through the current year, we cannot be sure as to whether we will meet the year-end target or not.

PH LI 02c - No further update – data released annually

PH LI 03a - No further update – data released annually

PH LI 03b - Mortality from CVD has increased slightly from 2016 to 2017 and as a result exceeded and failed to meet the target for the year.

PH LI 04a - 2016/17 data now published; provisional data resulted in same value as newly published data.

PH LI 04b - Indicator published by PHE has changed to % of people with a High/Very High happiness score. This indicator and target will be reviewed for the Q1 2018/19 QMR.

PH LI 05 - Though we did not meet the target for 2017, the rate of deaths from cancer (according to local data and workings) was lower than during 2016.

PH LI 06ai - No further update – data released annually

PH LI 06aii - No further update – data released annually

PH LI 06b - 2016/17 data now published; marginal change in rate from provisional data included in Q3

2017/18 QMR

PH LI 06c - Although Halton failed to meet the 75% target for flu vaccination uptake amongst those aged 65+, there was an improvement of 2.5% on the 2016/17 vaccination uptake.

ADULT SOCIAL CARE DEPARTMENT

Revenue Budget as at 31 March 2018

	Annual Budget £'000	Actual Spend £'000	**Variance** (Overspend) £'000
Expenditure			
Employees	13,761	13,407	354
Other Premises	392	424	(32)
Supplies & Services	1,366	1,364	2
Aids & Adaptations	113	106	7
Transport	207	209	(2)
Food Provision	195	182	13
Contracts & SLAs	495	498	(3)
Emergency Duty Team	95	95	0
Other Agency	749	750	(1)
Payments To Providers	1,467	1,478	(11)
Contribution to Complex Care Pool	20,647	20,647	0
Total Expenditure	**39,487**	**39,160**	**327**
Income			
Sales & Rents Income	-306	-315	9
Fees & Charges	-741	-640	(101)
Reimbursements & Grant Income	-1,102	-1,090	(12)
Transfer From Reserves	-375	-375	0
Capitalised Salaries	-177	-177	0
Government Grant Income	-854	-853	(1)
Total Income	**-3,555**	**-3,450**	**(105)**
Net Operational Expenditure	**35,932**	**35,710**	**222**
Recharges			
Premises Support	517	517	0
Asset Charges	347	347	0
Central Support Services	3,352	3,352	0
Internal Recharge Income	-2,189	-2,189	0
Transport Recharges	497	517	(20)
Net Total Recharges	**2,524**	**2,544**	**(20)**
Net Department Expenditure	**38,456**	**38,254**	**202**

Comments on the above figures

In overall terms, the Net Department Expenditure was £202,000 below budget.

Employee costs were underspent by £354,000. This was due to savings being made on vacancies within the department. The bulk of the staff savings were made in the Care Management and Initial Assessment teams. These services have undergone a review, a permanent savings target of £100,000 resulting from the deletion of a number of vacant posts has been incorporated into the 2018/19 budget

Fees & Charges income was under-achieved by £100,000. This was primarily due to the Community Meals income target built into the 2017-18 base budget. The impact of the shortfall in

budgeted income has been reviewed as part of the process in setting the 2018/19 base budget, and a permanent reduction of £65,000 has been applied to the target.

Capital Projects as at 31th March 2018

	2017-18 Capital Allocation £'000	Actual Spend £'000	Total Allocation Remaining £'000
Upgrade PNC	6	6	0
ALD Bungalows	199	0	199
Bredon Reconfiguration	56	73	(17)
Grangeway Court Refurbishment	0	12	(12)
Vine Street Development	100	67	33
Purchase of 2 Adapted Properties	520	0	520
Total	881	158	723

Comments on the above figures:

The £6,000 funding relating to the upgrading of the PNC represents the unspent capital allocation carried forward from the previous financial year to enable the scheme's completion. The total scheme has now completed, with residual payments to match this allocation.

Building work on the ALD Bungalows has been deferred to 2018/19. Approval has been granted by the Operational Director Finance to carry-forward the funding to the new financial year to allow the scheme's completion.

The Bredon Reconfiguration project is funded from previous year's Adult Social Care capital grant. The scheme, which commenced in 2016/17 with a total project budget of £343,000 has now been completed. The £17,000 overspend has been funded by savings from other capital schemes.

The £12,000 expenditure on Grangeway Court Refurbishment relates to unexpected residual costs following the scheme's completion in 2016/17. These costs are to be met from an underspend on capital costs relating to the Vine Street Development.

The Vine Street Development project relates to the adaptation of the Mental Health Resource Centre in Widnes in order to better meet service user's needs. Construction is now substantially completed, with the final payments due in the early part of the 2018/19 financial year.

The £520,000 capital allocation for the purchase of 2 adapted properties relates to funding received from the Department Of Health under the Housing & Technology for People with Learning Disabilities Capital Fund The funding is to be used for the purchase and adaptation of two properties to meet the particularly complex and unique needs of two service users. The scheme is anticipated to be completed during the 2018/19 financial year, and approval has been granted by the Operational Director of Financial Services to carry the funding forward to the new financial year.

