NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

Value Based Commissioning & Evidence Based Interventions Policy

Version 8
Date effective from February 2022

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1. Introduction

NHS Shropshire, Telford and Wrekin Clinical Commissioning Group (STW CCG) purchases the majority of healthcare services on behalf of the local population.

The CCG is required by law to operate within finite budgetary constraints. This means that the CCG has to prioritise resources and provide interventions with the greatest proven health gain for the population they serve. As a consequence, some referrals or interventions that patients may wish to receive, and which a clinician may wish to offer, cannot be funded. The intention is to ensure equity and fairness in respect of access to NHS funding and to ensure compliance with the NHS England Evidence Based Interventions Statutory Guidance.

The Value Based Commissioning restrictions and criteria outlined within this policy provides details of activity that is not routinely funded by the CCG and the specified criteria required for the funding of certain referrals or interventions.

Commissioners, General Practitioners and both NHS and Non-NHS Service Providers treating patients of NHS Shropshire, Telford and Wrekin CCG are expected to implement and adhere to this policy. The referral, management and audit processes and pathways are described in Appendix 1.

Very occasionally, a clinician may think that their patient's clinical situation is so different to other patients with the same condition that it is appropriate that they should have different treatments to others. In such circumstances, clinicians, on behalf of their patient, may make an Individual Funding Request (IFR) to STW CCG for a treatment, which is not routinely commissioned by the CCG. IFRs may be made in respect of STW CCG directly commissioned services and indeed any services, which are not commissioned. This route should only be used in exceptional circumstances and not as an alternative route to submitting a treatment for scrutiny through the Service Development process where there is likely to be a cohort (however small) of similar patients. For further details on what may be considered exceptional please see IFR policy which can be found on the CCG website:

https://www.shropshiretelfordandwrekinccg.nhs.uk/wp-content/uploads/2021110-Individual-Funding-Request-Policy-2021.pdf

Individual Funding Request (IFR) applications must be made by the specialist who will be providing the patient's treatment and full details of how the patient meets the clinical exceptionality criteria, as given in the IFR policy, should be provided on the application form. All supporting evidence of how the patient meets the exceptionality criteria or is unique within an identified cohort of patients should be submitted with the application form.
If a patient does not meet the clinical exceptionality criteria, as given within the IFR policy then funding should not be sought via the Individual Funding Request (IFR) route.

This Policy also includes clinically recommended restrictions around certain interventions and procedures where the risk may outweigh the potential benefit and these are known as Evidence Based Interventions (EBI).

EBI guidance is reviewed and refreshed nationally to reflect treatments and procedures where the evidence about their effectiveness or appropriateness may change. It is set out in this document and is primarily directed at clinicians and other NHS staff who make decisions about patient care. There are two parallel and complementary objectives to EBI. First, to reduce the number of inappropriate interventions carried out by clinicians in the healthcare system, and second, to improve the quality of care that patients receive. By reducing interventions which the evidence shows are less effective, it will free up valuable resources such as time, so that more effective interventions can be carried out. At a time when demand is exceeding available capacity and the COVID-19 pandemic is further stretching the system's finite resources, effective use of clinical time must be a priority. This is especially the case with surgical interventions which always carry the risk of complications or adverse reactions. Care should always focus on improving quality and standards. We will only achieve this if we innovate, maximise value and avoid waste.

The EBI list of recommendations is developed by an independent Expert Advisory Committee (the EAC), established in May 2019, to provide clinical leadership to the EBI programme. The Committee identified an initial long-list of interventions from clinical evidence including NICE guidance, Choosing Wisely recommendations, academic studies and CCGs' policies on Procedures of Limited Clinical Effectiveness (now known as Value Based Commissioning) collated through NHS Clinical Commissioners. At the same time, suggestions were taken from specialist clinicians, academics, commissioners, reflections from the EBI demonstrator community of 13 Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs). The EAC considered each test, treatment and procedure before drafting guidance in collaboration with stakeholders including clinicians, commissioners and patients. It took particular note of

- Advice from Medical Royal Colleges,
- specialist societies,
- clinicians,
- clinical commissioners,
- professional leaders and
- charities2
- opinions from patients by liaising with patient advocates and patient representative groups, including the Strategic Co-Production Group at NHS England and NHS Improvement,
- the Academy of Medical Royal Colleges' Patient and Lay Committee and
- The Patients Association to test the proposals and understand patients' priorities.

Helpful Referrer Reminders:

- Read the full policy before referring
- Add clinic letters pertinent to a treatment decision
- Check if there should be a PCN process followed before referring
- If the referral is for weight loss, consider whether Tier 2 Weight Management support has been fully attempted before considering referrals to Tier 3 & 4 secondary care weight loss support and bariatric surgery
- Consider whether it could be a need for advice & guidance instead of a face to face appointment

Out of Area Providers

As part of the ongoing gathering of provider activity data, the CCG BI team will undertake analysis of the activity data on a monthly basis. On a quarterly basis the CCG BI team will run an activity challenge report for OOA providers with regards to any activity relating to this policy.

In accordance with NHS Standard Contract Service Condition 36; the Contract Management Team will raise and progress any activity challenges with the individual provider and the provider must answer those queries promptly and fully.

2. BREAST

A range of breast surgical interventions are not funded where it is purely to restore or improve a patient's appearance. See Section 3 – Cosmetic/Aesthetic.

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

This policy does not apply to situations where patients require a cosmetic or reconstructive procedure to restore normal or near normal function or appearance as a direct consequence of trauma, burns, destructive surgery, cancer treatment or a recognised congenital malformation. These cases are eligible for NHS funding as part of the treatment plan under routine commissioning arrangements and would be subject to a planned course of treatment within an agreed timescale, which may be long term in some cases. However, further revision for cosmetic improvement will not be funded.'

3. CARDIOVASCULAR

3A	**Invasive Coronary Angiography for low risk, stable chest pain Subject to Audit** Invasive diagnostic coronary angiography should not be used as first line investigation, and should only be offered for low risk, stable chest pain as third-line investigation when the results of non-invasive functional imaging are inconclusive. Criteria Patient has significant findings on CT coronary angiogram (Significant coronary artery disease (CAD) found during CT coronary angiography is ≥ 70% diameter stenosis of at least one major epicardial artery segment or ≥ 50% diameter stenosis in the left main coronary artery) OR CT coronary angiography is inconclusive and further non-invasive functional imaging (either Stress echocardiography OR first-pass contrast-enhanced magnetic resonance (MR) stress perfusion OR MR imaging for stress-induced wall motion abnormalities OR Fractional flow reserve CT (FFR-CT) OR Myocardial perfusion scintigraphy with single photon emission computed tomography (MPS with SPECT) is inconclusive The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	K63.1, K63.2, K63.3, K63.4 K63.5, K63.6 K63.8, K63.9 AND Diagnosis code in any position NOT LIKE: I20.0, I20.1, I21.0-21.9, I22.0-9, I23.0-8 I24.0-9 I25.0-9

4. COSMETIC/AESTHETIC

VBC/EBI Policy Criteria		Procedure & Diagnosis Codes
4A	**Abdominoplasty or Apronectomy** **Not Funded** Abdominoplasty (Apronectomy or Tummy Tuck) surgery is not funded for cosmetic purposes.	S021 S022 S028 S029
4B	**Aesthetic Interventions (Restricted)** **Subject to Referral Interface Service assessment /audit of information** <u>The following interventions are not funded purely to restore or improve a patient's appearance</u>: • Botox Injections** • Blephoraplasty • Breast asymmetry • Breast augmentation • Breast mastopexy (sagging) • Breast nipple correction • Breast prosthesis removal and/or replacement • Breast reduction (and white light scanning) • Cleft earlobe surgery • Face, neck, brow or eyelid lift • Gynaecomastia surgery • Hair loss treatment and grafting • Hair removal (for hirsutism) • Hymenorraphy • Labial Trimming and Cosmetic Genital Procedures • Labiaplasty • Liposuction • Removal of benign skin lesions and vascular lesions • Removal of tattoos • Resurfacing of skin: dermabrasion, chemical peels and laser treatment • Pinnoplasty • Surgical fillers • Vaginoplasty • Any other procedure carried out purely for aesthetic purposes. **For all other uses, please see the CCG Botulinum Toxin (Botox) policy	S031, S032, S033, Z495, Z501, S621, S622, S628, S629 B29, B301, B302, B303, B304, B308, B309 B311, B312, B313, B314, B318, B319 B354, B356, B358, B359, P055, P056, P057, P058, P059, P055, P056 P057, P058, P059 P324, P325, P326, P327, P151,P154, P153, P158, P159 D033, C13, S011 S012, S013, S014, S015, S016, S018, S019, S606, S607 S608, S609, S211 S212, S213, S214 S218, S219,

<u>Nasal surgery will only be funded subject to:</u>
• Documented evidence of cleft lip and/or palate; OR
• Immediate post-traumatic reconstruction; OR
• Documented evidence of a nasal deformity with obstruction including:
  ○ significant breathing difficulties; AND
  ○ chronic (symptoms for >12 weeks); AND
  ○ unresponsive to all conventional medical treatment; AND
  ○ the obstruction is continuous (i.e. experienced at all times of the day)
 	
Rhinoplasty/Septoplasty/Septorhinoplasty will not be funded for cosmetic reasons
 	
These interventions will be funded for non-aesthetic reasons subject to:
• Documented evidence of a clinical reason for the surgery to be carried out (e.g. trauma).
 	
Psychological distress and social factors will not be accepted as a clinical reason to carry out a procedure.
 	
Please see separate sections regarding the policy for Hyperhidrosis, Nasal Surgery, Anal Skin Tags and Chalazia removal.
 	
<u>Scars & Keloids</u>
Scar Revision will only be considered after 2 years (to allow completion of the natural healing process) where one of the following criteria are met:
• scars that interfere with function following burns trauma OR
• serious scarring of the face - scars that are ragged and more than 2cm in length OR
• severe post-surgical scarring interfering with activities of daily living OR
• as an incidental part of another NHS procedure
 	
Keloid Scars Funding will only be considered for keloid scars on the face and where evidence is presented of:
• significant pain or pruritus (itching) OR
• physical disability due to contraction, tethering or recurrent breakdown
 	
<u>Congenital Vascular Lesions</u>
Not routinely funded with exception of:
• Facial and/or neck port wine stains in adolescents or adults OR
• Paediatric haemangiomas which:
  ○ Threaten life or function, including compromising eyesight, respiration, cardiac or hepatic function OR
  ○ Other internal lesions sited in an area liable to scar OR
	S331
	S332, S338, S339
	S091, S092, S601, S602
	S098, S099, S108, S109, S062, S063, S064,S065, S068,S069, S081, S082, S083, S041 S042, S043, S048, S049, S051 D062 D031, D032, D034 D068, D069, D063 S103, S113 S604 Y064, X851, Z601

○ Facial haemangiomas that are causing psychological distress by school age OR ○ Lesions which show a tendency to bleed or to become infected OR ○ Kasabach-Merritt syndrome (coagulopathy) Funding will not be available for keloid scars secondary to body piercing procedures. <u>Excision of Redundant Skin or Fat Buttock thigh and arm surgery will NOT routinely be funded except where:</u> • Age 19 or over AND • Significant functional disturbance (both physical and psychological) AND • Starting BMI above 40 or above 35 with co-morbidity OR • Current BMI of 26 or less AND weight stable for 18 months The referring clinician is responsible for ensuring that evidence of meeting the criteria is included when making a referral. The Referral Interface Service (RAS & TRAQS) is responsible for ensuring compliance with the policy and will reject any referrals that do not meet the criteria. NHSE Evidence Based Interventions – Category 2 (Breast Reduction & Benign Skin Lesions)	

5. COMPLEMENTARY / ALTERNATIVE

VBC/EBI Policy Criteria	Procedure & Diagnosis Codes
5A Alternative & Complementary Medicines/Therapies **Not Funded** Alternative or complementary medicines/therapies will not be funded as part of a standalone service. The alternative and complimentary therapies and alternative disciplines covered by this policy include: • Acupuncture (unless provided as part of a commissioned MSK pain/physio service) • Alexander Technique • Anthroposophical medicine • Aromatherapy • Bach and other flower remedies • Chinese herbal medicine • Chiropractic • Crystal therapy • Dowsing • Eastern medicine • Healing Nutritional medicine • Herbal medicine • Hypnotherapy • Iridology • Kinesiology • Maharishi Ayurvedic medicine • Massage • Meditation • Naturopathy • Neutralising Antigens/clinical ecology/environmental medicine • Osteopathy • Pilates • Radionics • Reflexology • Shiatsu • Yoga This list is not exhaustive.	A705 A706 X612 X613 X614 X618 X619 Y331

6. DERMATOLOGY

VBC/EBI Policy Criteria	Procedure & Diagnosis Codes
6A Removal of benign skin lesions **Subject to Referral Interface Service assessment /audit of information** This policy refers to the following benign lesions when there is diagnostic certainty and they do not meet the criteria listed below; • benign moles (excluding large congenital naevi) • solar comedones • corn/callous • dermatofibroma • lipomas • milia • molluscum contagiosum (non-genital) • epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts) • seborrhoeic keratoses (basal cell papillomata) • skin tags (fibroepithelial polyps) including anal tags • spider naevi (telangiectasia) • non-genital viral warts in immunocompetent patients • xanthelasmata • neurofibromata The benign skin lesions, which are listed above, must meet at least ONE of the following criteria to be removed; • The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires 2 or more courses of antibiotics (oral or intravenous) per year • There is repeated infection requiring 2 or more antibiotics per year • The lesion bleeds in the course of normal everyday activity • The lesion causes regular pain • The lesion is obstructing an orifice or impairing field vision • The lesion significantly impacts on function e.g. restricts joint movement • The lesion causes pressure symptoms e.g. on nerve or tissue • If left untreated, more invasive intervention would be required for removal • Facial viral warts • Facial spider naevi in children causing significant psychological impact	

The following are outside the scope of this policy recommendation: • Lesions that are suspicious of malignancy should be treated or referred according to NICE skin cancer guidelines. • Any lesion where there is diagnostic uncertainty, pre-malignant lesions (actinic keratoses, Bowen disease) or lesions with pre-malignant potential should be referred or, where appropriate, treated in primary care • Removal of lesions other than those listed above. Evidence of meeting the above criteria must be provided by the Referring Clinician and Secondary Care Clinicians prior to referral/request for prior approval for surgery. A prior approval code should be sought by the clinician conducting the procedure The referring clinician is responsible for ensuring that evidence of meeting the criteria is included when making a referral. The Referral Interface Service (RAS & TRAQS) is responsible for ensuring compliance with the policy and will reject any referrals that do not meet the criteria.	

7. EAR, NOSE & THROAT

VBC/EBI Policy Criteria		Procedure & Diagnosis Codes
7A	**Adult Snoring Surgery in the absence of Obstructive Sleep Apnoea (OSA))** **Not Funded** Surgery for snoring is not funded. NHS England Evidence Based Intervention Policy – Category 1.	F324 F325 F326
7B	**Ear Wax Removal / Microsuction of External Auditory Canal** **Subject to Referral Interface Service assessment /audit of information** NICE recommends that ear wax removal is offered to adults in primary care or community ear care services if the ear wax is contributing to hearing loss or other symptoms, or needs to be removed in order to examine the ear or take an impression of the ear canal (NICE NG98). A primary care locally commissioned service is in place in Shropshire, Telford and Wrekin for patients who require ear wax removal where the patient: • Has a previously diagnosed hearing impairment not solely caused by the presence of wax; and/or • Wears a hearing aid; and/or • Has been referred to the practice by audiology Removal of earwax in Community or Secondary Care will only be funded subject to: • Documented evidence of two or more attempts at irrigation of the ear canal in Primary Care which were unsuccessful OR • Documented evidence that the patient has previously experienced complications following irrigation of the ear canal in Primary Care or it has been repeatedly ineffective OR • There is a documented history of a middle ear infection in the last six weeks OR • The patient has a documented record of having undergone any form of ear surgery (except grommets that have extruded at least 18 months previously and the patient has been discharged from the ENT Service) OR • The patient has a perforation or there is a documented history of a mucous discharge in the last year OR • The patient has a confirmed diagnosis of cleft palate (repaired or not) OR • Documented evidence of the presence of acute otitis externa with pain and tenderness of the pinna OR • The patient has a confirmed foreign body or vegetable matter in the ear canal that could swell on irrigation OR	D07, D071, D072, D078, D079,

	• Where there is clear evidence that the procedure cannot be carried out safely in Primary Care (evidence must be given). Note: If removal of earwax within Secondary Care is required to carry out a procedure or to gain a view of the tympanic membrane this is considered as part of the overall outpatient tariff and no additional payment will be made. The referring clinician is responsible for requesting a Prior Approval Code for this intervention.	

7C	**Insertion of Grommets**
	Subject to Audit
	
	Surgery to insert grommets is funded subject to:
	
	Children
	• Documented evidence that the child has undergone specialist Audiology and/or ENT assessment AND
	• In children (under 18 years old) with documented evidence of at least 5 recurrences of acute otitis media, which required medical assessment and/or treatment, in the 12 months prior to referral; OR
	• In children (under 18 years old) with otitis media with effusion (OME) where:
	  ○ Documented evidence that OME has persisted after a period of at least three months watchful waiting from the date that the problem was first identified by the GP to the date of referral AND
	  ○ Documented evidence of hearing loss (of at least 25dB) - particularly in the lower tones (low frequency loss) - and evidence of a disability as a result of this hearing loss on at least 2 documented occasions (following repeat testing after 6-12 weeks) with either:
	  ▪ Delay in speech development OR
	  ▪ educational or behavioural problems attributable to the hearing loss OR
	  ▪ a significant second disability that may itself lead to developmental problems, e.g. Down's syndrome, Turner's syndrome or Cleft Palate.
	Adults
	• In patients where there is documented evidence of significant negative middle ear pressure measured on two sequential appointments AND
	• A documented record of significant on-going associated pain OR
	• Documented evidence of unilateral middle ear effusion where a post nasal space biopsy is required to exclude an underlying malignancy.
	
	The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.
		D151 – ICD-10 Criteria in the original

7D	**Tonsillectomy for Recurrent Tonsillitis (Restricted)** **Subject to Audit** Please note this guidance only relates to patients with recurrent tonsillitis. This guidance would not be applied to other conditions where tonsillectomy should continue to be funded. Tonsillectomy surgery for recurrent tonsillitis in both adults and children will only be funded subject to the following: • Documented evidence that sore throats are due to tonsillitis; AND • Documented evidence that the episodes of sore throat are disabling and prevent normal functioning; AND • Documented evidence of seven or more clinically significant, adequately treated sore throats in the preceding year; OR • Documented evidence of five or more such episodes in each of the two years prior to referral; OR • Documented evidence of three or more such episodes in each of the preceding three years; OR • Documented evidence that the patient has another medical condition where recurrent episodes of tonsillectomy are damaging to health e.g. acute and chronic renal disease resulting from acute bacterial tonsillitis, metabolic disorders where periods of reduced oral intake could be dangerous, etc. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	F34 F341 F342 Diagnosis Codes: J039, J350, J351

7E	**Nasal Surgery for Obstruction or Deformity**
	Subject to Audit
	
	Nasal surgery will only be funded subject to:
	• Documented evidence of cleft lip and/or palate; OR
	• Immediate post-traumatic reconstruction; OR
	• Documented evidence of a nasal deformity with obstruction including:
	  ○ significant breathing difficulties; AND
	  ○ chronic (symptoms for >12 weeks); AND
	  ○ unresponsive to all conventional medical treatment; AND
	  ○ the obstruction is continuous (i.e. experienced at all times of the day)
	
	Rhinoplasty/Septoplasty/Septorhinoplasty will not be funded for cosmetic reasons.
	
	The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.
		E023, E022, E024, E025, E026, E028, E029, E073, E078, E079

7F	**Endoscopic Sinus Surgery** **Subject to Audit** Criteria A diagnosis of CRS has been confirmed from clinical history and nasal endoscopy and / or CT scan Disease-specific symptom patient reported outcome measure confirms moderate to severe symptoms e.g. Sinonasal Outcome Test (SNOT-22) after trial of appropriate medical therapy (including counselling on technique and compliance) as outlined in RCS/ENT-UK commissioning guidance 'Recommended secondary care pathway' Pre-operative CT sinus scan has been performed and confirms presence of CRS. Note: a CT sinus scan does not necessarily need to be repeated if performed sooner in the patient's pathway Patient and clinician have undertaken appropriate shared decision-making consultation regarding undergoing surgery including discussion of risks and benefits of surgical intervention OR • Any suspected or confirmed neoplasia • Emergency presentations with complications of sinusitis (e.g. orbital abscess, subdural or intracranial abscess) • Patients with immunodeficiency • Fungal Sinusitis • Patients with conditions such as Primary Ciliary Dyskinesia, Cystic Fibrosis or NSAID-Eosinophilic Respiratory Disease (NSAID-ERD, Samter's Triad Aspirin Sensitivity, Asthma, CRS) • Treatment with topical and / or oral steroids contra-indicated • As part of surgical access or dissection to treat non-sinus disease (e.g. pituitary surgery, orbital decompression for eye disease, nasolacrimal surgery) The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	Where the procedure code in any position: Y76.1 AND Primary diagnosis code is: J32.0 J32.1 J32.2 J32.3 J32.4 J32.8 J32.9
7G	**Adenoid Removal** **Subject to Audit** Adjuvant adenoidectomy should not be routinely performed in children undergoing grommet insertion for the treatment of otitis media with effusion. Adjuvant adenoidectomy for the treatment of glue ear should only be offered when one or more of the following clinical criteria are met:	Procedure codes in any position are: E20.1, E20.4, E20.8, E20.9, D15.1 AND Primary diagnosis code IN:

• The child has persistent and / or frequent nasal obstruction which is contributed to by adenoidal hypertrophy (enlargement) • The child is undergoing surgery for re-insertion of grommets due to recurrence of previously surgically treated otitis media with effusion • The child is undergoing grommet surgery for treatment of recurrent acute otitis media. This guidance only refers to children undergoing adenoidectomy for the treatment of glue ear and should not be applied to other conditions where adenoidectomy should continue to be routinely funded: • As part of treatment for obstructive sleep apnoea or sleep disordered breathing in children (e.g. as part of adenotonsillectomy) • As part of the treatment of chronic rhinosinusitis in children • For persistent nasal obstruction in children and adults with adenoidal hypertrophy • In preparation for speech surgery in conjunction with the cleft surgery team. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	H65.2, H65.3 H65.4, H65.9, H66.1, H66.3, H66.4, H66.9, H68.1, H69.8, H69.9 AND Diagnosis codes in any position are NOT: G47.3, J32.0, J32.1, J32.2, J32.3, J32.4, J32.8, J32.9, Q35.1, Q35.3, Q35.5, Q35.7, Q35.9, Q37.0, Q37.1, Q37.2, Q37.3, Q37.4, Q37.5, Q37.8, Q37.9

8. FERTILITY

All guidelines and process relating to fertility, IVF and Gamete storage are detailed within the separate CCG Fertility, IVF and Gamete Storage Policies.