Pooled Budget Capital Projects as at 31st March 2018

	2017-18 Capital Allocation £'000	Actual Spend £'000	Total Allocation Remaining £'000
Disabled Facilities Grant	896	893	3
Stair lifts (Adaptations Initiative)	300	296	4
RSL Adaptations (Joint Funding)	250	240	10
Millbrow Residential Home	935	785	150
Madeline McKenna Residential Home	450	314	136
Total	**2,831**	**2,528**	**303**

Comments on the above figures:

Total DFG capital funding was allocated across schemes for DFG adaptations, Stairlifts, and joint-funded Residential Social Landlord adaptations. Total spend across all three projects was marginally below the funding allocation. The above total allocation includes an additional £147,000 DFG awarded in January 2018.

The £450,000 allocated for the purchase of the Madeline McKenna residential home included an allowance of £150,000 for the refurbishment of the premises. The purchase was completed in November 2017, and the establishment is now managed by Halton Borough Council's Adult Social Care department. The refurbishment of the premises is ongoing, and approval has been granted from the Operational Director Finance to carry forward the unspent capital funding to the 2018/19 financial year to ensure the completion of the required works

Similarly, Millbrow Residential Home was purchased in December 2017, and is now managed by Halton Borough Council's Adult Social Care Department. Again, the capital programme included an allocation for refurbishment (£200,000), and the unspent balance has been approved by the Operational Director Finance for carry- forward into the new financial year to allow the completion of the required works.

COMPLEX CARE POOL

Revenue Budget as at 31st March 2018

	Annual Budget £'000	Actual Spend £'000	Variance (overspend) £'000
Expenditure			
Intermediate Care Services	4,005	3,995	10
End of Life	194	195	(1)
Sub-Acute	1,734	1,734	0
Urgent Care Centres	815	784	31
Joint Equipment Store	815	1,053	(238)
CCG Contracts & SLA's	1,165	1,159	6
Intermediate Care Beds	687	687	0
BCF Schemes	1,700	1,698	2
Carers Breaks	434	270	164
Madeline McKenna Home	259	200	59
Millbrow Home	474	462	12
Contribution to Capital Costs	525	525	0
Adult Health & Social Care Services:			
Residential & Nursing Care	20,873	20,885	(12)
Domiciliary & Supported Living	14,084	14,097	(13)
Direct Payments	7,785	7,813	(28)
Day Care	458	473	(15)
Total Expenditure	**56,007**	**56,030**	**(23)**
Income			
Residential & Nursing Income	-5,876	-5,863	(13)
Domiciliary Income	-1,653	-1,618	(35)
Direct Payments Income	-458	-450	(8)
BCF	-9,661	-9,661	0
Improved Better Care Fund	-2,974	-2,974	0
CCG Contribution to Pool	-13,224	-13,224	0
ILF	-699	-699	0
Income from other CCG's	-113	-113	0
Madeline McKenna fees	-70	-85	15
Millbrow fees	-74	-54	(20)
Transfers from Reserves	-256	-201	(55)
All other income	-302	-299	(3)
Total Income	-35,360	-35,241	(119)
Net Expenditure	**20,647**	**20,789**	**(142)**
Overspend liability as per Joint Working Agreement:			
HCCG (38%)		-53	53
HBC (62%)		-89	89
Net Department Expenditure	**20,647**	**20,647**	**0**

Comments on the above figures:

The overall position for the Complex Care Pool budget is £142,000 over budget at the end of the financial year (including the HCCG liability share). Halton Borough Council's liability share is £89,000.

In accordance with the joint partnership agreement any overspend resulting at year end must be met by partners to the pool in line with their contributions for the year. For financial year 2017/18 this was 62% HBC and 38% HCCG. However agreement will be sought from the Complex Care Executive Partnership Board to carry this overspend forward to 2018/19 and be met by efficiencies in year

Intermediate Care Services is under budget by £10,000 due to a small number of staffing vacancies.

The End of Life Service delivered 14,551 hours at a cost of £195,000, marginally over the approved budget.

The Urgent Care Centre includes payments for the Rapid Clinical Assessment Team (RCAT) scheme which ended partway through the year, therefore this resulted in a £31,000 underspend at the end of the financial year.

The Joint Equipment out-turn spend is £238,000 over budget. There has been an unprecedented increase in demand for equipment, during the year, the main reason being due to increasing service users with complex needs now residing in their own homes. Bridgewater NHS Trust who provides the service has installed a new software system which should enable close monitoring of this budget in the next financial year.

The Carer's Breaks budget underspent by £163,000 due to the cessation of a couple of contracts. Also social work teams spent less than usual in this financial year on Direct Payment Carer's Breaks.

The council purchased Madeline McKenna Residential Home in November 2017 and Millbrow Residential Home in December 2017. As acquisition was only part year it was difficult to predict the budget required with the actual spend being £71,000 less than estimated. These budgets will be realigned in 2018/19 as necessary.