9. GASTROENTEROLOGY

VBC/EBI Policy Criteria	Procedure & Diagnosis Codes
9A Cholecystectomy for Gallstones & Bile Duct Stones (Restricted) **Subject to Audit** The CCG will fund Cholecystectomy for symptomatic gallstones subject to: • Documented evidence of acute cholecystitis or cholangitis OR • Documented evidence of recurrent biliary colic OR • Documented evidence of gall stone induced pancreatitis OR • Documented evidence of obstructive jaundice due to gall stones The CCG will not fund Cholecystectomy for patients with asymptomatic common gallbladder stones. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	J18, J181, J182, J183, J184, J185, J188, J189, J211 Diagnosis Codes: K802, K805
9B Upper GI Endoscopy **Subject to Audit** Upper GI Endoscopy should only be performed if the patient meets the following criteria: **Urgent: (Within two weeks)** Any dysphagia in line with the 2 week wait protocol Those aged 55 or over who have one or more of the following: • Treatment resistant dyspepsia (as above), upper abdominal pain with low haemoglobin level (blood level) OR • Raised platelet count with any of the following: nausea, vomiting, weight loss, reflux, dyspepsia, upper abdominal pain OR • Nausea and vomiting with any of the following: weight loss, reflux, dyspepsia, upper abdominal pain. **Surveillance endoscopy:** • Surveillance endoscopy should only be offered in patients fit enough for subsequent endoscopic or surgical intervention, should neoplasia be found. Many of this patient group are elderly and/or have significant comorbidities. Senior clinician input is required before embarking on long term endoscopic surveillance **Screening endoscopy can be considered in:** • Screening is not appropriate for all patients and should be performed in keeping with European expert guidelines	APC and OP Activity where the dominant procedure code is: G16.1-9, G19.1-9, G45.1-9, G65.1-9, G80.1-9

• Patients where screening is appropriate, for individuals aged 50 and over, with multiple risk factors for gastric cancer (e.g. H. Pylori infection, family history of gastric cancer - particularly in first degree relative -, pernicious anaemia, male, smokers). **Post excision of adenoma:** Following complete endoscopic excision of adenomas, gastroscopy should be performed at 12 months and then annually thereafter when appropriate. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	
9C Appropriate Colonoscopy on the management of Hereditary Colon Cancer **Subject to Audit** **This guidance applies to adults aged 19 years and over.** Colonoscopy should be used appropriately in the management of CRC in people who have been identified with an increased lifetime risk of CRC due to hereditary factors in accordance to the British society of Gastroenterology Guidelines. https://www.bsg.org.uk/clinical-resource/guidelines-for-the-management-of-hereditary-colorectal-cancer-from-the-bsg-acpgbi-ukcgg/ The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	
9D Repeat Colonoscopy **Subject to Audit** **This guidance applies to adults aged 19 years and over.** This will be commissioned in accordance with the British society of Gastroenterology Guidelines. https://www.bsg.org.uk/clinical-resource/bsg-acpgbi-phe-post-polypectomy-and-post-colorectal-cancer-resection-surveillance-guidelines/ The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	Where procedure code in any position is: H22.1, H22.8, H22.9, H68.1, H68.2, H68.3, H68.4, H68.8, H68.9 AND NOT IN H68.1, H68.3 And Diagnosis not like Z121
9E Early Endoscopic Retrograde Cholangiopancreatography (ERCP) in Acute Gallstone Pancreatitis without Cholangitis **Subject to Audit**	Where the procedure code in any position is:

This guidance applies to adults aged 19 years and over. Early ERCP in the treatment of acute gallstone pancreatitis should only be performed if there is evidence of cholangitis or obstructive jaundice with imaging evidence of a stone in the common bile duct. Early ERCP refers to ERCP being performed on the same admission, ideally within 24 hours The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	J43.1 OR J43.2, J43.3, J43.8, J43.9 Diagnosis code in any position is: K85.1 AND The procedure date is 3 days or fewer after the admission date.

10. GENERAL SURGERY

VBC/EBI Policy Criteria	Procedure & Diagnosis Codes
10A Anal Skin Tags **Not Funded** Removal is not routinely funded.	H482, 448, 489
10B Hernia Management & Repair **Subject to Audit** Surgery for hernia is funded subject to: • Documented evidence that the patient has symptoms of incarceration, strangulation or obstruction OR • Where the patient has a femoral hernia OR • Where the patient has a Spigelian hernia OR For Inguinal Hernias where: • Documented evidence of difficulty in reducing the hernia OR • There is a documented diagnosis of an inguino-scrotal hernia OR • There is a documented record of pain with strenuous activity, prostatism or discomfort significantly interfering with activities of daily living OR For abdominal (including incisional and umbilical) hernias where: • There a documented record of pain/discomfort significantly interfering with activities of daily living; AND • For patients with a recorded BMI≥30kg/m2, who have been advised on weight reduction (including the free NHS weight loss guide) to reduce the risks of recurrence and post-operative complications; OR • There is a documented record that the hernia is causing difficulty with the fitting of a stoma appliance, e.g. bag leaking or skin damage. For incisional hernias, surgery will be funded where a significant increase in size is noted over time. Surgery for the repair of Divarication of Recti is not funded. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	T20, T201, T202, T203, T204, T208,T209, T21,T211, T212, T213, T214, T218, T219, T22, T221,T222, T223, T228, T229, T23, T231, T232, T233, T234, T238, T239, T24, T241, T242, T243, T244, T248,T249, T25, T251, T252, T253, T258,T259, T26, T261, T262, T263, T264, T268, T269,T27, T271,T272, T273, T278,T279, T28,
10C Haemorrhoid Surgery **Subject to Audit** Surgery will be funded subject to: • Documented evidence of recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding;	H55, H551, H552, H553, H558, H559, H52, H53, H568, H569,

	OR • Documented evidence of irreducible and large external haemorrhoids The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	
10D	**Tier 3 Weight Management** **Subject to Referral Interface Service assessment /audit of information** Patients may only be referred for Tier 3 Weight Management subject to: • The patient being aged 18 or over AND • Patient has attempted to lose weight by other reasonable available methods. AND • The patient has a documented BMI measurement of 35 or over for at least 24 months with significant comorbidities up to the time of referral OR • The patient has a documented BMI measurement of 40 or over for at least 24 months up to the time of referral without comorbidities OR • Documented evidence that the patient has recent-onset (diagnosed within 12 months prior to referral) type 2 diabetes with a recorded BMI measurement of 30 or over at the time of referral OR The referring clinician is responsible for ensuring that evidence of meeting the criteria is included when making a referral. The Referral Interface Service (RAS & TRAQS) is responsible for ensuring compliance with the policy and will reject any referrals that do not meet the criteria.	N/A
10E	**Bariatric Surgery (Tier 4 Weight Management)** **Subject to Referral Interface Service assessment /audit of information** Bariatric surgery will only be funded subject to the following: For patients with a documented BMI of 35 or over at the time of referral: • The patient is aged 18 years or older AND • The patient has a documented record of significant comorbidities for at least 24 months AND • Documented evidence that the patient has recently completed a Tier 3 weight management programme for 12 months with a stabilisation period of at least 6 months before the date of referral to Tier 4. For patients with a documented BMI of 40 or over at the time of	G28, G281, G282, G283, G284, G285, G288, G289, G30, G301, G302, G303, G304, G305, G308, G309, G31, G310, G311, G312, G313, G314, G315, G316, G318, G319, G48, G481, G485, G488, G489, G716

	referral: • The patient is aged 18 years or older AND • The patient has a documented record of having a BMI of 40 or over for at least 24 months AND • Documented evidence that the patient has recently completed a Tier 3 weight management programme for 12 months with a stabilisation period of at least 6 months before referral. The referring clinician is responsible for ensuring that evidence of meeting the criteria is included when making a referral. The Local Referral Interface Service (RAS & TRAQS) is responsible for ensuring compliance with the policy and will reject any referrals that do not meet the criteria.	
10F	**Vasectomy under General Anaesthetic (GA)** **Subject to Referral Interface Service assessment /audit of information** Vasectomy under general anaesthetic will only be funded subject to the following: • Documented evidence of a previous adverse reaction to local anaesthesia; OR • Documented evidence of scarring or deformity (e.g. due to cryptorchidism or from previous scrotal surgery or trauma) that makes vasectomy under local anaesthetic difficult to undertake; OR • Documented evidence of a medical condition that makes vasectomy under local anaesthetic difficult to undertake; OR • Documented evidence that the patient is on anticoagulation therapy (increased risk of postoperative haematoma formation). The referring clinician is responsible for ensuring that evidence of meeting the criteria is included when making a referral. The Local Referral Interface Service (RAS & TRAQS) is responsible for ensuring compliance with the policy and will reject any referrals that do not meet the criteria.	
10G	**Repair of Minimally Symptomatic Inguinal Hernia** **Subject to Audit** Criteria • There is a history of incarceration, difficulty in reducing the hernia, • Increased risk of strangulation (high risk in female patients) • Inguino-scrotal hernia • Progressive increase in size of hernia (month-on-month) • Significant pain or discomfort sufficient to cause significant functional impairment	Where procedure code in dominant position is: T20.1, T20.2, T20.3, T20.4, T20.8, T20.9 AND Primary diagnosis code is:

AND There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	K402, K409

11. GYNAECOLOGY

VBC/EBI Policy Criteria		Procedure & Diagnosis Codes
11A	**Dilatation and Curettage (D&C) for Heavy Menstrual Bleeding** **Not Funded** Dilation and curettage for treatment of Menorrhagia is not funded. NHS England Evidence Based Intervention Policy – Category 1	Q10
11B	**Reversal of Female Sterilisation** **Not Funded** Reversal of female sterilisation is not routinely funded.	Q29, Q298 Q299, Q37 Q371, Q378 Q379
11C	**Routine Doppler Ultrasound Of Umbilical & Uterine Artery In Antenatal Care** **Not Funded** Routine Doppler ultrasound of umbilical and uterine arteries is not routinely funded for low risk pregnancies. (low risk – determined via midwife through antenatal screening and previous medical/ gynae/obstetric history and Gynae Consultant	R421, R422 Diagnosis Code: Z34
11D	**Hysteroscopy for Menorrhagia/Heavy Menstrual Bleeding (HMB)** **Subject to Referral Interface Service assessment /audit of information** Hysteroscopy for menorrhagia/HMB is funded subject to: • Documented evidence of medical management which has not been successful; AND • Documented reports of intermenstrual bleeding (IMB) OR • Evidence of a diagnostic scan suggestive of uterine pathology, i.e. fibroids and polyps; OR • Documented evidence of risk factors for endometrial pathology. The referring clinician is responsible for ensuring that evidence of meeting the criteria is included when making a referral. The Local Referral Interface Service (RAS & TRAQS) is responsible for ensuring compliance with the policy and will reject any referrals that do not meet the criteria.	Q189 Q188 Diagnosis Code: N920 N921 N926
11E	**Intrauterine Systems (IUSs e.g. Mirena Coils) (Restricted)** **Subject to Referral Interface Service assessment /audit of information** Patients may be referred for a Levonorgestrel intrauterine system (IUSs) e.g. Mirena Coil to be fitted in Secondary Care subject to:	Q121 Q122

	• Documented evidence of a specific medical issue that prevents fitting or removal by Primary Care OR • Documented evidence of one or more failed attempts to fit/remove in primary care. Note: In the event of an appropriately trained clinician being unavailable in primary or community care, RAS/TRAQs should be notified as soon as possible and referrals into Secondary Care in these instances will be considered on a case by case basis. The referring clinician is responsible for ensuring that evidence of meeting the criteria is included when making a referral. The Referral Interface Service (RAS & TRAQS) is responsible for ensuring compliance with the policy and will reject any referrals that do not meet the criteria. IUS's fitted in Secondary Care are routinely funded where the following criteria applies: • Documented evidence that it is being fitted as part of contraception provided in conjunction with a termination of pregnancy OR • The decision to fit the IUS is made as part of an operative procedure	
11F	**Female Pelvic Organ Prolapse** **Subject to Audit** The CCG will fund surgery for pelvic organ prolapse for women where the following criteria are met: • Symptomatic prolapse AND • Documented evidence that supervised physiotherapy including pelvic floor muscle training for a minimum of 3 months has not been successful; AND • Documented evidence that risk factors have been addressed including weight loss advice, treatment for chronic cough and treatment for constipation; AND • Documented evidence that a pessary (ring or shelf) has been unsuccessful or is contraindicated; OR • Symptomatic prolapse that is visible at or below the vaginal introitus; OR • Documented reports of associated obstructed defecation; OR • Documented evidence that topical oestrogen therapy has been unsuccessful after 3 months or is contraindicated. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	P231 P232 P233
11G	**Hysterectomy +/- Oophorectomy for Menorrhagia/Heavy Menstrual Bleeding (HMB)**	Q072

	Subject to Audit Hysterectomy for the management of menorrhagia/HMB is funded subject to: • Documented evidence that a trial with a levonorgestrel intrauterine system (IUS), e.g. Mirena (unless contraindicated) has failed to relieve symptoms after a minimum of at least 6 cycles of menstrual cycles to see the benefits of the treatment. OR • Documented evidence that other less invasive treatment options have been tried and failed (e.g. non-steroidal anti-inflammatory agents, tranexamic acid, endometrial ablation, uterine-artery embolism) unless contra-indicated. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes. NHSE Evidence Based Intervention – Category 2	Q074 Q082 Q075 R251 Diagnosis Codes: N920, N921, N926

12. NEUROLOGY

VBC/EBI Policy Criteria		Procedure & Diagnosis Codes
12A	**Extracorporeal Shockwave Therapy** **Not Funded** Extracorporeal shockwave therapy is not funded for the treatment of: • Tennis Elbow • Plantar Fasciitis • Achilles Tendinopathy • Greater Trochanteric Pain Syndrome • Tendonitis/Tendinopathy of the shoulder • Peyronie's Disease Extracorporeal Shockwave Therapy for other indications, for example the destruction of urinary tract stones, is not included in this policy.	T745
12B	**Spinal Cord Stimulation for Chronic Pain** **Subject to Audit** Spinal Cord Stimulation for chronic pain is funded subject to: • Documented evidence that the patient has chronic pain of neuropathic origin AND • Documented evidence that the patient has continued to experience chronic pain (measuring at least 50 mm on a 0–100 mm visual analogue scale) for at least 6 months despite appropriate conventional medical management AND • Documented evidence that the patient has received a successful trial of stimulation as part of an assessment by a Pain Management Service. If different spinal cord stimulation systems are considered to be equally suitable for a patient, the least costly should be used. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	A483 A484 A485 A486 A487

13. OPHTHALMOLOGY

VBC/EBI Policy Criteria		Procedure & Diagnosis Codes
13A	**Laser Surgery for Short Sight (Myopia)** **Not Funded** Laser surgery for correction of short sight is not routinely funded.	C442,C448, C449, C461, C444, C445 Diagnosis Code: H521
13B	**Cataract Surgery** **Subject to Audit** This policy applies to both first and second eyes, with a best corrected visual acuity of 6/12 or worse in the affected eye being used as the threshold for cataract surgery. Cataract surgery will be funded if one or more of the following criteria are met: • Visual acuity is 6/12 or worse OR • Patients who are still working in an occupation in which good acuity is essential to their ability to continue to work (e.g. watchmaker) OR • Patients with posterior subcapsular cataracts and those with cortical cataracts who experience problems with glare and a reduction in acuity in bright conditions OR • Patients who need to drive at night who experience significant glare due to cataracts which affects driving OR • Patients who have difficulty with reading due to lens opacities OR • Patients with visual field defects borderline for driving, in whom cataract extraction would be expected to significantly improve the visual field OR • Patients with significant optical imbalance (anisometropia or aniseikonia) following cataract surgery on the first eye OR • Patients with glaucoma who require cataract surgery to control intra ocular pressure OR • Patient with diabetes who require clear views of their retina to look for retinopathy OR • Patients with wet macular degeneration or other retinal conditions who require clear views of their retina to monitor their disease or treatment (e.g. treatment with antiVEGFs) The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	Procedure Code: C751, C71, C72, C73, C74, C75 Diagnosis Codes: H25, H26

13C	**Chalazia Removal** **Subject to Audit** Incision and curettage (or triamcinolone injection for suitable candidates) of chalazia is funded subject to ONE of the following criteria being met: • Has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks OR • Interferes significantly with vision OR • Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy OR • Is a source of infection that has required medical attention twice or more within a six month time frame OR • Is a source of infection causing an abscess which requires drainage OR • If malignancy (cancer) is suspected, e.g. Madarosis/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	C121 C124 C122 C198 C191

14. ORTHOPAEDICS

VBC/EBI Policy Criteria		Procedure & Diagnosis Codes
14A	**Autologous Cartilage Transplantation of the Knee** **Not Funded** Autologous Cartilage Transplant will not be funded by the CCG.	W853 W714 W982
14B	**Radiation Therapy for Dupuytren's Contracture in Adults** **Not Funded** Radiation therapy for the treatment of Dupuytren's Contracture is not funded.	X65.4 Y91.9 Z89.4
14C	**Hip & Knee Replacement Surgery** **Subject to Audit** Hip & knee replacement surgery is only funded subject to the following: • Documented evidence that the patient has been reviewed by the MSK Triage and Assessment service AND • Documented evidence that the patient has engaged with exercise and physiotherapy, and used appropriate analgesia to relieve symptoms for a minimum of 3 months AND • The patient has a documented BMI measurement of less than or equal to 40 at the time of referral or BMI over 40 including weight loss management for 6 months OR • Documented evidence that the symptoms are refractory to non-surgical treatment (including analgesia, exercise, physiotherapy and weight loss (including the free NHS 12 week weight loss guide), where appropriate). The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes. This is a temporary increase of the upper BMI limit to 40 for good reason due to covid, and will be reviewed and re-considered in the next policy update scheduled in 2023. For the duration of this change from <35 to <40 providers will be required to participate in a six monthly audit as part of the contract management process in order to ensure that there have been no adverse outcomes for this group of patients (see appendix 2, audit process).	W371, W381, W391, W401, W411, W421, O181, W951, W931, W941
14D	**Primary Resurfacing Arthroplasty of Joint** **Subject to Audit**	W581.

	Primary resurfacing arthroplasty of joint will be funded subject to: • Documented evidence that the patient has been reviewed by the MSK Triage and Assessment service AND • Documented evidence that the patient is likely to outlive conventional primary hip replacements AND • Documented evidence that the patient has engaged with exercise and physiotherapy, and used appropriate analgesia to relieve symptoms for a minimum of 3 months AND • The patient has a documented BMI measurement of less than or equal to 40 at the time of referral or BMI over 40 including weight loss management for 6 months (including the free NHS weight loss guide); OR • Documented evidence that the symptoms are refractory to non-surgical treatment (including analgesia, exercise, physiotherapy and weight loss, where appropriate) The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes. This is a temporary increase of the upper BMI limit to 40 for good reason due to covid, and will be reviewed and re-considered in the next policy update scheduled in 2023. For the duration of this change from <35 to <40 providers will be required to participate in a six monthly audit as part of the contract management process in order to ensure that there have been no adverse outcomes for this group of patients (see appendix 2, audit process)	
14E	**Diagnostic and Therapeutic Arthroscopy of Knee Joint Subject to Audit** Diagnostic and therapeutic arthroscopy of Knee Joint is funded subject to: • Documented evidence that the patient has been reviewed by the MSK Triage and Assessment service AND • Clinical examination by the MSK Triage and Assessment Service OR • An MRI scan has demonstrated clear evidence of an internal joint derangement (meniscal tear, ligament rupture or loose body) AND • Where conservative treatment has failed OR • Where it is clear that conservative treatment will not be effective OR • Knee pain with diagnostic uncertainty following an MRI scan OR • Suspected malignancy, infection, nerve root impingement, bony fracture or avascular necrosis OR • Clear history of trauma The clinician undertaking the intervention is responsible for ensuring	W822 Diagnosis Codes: M2320 M2321 M2322 M2323 M2324 M2325 M2326 S832 M2330 M2336 M2334 M2335.

	that documented evidence is recorded for audit purposes.	
14F	**Arthroscopic Knee Washout (lavage and debridement) for Osteoarthritis** **Subject to Audit** Arthroscopic knee washout (lavage and debridement) should not be used as a treatment for osteoarthritis because it is clinically ineffective. Arthroscopic knee washout (lavage and debridement) is funded subject to: • Documented history of mechanical locking (as opposed to morning joint stiffness, giving-way or X-ray evidence of loose bodies); AND • Confirmed diagnosis of osteoarthritis of the knee. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	When der.Spell_Dominant_Procedure in ('W821','W822','W823','W828','W829','W851','W852','W853','W858','W859','W861+KNEE','W831+KNEE','W832+KNEE','W833+KNEE','W834+KNEE','W835+KNEE','W836+KNEE','W837+KNEE','W838+KNEE','W839+KNEE','W841+KNEE','W842+KNEE','W843+KNEE','W844+KNEE') and (APCS.Age_At_Start_of_Spell_SUS between 18 and 120) and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and der.Spell_Primary_Diagnosis like 'M1[57]%' then 'C_knee_arth'
14G	**Femeroacetabular Surgery for Hip Impingement / Arthroscopy of Hip** **Subject to Audit** Open or arthroscopic femeroacetabular surgery for hip impingement will be funded subject to documented evidence of:	W881 W888 W889 Z843

	• Pain – motion or position related, in the hip or groin AND • Positive clinical signs – impingement test and restricted range of motion AND • Labral tear or bony morphology in keeping with FAI has been confirmed on diagnostic imaging AND • The patient has completed a trial of conservative therapy. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	
14H	**Arthroscopic Shoulder Decompression for Subacromial Shoulder Pain** **Subject to Audit** Arthroscopic Shoulder Decompression for Subacromial Shoulder Pain is funded subject to: • Documented evidence that the patient has been reviewed by the MSK Triage and Assessment service AND • The patient has received physiotherapy and appropriate analgesia for a minimum of 3 months OR • The Patient has persistent or progressive symptoms, in spite of all appropriate non-operative treatment The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	0291 O071 W971 W975 T791 T794 Diagnosis Codes: M754 M755 M751 M1991.
14I	**Spinal Decompression/Discectomy (Restricted)** **Subject to Audit** Spinal decompression surgery will only be funded subject to: • Documented evidence that the patient has been diagnosed with Sciatica • Documented evidence that conservative measures including self-management, exercise, psychological therapy and Any type of suitable analgesia have been tried over a period of 6 months and have failed to improve pain and/or function. OR • Documented evidence that the surgery was performed as part of urgent or emergency surgery for a red flag condition (e.g. Cauda Equina Syndrome). The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	V221 V228 V242 V254 V255
14J	**Implants for Chronic Sacroiliac Pain (including iFuse)** **Subject to Audit** Implant surgery to treat chronic sacroiliac pain (including the iFuse Implant System) is funded subject to:	W621 Z841