The Adult Health and Social Care outturn was £124,000 over budget for the financial year. It was recognised early on in the year that this budget was under significant pressure and a recovery working group was set up to address the issues. Some of these pressure areas are analysed below:-

Residential & Nursing Care

Continuing Health Care (CHC) and Joint Funded Care (JFC) packages has seen an increased spend in 2017.18 as an increasing number of people are deemed eligible for CHC. These service users are also receiving care for longer periods of time than previously. A number of these care packages were transitionally funded placements which had not been assessed within the 28 day timescale. As part of the recovery plan, the CHC team targeted these and there has been a marked improvement in the number of reviews being completed on time. Some of these packages have also been deemed not eligible for CHC and should therefore generate some additional income from client contributions. The focus on these will continue into the new financial year. CHC is being looked at nationally by NHS England

The recovery group will also continue to focus on high cost packages of care and out of borough placements.

Count and Spend:
The total number of clients receiving a permanent residential care package has decreased from 599 clients in April to 548 clients in March. The average weekly cost of a permanent residential package of care increased from £586 to £606 for the same period.

Domiciliary & Supported Living
A number of service users that are in residential homes but receiving extra 1 to 1 support have cost approximately an additional £336,000 in 2017.18. Some of these packages have been reviewed and reduced during the year and will continue to be reviewed in the new financial year. The 1 to 1 block contract with St Luke's has now ended and service users will be assessed on a case by case basis.

Count and Spend:
The total number of clients receiving a domiciliary care package decreased by 12.4% from 788 clients in April to 690 clients in March. However, the average cost of a domiciliary care package has increased by 9.5% from £299 in April to £326 in March.

Direct Payments
Service users that were previously in long term hospital settings funded via Health are now in receipt of services provided by the council. Those clients are now receiving joint funded Direct Payments. Halton CCG has contributed £256,000 towards this additional cost but it is still an ongoing pressure on the authority's budget.

Count and Spend:
The total number of clients receiving a Direct Payment (DP) has increased by 7% from 470 clients in April to 503 clients in March. The average cost of a DP package has remained the same at £323.

Contingency budget from the CCG minimum contribution to the Better Care Fund and Additional Better Care Fund monies have been utilised to offset budget pressures mentioned above and which have been reported during the course of 2017/18. The financial recovery action plan has already been implemented by the Pool Manager to look at reducing adult health and social care costs and this will continue into 2018/19 to ensure a balanced budget is achieved at year end. This will be particularly important given the Additional Better Care Fund monies used to help reduce the scale of the overspend position will be significantly reduced in 2018.19 and again in 2019.20.

PUBLIC HEALTH & PUBLIC PROTECTION DEPARTMENT

Revenue Budget as at 31st March 2018

	Annual Budget £'000	Actual Spend £'000	**Variance** (Overspend) £'000
Expenditure			
Employees	3,255	3,186	69
Other Premises	5	5	0
Supplies & Services	249	253	(4)
Contracts & SLA's	6,792	6,792	0
Transport	8	8	0
Other Agency	18	17	1
Transfer to Reserves	209	209	0
Total Expenditure	**10,536**	**10,470**	**66**
Income			
Other Fees & Charges	-105	-78	(27)
Reimbursements & Grant Income	-238	-212	(26)
Government Grant	-10,457	-10,457	0
Transfer from Reserves	-652	-652	0
Total Income	**-11,452**	**-11,399**	**(53)**
Net Operational Expenditure	**-916**	**-929**	**13**
Recharges			
Premises Support	126	126	0
Central Support Services	1,253	1,253	0
Transport Recharges	21	19	2
Internal Recharge Income	-94	-94	0
Net Total Recharges	**1,306**	**1,304**	**2**
Net Department Expenditure	**390**	**375**	**15**

Comments on the above figures

In overall terms the Net Departmental Expenditure is £15,000 under budget at the end of the financial year.

Employee costs are £69,000 below budget at the year-end, due to savings being made on vacancies within the department. The majority of the vacancies have now been appointed to and it is not anticipated this under spend will continue in the new financial year.

Income underachieved by £53,000, Other Fees & Charges income by £27,000 and Reimbursements & Grant income by £26,000. This is due to income targets of £50,000 included in the Health & Wellbeing Division's budget not being achieved. Actual income has been received but in accordance with guidelines, income received from services funded through Public Health must be reinvested back into Public Health and not the Council's General Fund. The income target will be reviewed during the 2018/19 financial year.

APPENDIX 2 – Explanation of Symbols

Symbols are used in the following manner:

Progress		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	*Indicates that the annual target is on course to be achieved.*
Amber		Indicates that it is uncertain or too early to say at this stage, whether the milestone/objective will be achieved within the appropriate timeframe.	*Indicates that it is uncertain or too early to say at this stage whether the annual target is on course to be achieved.*
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	*Indicates that the target will not be achieved unless there is an intervention or remedial action taken.*

Direction of Travel Indicator

Where possible performance measures will also identify a direction of travel using the following convention

Green		*Indicates that* **performance is better** *as compared to the same period last year.*
Amber		*Indicates that* **performance is the same** *as compared to the same period last year.*
Red		*Indicates that* **performance is worse** *as compared to the same period last year.*
N/A		*Indicates that the measure cannot be compared to the same period last year.*