	• Documented evidence of a positive response to a diagnostic injection of local anaesthetic in the sacroiliac joint; AND • Documented evidence that non-surgical management has been inadequate in controlling the patient's pain for a minimum of 3 months. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	
14K	**Bunion Surgery** **Subject to Audit** Surgery to remove bunions will only be funded subject to: • Documented evidence that the patient has been reviewed by the MSK Triage and Assessment service AND • Documented evidence that conservative measures have failed to benefit after 3 months (these include trying accommodative footwear, considering orthoses and using appropriate analgesia) OR • Documented evidence of recurrent or chronic ulceration or infection. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	W791 W792 Diagnosis Codes: M201.
14L	**Dupuytren's Contracture Release in Adults** **Subject to Audit** An intervention (needle fasciotomy, fasciectomy and dermofasciectomy) will be funded subject to: • Documented evidence that the patient has been reviewed by the MSK Triage and Assessment service AND • Documented evidence of finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint. OR • Documented evidence of severe thumb contractures which interfere with function The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	when left(der.Spell_Dominant_Procedure,4) in ('T521','T522','T525','T526','T541') and (APCS.Age_At_Start_of_Spell_SUS between 18 and 120) and left(der.Spell_Primary_Diagnosis,4)='M720' then 'N_dupuytr'
14M	**Trigger Finger Release** **Subject to Audit** Cases interfering with activities or causing pain should first be treated with: • One or two steroid injections which are typically successful (strong evidence), but the problem may recur, especially in	when der.Spell_Dominant_Procedure in ('T692+HAND','T691+HAND','T698+HAND',''

	diabetics; OR • splinting of the affected finger for 3-12 weeks. Surgery will be funded subject to: • Documented evidence that the patient has been reviewed by the MSK Triage and Assessment service AND • The triggering persists or recurs after one of the above measures (particularly steroid injections); OR • The finger is permanently locked in the palm; OR • The patient has previously had 2 other trigger digits unsuccessfully treated with appropriate non-operative methods; The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	T699+HAND','T701+HAND','T702+HAND','T718+HAND','T719+HAND','T723+HAND','T728+HAND','T729+HAND','Z894+HAND','Z895+HAND','Z896+HAND','Z897+HAND') and (APCS.Age_At_Start_of_Spell_SUS between 18 and 120) and der.Spell_Primary_Diagnosis like '%M653%' then 'P_trigger_fing'
14N	**Ganglion Excision** **Subject to Audit** **This guidance applies to adults aged 19 years and over.** Ganglion excision is funded subject to: • Documented evidence that the patient has been reviewed by the MSK Triage and Assessment service AND <u>Wrist ganglia</u> • Documented evidence that aspiration of the ganglion has failed to resolve the pain or tingling/numbness; AND • Documented evidence of restricted hand function <u>Seed ganglia at the base of a digit</u> • The ganglion is causing the patient pain; AND • Documented evidence that puncturing and/or aspiration of the ganglion using a hypodermic needle has failed to relieve symptoms; <u>Mucous cysts at the DIP joint</u> • Documented recurrent spontaneous discharge of fluid; AND/OR • Documented evidence of a significant nail deformity The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	when left(der.Spell_Dominant_Procedure,4) in ('T591','T592','T598','T599','T601','T602','T608','T609') and der.Spell_Primary_Diagnosis like '%M674%' then 'O_ganglion'
14O	**Carpal Tunnel** **Subject to Audit**	when left(der.Spell_

	Surgical release of the carpal tunnel is funded subject to: • Patients must have been assessed by the MSK triage and assessment service AND • The patient has acute severe symptoms that persist for more than 4 months after conservative therapy with local corticosteroid injection and nocturnal splinting OR • There is neurological deficit or median nerve denervation, e.g. sensory blunting, muscle wasting or weakness of the nar abduction AND • Severe symptoms significantly interfering with daily activities and sleep The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	Dominant_Procedure,4) in ('A651','A659') and der. Spell Primary_ Diagnosis like '%G560%' then 'M_carpal'
14P	**Arthroscopic surgery for meniscal tears** **Subject to Audit** Criteria • Non-operative treatments (including paracetamol and topical NSAIDS) have not settled symptoms after 3 months/persistent symptoms ongoing and an MRI has revealed an unstable meniscal tear • The patient has had an acute injury and an MRI scan reveals a potentially reparable meniscus tear • Patient has a locked knee and required an urgent assessment, which showed a bucket handle tear of the meniscus to be present. AND • The patient has gone through a shared decision making process and understands the risks of surgery. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes	Where the dominant procedure code is: W82.1, W82.2, W82.3, W82.8, W82.9 AND Diagnosis code in primary position is: M23.2, M23.3, S83.2
14Q	**Lumbar Discectomy** **Subject to Audit** **This guidance applies to adults aged 19 years and over.** Criteria • Patient has compressive nerve root signs and symptoms have lasted at least three months (or are severe cases) • Non-operative management has failed to resolve symptoms • Concordant MRI changes are present The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes	Where the procedure code in dominant position is: V29.1, V29.2, V29.3, V29.4, V29.5, V29.6, V29.8, V29.9, V33.1, V33.2, V33.3, V33.4, V33.5, V33.6, V33.7, V33.8, V33.9, V35.1, V35.8, V35.9,

		V51.1, V51.8, V51.9, V52.1, V52.2, V52.5, V52.8, V52.9, V58.1, V58.2, V58.3, V58.8, V58.9, V60.1, V60.2, V60.3, V60.8, V60.9 Primary diagnosis code is: M50.0,M50.1, M51.0, M51.1, M54.1, M54.2, M54.3, M54.4
14R	**Knee MRI when Symptoms are Suggestive of Osteoarthritis** **Subject to Audit** **This guidance applies to adults aged 19 years and over.** An MRI of the knee is not usually needed for the diagnosis of Osteoarthritis. Criteria • Patient has severe symptoms but relatively mild osteoarthritis on standard X-rays.OR • Patient is working up for possible HTO (High Tibial Osteotomy) or partial knee replacement (to focus on the state of the anterior cruciate ligament and retained compartments). The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes	Primary procedure code is: U133 With procedure in any position: Z84.6, O13.2
14S	**Vertebral Augmentation (vertebroplasty or kyphoplasty) for Painful Osteoporotic Vertebral Fractures** **Subject to Audit** **This guidance applies to adults aged 19 years and over.** • As per advice in the NICE Technology Appraisal Guidance 279 (TAG 279), VP or KP may be considered: • In cases where patients have ‘severe (7/10 or greater on VAS scale) ongoing pain after a recent, unhealed vertebral fracture despite optimal pain management’ in particular hospitalised older people • Where the acute vertebral fracture has been proven on imaging and correlates with the site of maximal pain on clinical examination • The decision to treat should be taken after multidisciplinary team discussion • The procedure should take place at a facility with access to spinal	Procedure code in dominant position is: V444 Primary diagnosis code is: M80.0, M80.1, M80.2, M80.3, M80.4, M80.5, M80.8, M80.9

	surgery services • Processes for audit and clinical governance should be in place • VP/KP must be performed in conjunction with additional measures to improve bone health. Criteria • Patient has severe (7/10 or greater on VAS scale) ongoing pain after a recent, unhealed vertebral fracture despite optimal pain management • The acute vertebral fracture has been proven on imaging and correlates with the site of maximal pain on clinical examination • Multidisciplinary team discussions have taken place • The procedure will take place at a facility with access to spinal surgery services • Processes for audit and clinical governance are in place Vertebroplasty must be performed in conjunction with additional measures to improve bone health The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes	
14T	**MRI Scan of the Hip for Arthritis** **Subject to Audit** Criteria • The patient is under 45 • The patient does not have activity-related joint pain • The patient has morning stiffness lasting more than 30 mins OR • Suggestions of infection, e.g. pyrexia, swollen and red joint, significant irritability, other risk factors of septic arthritis • Patient has suffered trauma • Patient has history or family history of an inflammatory arthropathy • Mechanical, impingement type symptoms • Prolonged and morning stiffness • History of cancer or corresponding risk factors • Suspected Osteonecrosis / Avascular necrosis of the hip • Suspected transient osteoporosis • Suspected periarticular soft tissue pathology e.g. abductor tendinopathy The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes	Where the primary procedure is: U13.3, U21.1 With procedure in any position: Z84.3, Z84.8, Z84.9, Z90.2

15. OTHER

VBC/EBI Policy Criteria		Procedure & Diagnosis Codes
15A	**Therapeutic Community Method Treatment for Borderline Personality Disorder** **Not Funded** This is not routinely funded.	N/A
15B	**Open or Upright MRI Scans** **Subject to Referral Interface Service assessment / audit of information** Open or Upright MRI scans will only be funded subject to: Claustrophobia • Documented evidence that the patient is claustrophobic and has previously failed an MRI scan with oral sedation (unless contraindicated) in a wide bore MRI scanner at a local NHS trust; AND/OR Patient Size • Documented evidence that an MRI scan in a wide bore scanner at a local NHS trust has been unsuccessful due to the size of the patient and restriction of the MRI scanner tunnel. The referring clinician is responsible for ensuring that evidence of meeting the criteria is included when making a referral. The Referral Interface Service (RAS & TRAQS) are responsible for processing the referral and ensuring All required evidence is provided, where this is not the case referrals will be rejected.	N/A
15C	**Hydrotherapy** **Position Statement** This position statement covers the use of hydrotherapy in place of land-based physiotherapy. **It is the responsibility of the referring and treating physiotherapist to ensure compliance with this commissioning advice.** The choice of land or water based NHS physiotherapy is at the discretion of the provider service. As outcomes for land and water based physiotherapy are equivalent, providers will deliver either service within the agreed standard land	N/A

	based physiotherapy first and follow up tariff prices i.e. **the CCGs will not pay a separate tariff for Hydrotherapy.** **NB:** Since hydrotherapy is not considered to be an essential service, this policy applies only where local provision is available. Where local provision is not available, patients should receive land-based physiotherapy.	
15D	**Helmet Therapy for Treatment of Positional Plagiocephaly/ Brachycephaly in Children** **Not Funded** **This guidance applies to children aged 2 years and under.**	Select records from APC data where: Procedure code is: V04.8, V049 Diagnosis code is: Q67.3

16. PAIN

VBC/EBI Policy Criteria		Procedure & Diagnosis Codes
16A	**Inpatient (Residential) Pain Management or Cognitive Behavioural Therapy Programmes** **Not Funded** Inpatient (residential) placements for 'pain management programmes' or cognitive behavioural therapy is not funded.	N/A
16B	**Low Back Pain** **Not Funded** The CCG does not commission the following investigations or treatments for patients with low back pain with or without sciatica: • Belts or corsets • Traction Electrotherapies • Ultrasound • Percutaneous electrical nerve simulation (PENS) • Transcutaneous electrical nerve simulation (TENS) • Interferential therapy • Spinal fusion for people with low back pain • Disc replacement in people with low back pain	A707
16C	**Spinal Fusion for Low Back Pain (Not funded)** **Not Funded** Spinal fusion surgery for the management of low back pain is not funded.	V511 V38.2 V38.3 V38.4, V38.5, V38.6, V40.4 Diagnosis Codes: M54.5, M54.9
16D	**Trigger Point Injections** **Not Funded** Trigger Point Injections are not funded.	A735, A739, X37, X375, X378, X379 X38 –
16E	**Spinal Injections for Management of Back Pain** **Not Funded** The following spinal injections for the management of back pain are not funded: • Facet Joint Injections • Therapeutic Medial Branch Blocks • Intradiscal Therapy • Trigger Point Injections	V544, A52, A521, A522, A528, A529, A577, A735, W903, A78, A781, A782, A783, A784, A785, A788, A789, V48,

	• Epidural steroid injections • Pulsed Radiofrequency • Any other spinal injections not specifically covered above. Reference: NHS England Evidence Based Intervention Policy – Category 1 The following injections are commissioned subject to all criteria being met: **Diagnostic Medial Branch Block Injections** **Subject to Audit** • Medial Branch Block Injections will be funded only as a diagnostic procedure prior to Radiofrequency Denervation. • One Medial Branch Block (MBB) Injection only will be funded unless there is documented evidence of a change in presentation that would clinically require a second diagnostic MBB. **First Radiofrequency Denervation** **Subject to Audit** Initial treatment with radiofrequency denervation will be funded subject to: • The patient being aged 18 or over AND • Documented evidence that all conservative measures, including physiotherapy, exercise and pharmacological treatments have been undertaken and have failed; AND • Documented evidence that the patient is receiving treatment from a Pain Management Multi-disciplinary Team; AND • Documented evidence that the patient has received successful (>70% improvement on a validated assessment tool) Diagnostic Medial Branch Block Injection. • Treatment must be under X-ray guidance. **Repeat Radiofrequency Denervation** **Subject to Audit** Repeat Radiofrequency is funded subject to: • Documented evidence that the initial benefit from radiofrequency denervation lasted a minimum of 16 months following the date of initial treatment. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	V481, V482, V483, V484, V485, V486, V487, V488, V489, A572, A573, A574, A575, A604, A605, A608, A609 Where procedure code in dominant position is: V48.5, V48.7 AND Procedure code in any position is Z674, Z675, Z676, Z677, Z993 AND Primary diagnosis code is: M518, M519, M545, M549
16F	**Shoulder Radiology: Scans for Shoulder Pain and Guided Injections** **Subject to Audit**	Where the procedure code in any position is:

	This guidance applies to adults aged 19 years and over. **Scans for Shoulder Pain** Ultrasound, MRI or CT scan has been requested by secondary care services that are responsible for the definitive treatment of the patient **Guided Injections** Image guided subacromial injections are not recommended in primary, intermediate or secondary care. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	U13.2, U13.3, U13.4, U13.5, U13.6, U21.1, U21.2, U21.6, U21.7 AND procedure code in any position is: Z81.2, Z81.3, Z81.4, Z81.8, Z81.9, Z89.1, Z54.2, Z54.8, Z54.9, Z68.8, Z68.9 AND procedure code in any position is not: W903+Shoulder ORW904+ Shoulder
16G	**Low Back Pain Imaging** **Subject to Audit** **This guidance applies to adults aged 19 years and over.** Criteria • Do not routinely offer imaging in a non-specialist setting for people with low back pain with or without sciatica in the absence of red flags, or suspected serious underlying pathology following medical history and examination. • Imaging in low back pain should be offered if serious underlying pathology is suspected. Serious underlying pathology includes but is not limited to: cancer, infection, trauma, spinal cord injury (full or partial loss of sensation and/or movement of part(s) of the body) or inflammatory disease. • Patients presenting with low back pain and sciatica should be reviewed in accordance with the low back pain and sciatica guidance [NG59]. Patients presenting with low back pain without sciatica should be reviewed and if none of the above serious underlying pathology are suspected, primary care management typically includes reassurance, advice on continuation of activity with modification, weight loss, analgesia, manual therapy and reviewing patients who are high risk of developing chronic pain (i.e. STaRT Back). • NICE guidelines recommend using a risk assessment and stratification tool, (e.g. STaRT Back), and following a pathway such as the National Back and Radicular Pain Pathway, to inform shared decision making and create a management plan. Consider a combined physical and psychological programme for	Where any procedure is: U05.4, U05.5, U13.2,U13.3, U13.5, U13.6, U21.1, U21.2, U21.6, U21.7 WITH: Z66.5 (in any position) OR O16.2 (in any position)

	management of sub-acute and chronic low back pain (greater than 3 to 6 months duration) e.g. Back Skills Training (BeST). Consider referral to a specialist centre for further assessment and management if required. Imaging within specialist centres is indicated only if the result will change management. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	

17. UROLOGY

VBC/EBI Policy Criteria		Procedure & Diagnosis Codes
17A	**Reversal of Male Sterilisation** **Not Funded** Reversal of male sterilisation is not routinely funded.	N18 , N181 N182, N188 N189
17B	**Circumcision** **Subject to Audit** Circumcision surgery will only be funded subject to: • Documented evidence of phimosis in children with spraying, ballooning and/or recurrent infection OR • Documented evidence of adult phimosis or paraphimosis OR • Recurrent (>3 documented episodes) of balanitis or balanoposthitis OR • Documented evidence of balanitis xerotica obliterans OR • Documented evidence of dermatological disorders unresponsive to treatment OR • Documented evidence of congenital urological abnormalities when skin is required for grafting OR • Documented reports of interference with normal sexual activity in adult males OR • For UTI prevention in patients with documented evidence of an abnormal urinary tract OR • Risk of malignancy OR • Significant local trauma The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	N303 N284
17C	**Treatment for Erectile Dysfunction** **Subject to Audit** Surgical treatment for erectile dysfunction is funded subject to documented evidence of one of the following diagnosis's: • Diabetes OR • Multiple sclerosis OR • Parkinson's disease OR • Poliomyelitis OR • Prostate cancer OR • Prostatectomy OR • Radical pelvic surgery OR	N326

	• Severe pelvic injury OR • Renal failure treated by dialysis or transplant OR • Single gene neurological disease OR • Spinal cord injury OR • Spina bifida In patients with Peyronie's disease and erectile dysfunction is not responding to medical treatments, the surgical correction of the curvature with concomitant penile prosthesis implantation should be considered. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	
17D	**Removal of Kidney Stones** **Subject to Audit** **This guidance applies to adults aged 19 years and over.** Criteria • Renal stones are 5-10mm and not suitable for watchful waiting, shockwave lithotripsy is to be offered as first-line treatment (unless contra-indicated or not targetable) OR • Renal Stones are 10-20mm shockwave lithotripsy can be considered as first-line treatment (if treatment can be given in a timely fashion) • Renal stones are 10-20mm and shockwave lithotripsy is contraindicated or ineffective, then ureteroscopy can be considered. • Renal stones are over 20mm (including staghorn), percutaneous nephrolithotomy (PCNL) can be offered as first-line treatment The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	Where procedure code in dominant position is: M09.4, M09.8, M16.4, M26.1, M26.2, M26.3, M27.1, M27.2, M27.3, M27.8, M28.1, M28.2, M28.3, M28.4, M28.5, M28.8, M28.9 AND Primary diagnosis code is: N20.0, N20.1, N20.2, N20.9
17E	**Cystoscopy for Men with Uncomplicated Lower Urinary Tract Symptoms** **Subject to Audit** Criteria • The patient has lower urinary tract symptoms (LUTS) and suffers recurrent urinary tract infections OR • The patient has lower urinary tract symptoms (LUTS) and has sterile pyuria (urine dip positive for leukocytes without bacterial growth) • The patient has lower urinary tract symptoms (LUTS) and haematuria • The patient has very significant/profound lower urinary tract symptoms (LUTS)	Where procedure code in dominant position is:M45.5, M45.8, M45.9 AND Procedure codes in any position are NOT: M45.1 Diagnostic endoscopic examination of bladder and biopsy of lesion

	• The patient has lower urinary tract symptoms (LUTS) with pain around urinary tract • The patient has lower urinary tract symptoms (LUTS) and risk factors such as long smoking history, travel or occupational history suggesting a high risk of malignancy, or previous urogenital surgery The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	of bladder NEC M45.2 Diagnostic endoscopic examination of bladder and biopsy of lesion of prostate NEC M45.3 Diagnostic endoscopic examination of bladder and biopsy of lesion of bladder using rigid cystoscope M45.4 Diagnostic endoscopic examination of bladder and biopsy of lesion of bladder using rigid cystoscope AND Patient gender is male
17F	**Surgical Intervention for Benign Prostatic Hyperplasia Subject to Audit** Criteria • The person is healthy and has complicated benign prostatic hyperplasia (i.e. chronic retention with renal impairment) as evidenced by hydronephrosis and impaired GFR OR • Other evidence of complicated BPH (e.g. urinary tract infections, bladder stones or acute urinary retention) • Bothersome LUTS persist alongside high, or unchanged International Prostate Symptom Scores despite optimal conservative and drug treatment AND • Shared Decision making process has been carried out and the person has been counselled thoroughly regarding alternatives. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	Where the procedure code in dominant is: M61.1, M61.2, M61.3, M61.4, M61.8, M61.9, M64.1, M65.1M65.2, M65.3, M65.4, M65.5, M65.8, M65.9, M66.1, M66.2, M68.1, M68.3 AND Primary diagnosis code is: N40 Hyperplasia of prostate AND of these Diagnosis code in any position is NOT: C61

		Malignant neoplasm of prostate AND Patient gender is male
17G	**Prostate-specific antigen (PSA) test** **Subject to Audit** **This guidance applies to male adults aged 19 years and over.** Note: PSA testing for prostate cancer should be avoided if man has: • An active or recent urinary infection (PSA may remain raised for many months). • Had a prostate biopsy in the previous 6 weeks. Both of which are likely to raise PSA and give a false positive result. PSA testing for prostate cancer is not recommended in asymptomatic men (unless they are at high risk of prostate cancer i.e. Black and/or family history). This is because the benefits have not been shown to clearly outweigh the harms. In particular, there is concern about the high risk of false positive results. Where PSA test results are mildly raised above the age specific range for an individual patient, it may be appropriate to repeat the test within two to three months to monitor the trend. Criteria • The man is asymptomatic and over age 40 and at higher risk of prostate cancer (e.g. they are Black and/or have a family history of prostate cancer) OR • Symptomatic men with lower urinary tract symptoms (LUTS), such as nocturia, urinary frequency, hesitancy, urgency or retention, visible haematuria • Erectile dysfunction • Symptoms that could be due to advanced prostate cancer (for example lower back pain, bone pain, weight loss). AND • A careful discussion about the potential risks and benefits of PSA testing has been held, allowing for shared decision The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	No coding is available

18. VASCULAR

VBC/EBI Policy Criteria		Procedure & Diagnosis Codes
18A	**Venous Angioplasty for the treatment of Multiple Sclerosis** **Not Funded** Venous angioplasty for the treatment of Multiple Sclerosis is not funded.	L946, L947, L948, L949 Diagnosis Code: G35
18B	**Varicose Vein Interventions** **Subject to Referral Interface Service assessment / audit of information** Refer people to a vascular service if they have any of the following: • Symptomatic* primary or recurrent varicose veins OR • A non-healing venous leg ulcer *Symptomatic: “Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching).” The referring clinician is responsible for ensuring that evidence of meeting the criteria is included when making a referral. The Referral Interface Service (RAS & TRAQS) is responsible for ensuring compliance with the policy and will reject any referrals that do not meet the criteria.	L84.1, L84.2, L84.3, L84.4, L84.5, L84.6, L84.8, L84.9, L85.1, L85.2, L85.3, L85.8, L85.9, L86.1, L86.2, L86.3, L86.8, L86.9, L87.1, L87.2, L87.3, L87.4, L87.5, L87.6, L87.7, L87.8, L87.9, L88.1, L88.2, L88.3, L88.8, L88.9, L83.2, L83.1, L83.8, L83.9

Appendix 1

Policy Use, Management & Audit Pathway

Referrals

Shropshire Telford and Wrekin CCG process referrals and offer choice where applicable through the use of a referral interface service. For patients registered with Shropshire GP Medical practices this will be undertaken through the RAS (Shropshire Referral Assessment Service) arm of the service, and for those registered with Telford GP Medical practices the TRAQS (Telford Referral Assessment & Quality Service) arm of the service. This is a continuity of existing practice and is not changed by the refreshed VBC Policy.
RAS also perform a referral interface service for other specific CCG's along the Welsh Border to ensure that those patients are offered a choice of being seen under English RRT rules.

Both RAS and TRAQS will review VBC/EBI referrals and any that are identified as unclear or lacking necessary detail will be returned to the referrer with a request for further information. If further information is not subsequently supplied, the referral will be rejected.
The service will soon be moving towards utilising software screening processes in which any incomplete referrals will be automatically rejected.

Please note that where this Policy refers to children or adults, unless specifically stated otherwise, an adult is considered to be aged 16 or over.

Outcomes

Not Funded

All procedures listed within the VBC/EBI Policy as 'Not Funded' will not be funded in any circumstances. Where a referral is completely rejected, the referrer may wish to consider whether the Patient meets the exceptionality criteria highlighted in the IFR Policy to enable IFR funding to be sought - see separate IFR Policy.

In line with the NHS Standard Contract Service Condition 29.22, the Service Provider will not be paid for any interventions listed as 'Not Funded' except if IFR funding has been approved by the IFR team.

Integrated Care System (ICS) Partners have entered into an Intelligent Fixed Payment (IFP) arrangement so that system resources are allocated to partner organisations in a fixed manner. In practice this supersedes pbr payment for interventions and the delivery risk sits with providers for delivery cost of activity.

Activity undertaken that is not in line with the VBC policy will be monitored and raised with the provider at Contract Review Meetings. The agreed audit process will be used to assess and evaluate the implementation of the VBC policy and review practice against the policy standards/criteria to enable improvements in clinical practice and/or the policy.

Subject to Referral Interface Service assessment / audit of information

Where a referral is made by a GP for an intervention, the referring clinician must submit evidence of how the patient meets the criteria when making the referral. This evidence

should be attached or included within the referral and submitted via normal local processes to RAS or TRAQS. As previously described referrals not containing the necessary information / evidence that the request meets the criteria set out within this policy will be returned to the requester.

If the criteria within the VBC Policy are met, the referral will be processed by RAS / TRAQS in line with normal practice and confirmation of the approval along with a Prior Approval Authorisation Code (PAAC) will be included within the Triage Referral Form.

If the criteria within the VBC Policy are not met, RAS/TRAQS will reject the referral and communicate the reason for this to the referrer. There remains the option to the referrer of considering whether it meets the criteria requirements and is clinically appropriate for an individual funding request where the VBC referral has been rejected.

RAS/TRAQS will record all approved and rejected referrals.

If a Service Provider receives a referral for a procedure under this VBC Policy for a NHS Shropshire, Telford and Wrekin CCG registered patient through any means other than via RAS/ TRAQS, these referrals should be rejected on the basis that this approval has not been requested or granted.

Subject to Audit

Procedures and interventions that are Subject to Audit may be undertaken by a Service Provider where the treating clinician is content that documented evidence of how the patient meets the criteria is recorded and would be readily available to Commissioners in the event of an audit being undertaken. The responsibility for ensuring that the patient meets the specified criteria within the VBC/EBI Policy lies with the treating clinician within the Service Provider undertaking the intervention.

The CCG Contracts team will undertake a monthly monitoring review of Provider activity against the procedure codes where there is no approval code.

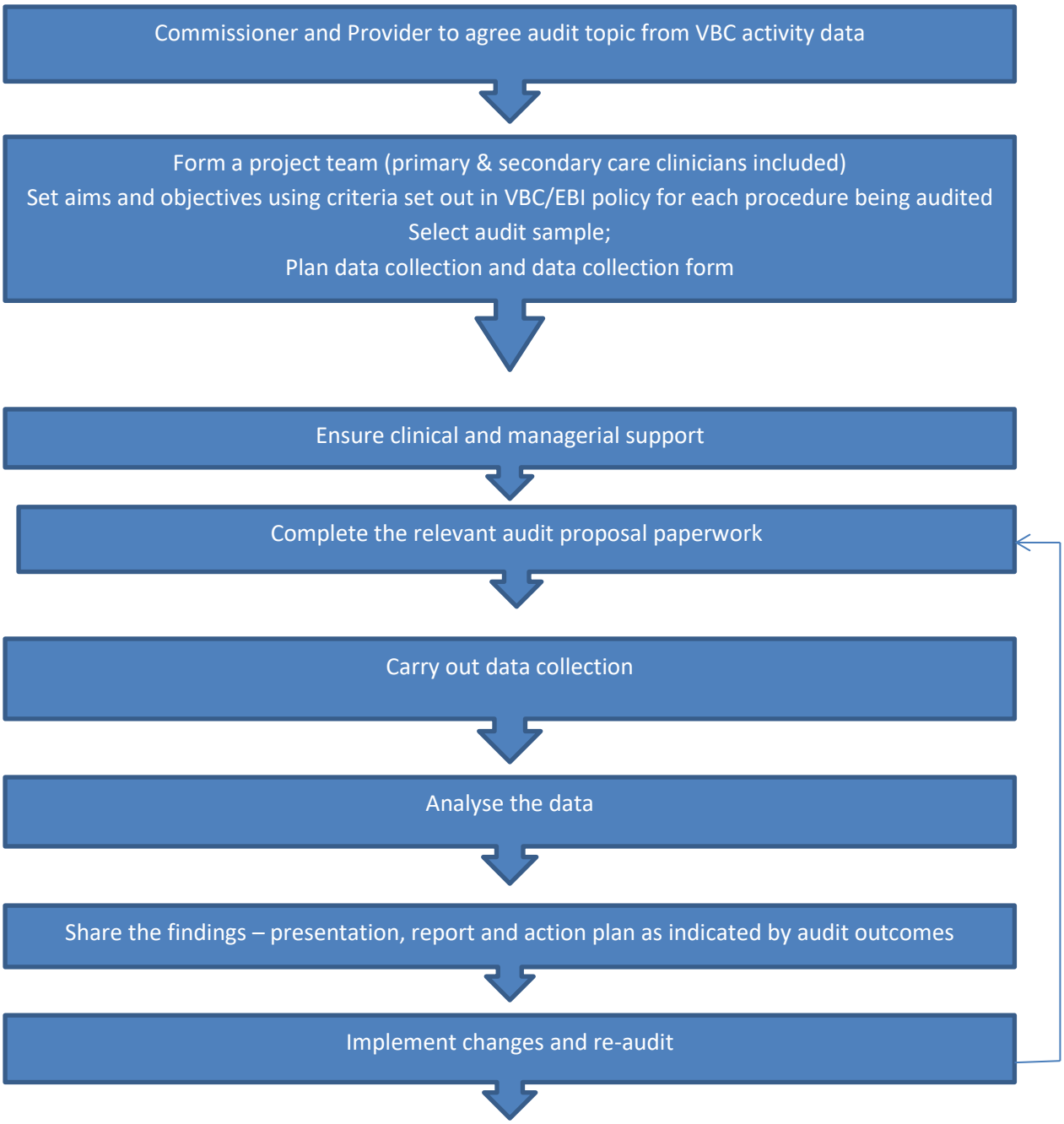
The Service Providers will also work with the CCG on a quarterly basis to undertake a retrospective audit against the cases where VBC activity has been undertaken without an approval code, in order to:

- determine the validity and clinical rationale of providing those procedures, or
- identify those cases where procedures have been undertaken without a code that cannot be clinically justified.

The results of this quarterly audit shall be used to work with the Service Providers in ensuring compliance with the Policy and its contents, and thereby ensuring existing resource is utilised effectively and efficiently on services that are commissioned. This audit and its outputs also provide ongoing feedback of learnings to clinicians, and ensure patient safety. See ***Appendix 2*** for illustration of the audit process

Appendix 2

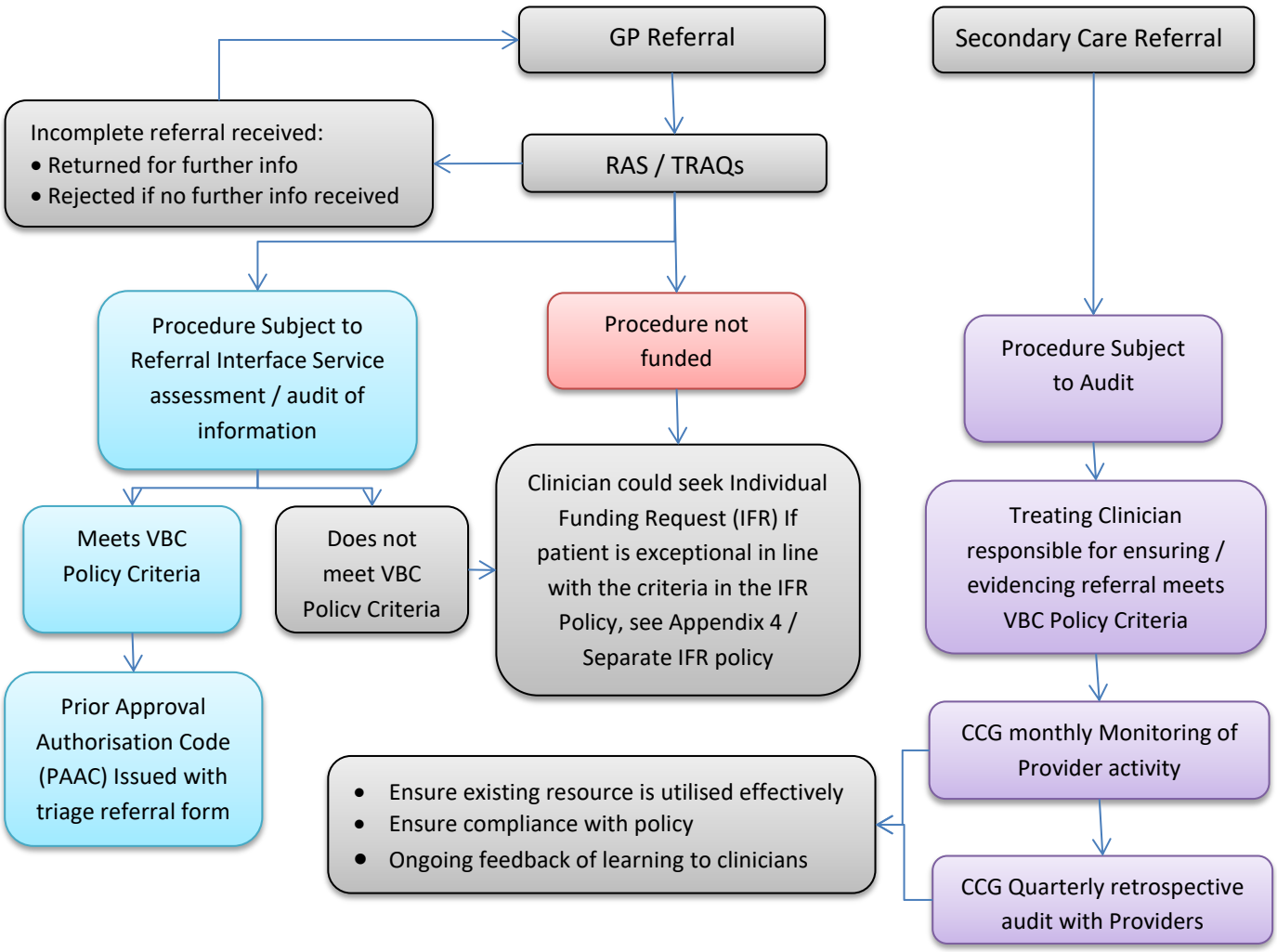
Value Based Commissioning (VBC) and Evidenced based Interventions (EBI) Policy – Audit Process



Appendix 3

Flow Chart showing

Policy Use, Management & Audit Pathway



Appendix 4

Individual Funding Request (IFR) process

Before an Individual Funding Request is submitted the IFR Policy should have been read by the requesting clinician. It can be found on the CCG website:

https://www.shropshiretelfordandwrekinccg.nhs.uk/wp-content/uploads/2021110-Individual-Funding-Request-Policy-2021.pdf

If a patient meets the exceptionality criteria as defined in the IFR Policy then a funding request may be submitted by the specialist, who will be providing the requested treatment. IFRs should not be submitted by GPs. The application form is available on the CCG Website: https://www.shropshiretelfordandwrekinccg.nhs.uk/advice-for-professionals/traqs/

The completed form and any supporting evidence should be sent to: stwccgsafehaven@nhs.net

Once an IFR application form has been received, it is pre-screened to assess whether it meets the definition of clinical exceptionality as given in the IFR Policy. Applications, which do not meet the appropriate criteria, are declined at pre-screening and a letter giving the reason for the decision is sent/e-mailed to the clinician who submitted the request.

Applications, which do meet the criteria, are submitted to a screening panel, which is responsible for making the funding decision and a letter giving the reason for the decision is sent/e-mailed to the clinician who submitted the request.

Please see IFR Policy for further detail of this process.

Appendix 5

Clinical Glossary

A

Adenoma - Adenomas are a type of non-cancerous tumor or benign that may affect various organs.
Angina - Angina is chest pain caused by reduced blood flow to the heart muscles. It's not usually life threatening, but it's a warning sign that you could be at risk of a heart attack or stroke.
Angiogram / Angiography - Angiography is a type of X-ray used to check the health of your blood vessels and how blood flows through them.
Acute gallstone pancreatitis without cholangitis - Cholangitis is an inflammation in the bile duct. Gallstones are small stones that form in your gallbladder. They can sometimes trigger acute pancreatitis if they move out of the gallbladder and block the opening of the pancreas.
Appendicitis - Appendicitis is a painful swelling of the appendix.
Adenoids - Adenoids are small lumps of tissue at the back of the nose, above the roof of the mouth. These can become swollen after a bacterial or viral infection, or after a substance triggers an allergic reaction.
Arthritis - Arthritis is a common condition that causes pain and inflammation in a joint.
Arrhythmias - Arrhythmias are abnormal heart rhythms.
Arthroscopic surgery - is a procedure usually performed under general anaesthesia.
A fibreoptic telescope (arthroscope) attached to a video camera is inserted through a small incision near the knee joint, and saline is introduced via a cannula in a further incision near the joint.
Acute Myocardial Infarction (MI) - Acute myocardial infarction is the medical name for a heart attack.
Acute Coronary Syndrome (ACS) - A significant blockage in the coronary arteries, the term covers MI and unstable angina comprise ACS.

B

Barrett's Oesphagus - Barrett's oesophagus is when the cells lining the lower part of your oesophagus (gullet) get damaged by acid and bile repeatedly coming up from your stomach. Over time, the cells may become abnormal and there's a small risk that cancer will develop.
Benign Prostatic Hypertrophy (Benign prostate enlargement (BPE) – Benign prostate enlargement (BPE) is the medical term to describe an enlarged prostate, a condition that can affect how you pass urine.
Brachycephaly (Flat head syndrome) - Flat head syndrome in babies where the back of the head becomes flattened, causing the head to widen, and occasionally the forehead bulges out.
Blood transfusion - A blood transfusion is when you're given blood from someone else (a donor).

Brittle bones (Osteoporosis) - Osteoporosis is a health condition that weakens bones, making them fragile and more likely to break. It develops slowly over several years and is often only diagnosed when a fall or sudden impact causes a bone to break (fracture).

C

Cholecystectomy - A surgical procedure that removes the gallbladder.
Choledocholithisis - The presence of a gallstone in the common bile duct.
Chronic rhinosinusitis with Nasal Polyposis (CRSwNP) - Chronic rhinosinusitis with nasal polyps is diagnosed by the presence of both subjective and objective evidence of chronic sinonasal inflammation.
Computerised Tomography (CT) scan - uses X-rays and a computer to create detailed images of the inside of the body.
Creatinine Kinase tests (Lipid lowering therapy) - Creatine Kinase levels are the clinical measure of muscle damage (rhabdomyolysis) and are widely used to monitor the safe use of lipid lowering therapy.
Cystoscopy – A cystoscopy is a procedure to look inside the bladder using a thin camera called a cystoscope.
Cranial Moulding Orthosis - Helmet moulding therapy, or cranial orthosis, is a type of treatment in which a baby is fitted with a special helmet to correct the shape of the skull.
Coronary angiography - Invasive diagnostic procedure that provides information about the structure and function of the heart. It is considered the best method for diagnosing coronary artery disease.
Coronary heart disease (CHD) - Coronary heart disease is the term that describes what happens when your heart's blood supply is blocked or interrupted by a build-up of fatty substances in the coronary arteries.
Cardiomyopathy - A general term for diseases of the heart muscle, where the walls of the heart chambers have become stretched, thickened or stiff.
Coronary revascularization - In medical and surgical therapy, revascularization is the restoration of perfusion to a body part or organ that has suffered ischemia. It is typically accomplished by surgical means.
Cardiovascular disease (CVD) - Cardiovascular disease is a general term for conditions affecting the heart or blood vessels.
Chest radiograph - Another term for a chest x-ray.
Cardiothoracic surgery - Cardiothoracic surgery (also known as thoracic surgery) is the field of medicine involved in surgical treatment of organs inside the thorax (the chest), generally treatment of conditions of the heart (heart disease) and lungs (lung disease).
Cardiopulmonary exercise testing (CPET) - Cardiopulmonary exercise testing is a non-invasive method used to assess the performance of the heart and lungs at rest and during exercise.

D

Discectomy - A discectomy is a surgical treatment of pain caused by a prolapsed disc in your back. It is the surgical removal of the disc material that is irritating the nerve root.
Dural tear - Where the thin covering over the spinal cord is damaged.
Dyspepsia – Indigestion.

E

Electrocardiogram (ECG) - An electrocardiogram is a simple test that can be used to check your heart's rhythm and electrical activity.
Endoscopic retrograde cholangio- pancreatography (ERCP) - An invasive procedure that involves a small camera (endoscope) being placed into your mouth and fed through to look at the area around your small intestine, pancreas and biliary tree.

F

Flat head syndrome (plagiocephaly and brachycephaly) - Babies sometimes develop a flattened head when they're a few months old, usually as a result of them spending a lot of time lying on their back.
Fusion surgery - Spinal fusion surgery involves the use of surgical implants and/or bone graft to obliterate motion between vertebrae.

H

Haematoma - When the blood vessels under your skin are damaged and blood leaks out and pools, resulting in a bruise.
Haemothorax - A collection of blood between the chest wall and the lung cavity.
Heart tracing (ECG) - A simple test that can be used to check your heart's rhythm and electrical activity
Hernia - A hernia occurs when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall.

I

Indolent disease - A disease that causes no pain or other symptoms and is not causing immediate health effects.
Interval cholecystectomy – The removal of a diseased gallbladder after drainage for acute infection.
Intermediate care - Care provided to patients who are medically stable but too unstable to be treated in alternative healthcare settings such as home, ambulatory, or a nursing home and need some rehabilitation or step-down care until they are stable enough to go home or elsewhere. (NIHR)
Inguinal hernia - The most common type of hernia which occurs when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall.
Ischaemia - Ischemia or ischaemia is a restriction in blood supply to tissues, causing a shortage of oxygen that is needed for cellular metabolism (to keep tissue alive).

K

Knee arthroscopy - Knee arthroscopy is a surgical technique that can diagnose and treat problems in the knee joint.
Kidney stones - Waste products in the blood can occasionally form crystals that collect inside the kidneys. Over time, the crystals may build up to form a hard stone like lump.

L

Left bundle branch block (LBBB) - Left bundle branch block is a blockage of electrical impulses to the heart's left ventricle.
Lower urinary tract symptoms (LUTS) – Lower urinary tract symptoms comprise of storage, voiding and post-micturition symptoms affecting the lower urinary tract.
Lung metastases - Lung metastasis is cancer that started in another part of the body and spread to the lungs.

M

Magnetic resonance imaging (MRI) scan - Magnetic resonance imaging is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.
Mechanical axial low back pain - A variety of structures in the low back can cause axial or mechanical lower back pain, such as a degenerated disc, facet joint problems, and damage to soft tissues – muscles, ligaments, and tendons.
Malignant - A term for diseases in which abnormal cells divide without control and can invade nearby tissues. Malignant cells can also spread to other parts of the body through the blood and lymph systems.
Myocardial infarction (MI) - Also known as a heart attack, occurs when blood flow decreases or stops to a part of the heart, causing damage to the heart muscle.

N

Non-cardiac - Refers to any procedure not involving the heart or major blood vessels.

O
Osteoarthritis (OA) - The commonest form of arthritis, characterised by joint pain accompanied by a varying degree of functional limitation and reduced quality of life.
Osteonecrosis - When the bone tissue doesn’t get enough blood supply and dies.
Osteoporotic vertebral fractures - Osteoporotic vertebral fractures cause pain and an associated reduction in mobility. Osteoporotic bones are of reduced density and are more susceptible to fractures.
Overdiagnosis - Making people patients unnecessarily, by identifying problems that were never going to cause harm or by medicalising ordinary life experiences through expanded definitions of diseases. (BMJ)

P

Paced ventricular rhythm - An electrocardiographic finding in which the ventricular rhythm is controlled by an electrical impulse from an artificial cardiac pacemaker.
Patient body habitus - Physique / Build.
Pancreatitis – Pancreatitis is a condition where the pancreas is inflamed and is not working properly as a result. It can be acute or chronic.
Percutaneous - Through the skin.
Plagiocephaly (Flat head syndrome) - Flat head syndrome in babies where the head is flattened on 1 side, causing it to look asymmetrical; the ears may be misaligned, and the head looks like a parallelogram when seen from above, and sometimes the forehead and face may bulge a little on the flat side.

Pneumothorax - A collapsed lung where air leaks into the space between the chest wall and the lung cavity.
Primary care services - Provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services. (NHS England)
Prognosticate Coronary Heart Disease (CHD) – Where a person is predicted to be at significant risk of coronary heart disease.
Prostate-specific antigen (PSA) - Is a protein produced by the prostate gland. Blood PSA levels can be elevated in prostate cancer as well as a number of other conditions including benign prostatic hypertrophy, prostatitis and urinary tract infection.
Pulmonary oedema - A condition caused by excess fluid on the lungs.

R

Radiofrequency facet joint denervation - Facet joint radiofrequency denervation is a procedure in which nerve fibres supplying the painful facet joints are selectively destroyed by heat produced by radio waves and delivered through a needle.
Radionucleotide myocardial perfusion imaging - Used to assess the heart condition, it involves taking pictures of the heart in action and the flow of blood within the heart.
Revascularisation - The restoration of perfusion to a body part or organ that has suffered ischemia
Renal disease - The name for a disease or condition that mainly affects the kidneys.

S

Secondary care - Sometimes referred to as 'hospital and community care', can either be planned (elective) care such as a cataract operation, or urgent and emergency care such as treatment for a fracture. (NHS Providers)
Sepsis - A serious infection that causes your immune system to attack your body.
Shock wave lithotripsy (SWL) - A non-invasive fragmentation of kidney stones or gallstones with shock waves generated outside the body
Spinal fusion surgery - Involves the use of surgical implants and/or bone graft to obliterate motion between vertebrae.
Sound wave therapy - Can be used for removing kidney stones.
Stress echocardiograms - Stress echocardiography is a test that uses ultrasound imaging to show how well your heart muscle is working to pump blood to your body.

T

Transurethral incision of the prostate (TUIP) - Surgical treatment to reduce the size of an enlarged prostrate by making incision.
Transurethral needle ablation of the prostate (TUNA) - Is a technique that uses low energy radio frequency delivered through two needles to ablate excess prostate tissue.
Transurethral resection of prostate (TURP) - Is a therapeutic procedure involving removal of tissue from the inner aspect of the prostate using diathermy, via an endoscopic approach. It is commonly undertaken for voiding LUTS presumed secondary to BPE.

Transurethral vaporisation of the prostate (TUVP) - Utilises the heat from high voltage electric current which ablates obstructive prostatic tissue and seals the surrounding blood vessels

U

Upper GI endoscopy - A procedure that allows your doctor to look at the inside lining of your oesophagus, your stomach, and the first part of your small intestine (duodenum).
Ureteroscopy (URS) - A procedure to examine in the inside of your urinary tract using a small lighted viewing scope
Urology - The branch of medicine that focuses on surgical and medical diseases of the male and female urinary tract system

V

Valvular heart disease - Occurs when the valves of the heart become diseased or damaged, affecting the blood flow through the body and putting extra strain on the heart.
Ventricular pre-excitation - An abnormality in the electrical functioning of the heart which may cause rapid heart rates. The abnormality affects the electrical signal between the atria and ventricles.
Vertebroplasty (VP) - A procedure which involves the injection of cement (typically polymethylmethacrylate (PMMA)) into the fractured vertebral body via a needle inserted through the skin, using image guidance.
Vertebral compression fractures - A break in a bone of the spinal column that results in a reduction in height of that bone.

Appendix 6

Frequently Asked Questions

Q1. If my request for treatment has been declined by the TRAQS/RAS team, can I apply for an Individual Funding Request (IFR)?

A1. If a request has been declined by either the TRAQS or RAS team and the patient meets the exceptionality criteria given in the IFR Policy then the specialist treating the patient may submit an Individual Funding Request by completing the application form and submitting it, along with all supporting evidence to STWCCGsafehaven@nhs.net. If the patient is not exceptional or unique within an identified clinical cohort then funding approval should not be sought via the IFR route.

Q2. If my patient does not meet the eligibility criteria in the VBC/EBI Policy and is not clinically exceptional, how do I get funding?

A2. If your patient does not meet the eligibility criteria in the VBC policy or the exceptionality criteria in the IFR Policy then funding may not be gained via the IFR route. It is, however, possible for the clinician who wishes to carry out the treatment to submit a business case for the commissioning of the treatment requested.

Q3. If I require further information regarding an IFR application or IFR funding decision made who do I contact?

A3. If you require further information in relation to an IFR application or funding decision you may contact the IFR Team/Medicines Management Team via: STWCCGsafehaven@nhs.net

Q4. Where do I send Egg/Sperm Preservation requests for Transgender Patients?

A4. Egg/Sperm Preservation requests should be sent direct to the Birmingham Women's Fertility Centre. The service has its own proforma.