Procedures of Lower Clinical Value (PLCV)

Engagement report on the behalf of Birmingham CrossCity, Birmingham South Central and Solihull Clinical Commissioning Groups (CCGs)

July 2016

Data protection

This engagement has been undertaken by NHS Birmingham CrossCity, Birmingham South Central, and Solihull Clinical Commissioning Groups (CCGs).

All comments received by contributors have remained anonymous. Information provided will be processed only by the CCGs listed above to help us improve how we commission local health services. The data will not be used for any other purpose.

All data will be held securely and the information you provide will be treated as confidential.

Engagement team and report production

The public engagement has been led by Midlands and Lancashire Commissioning Support Unit (CSU), on behalf of NHS Birmingham CrossCity, Birmingham South Central, and Solihull Clinical Commissioning Groups (CCGs).

The data analysis and engagement report have been undertaken by Midlands and Lancashire Commissioning Support Unit (CSU) and NHS Birmingham CrossCity CCG.

Glossary

TERM	MEANING
Abdominoplasty/Apronectomy	A procedure to reduce excess skin and fat, improve abdominal contours and scars, and tighten muscles. This is sometimes called a 'tummy tuck'.
Active treatment	Treatment and care to manage a particular disease / condition, for example cancer treatment, renal dialysis.
Adenoidectomy	A procedure to remove the adenoids – lumps of tissue at the back of the nose
Aesthetics	These are procedures which relate to cosmetic procedures which are intended to restore or improve a person's appearance
Alopecia	Hair loss
Analgesics	Painkillers
Asymptomatic	Without symptoms
Augmentation	Increasing in size, for example breast augmentation
BCH	Birmingham Children's Hospital NHS Foundation Trust
BCHC	Birmingham Community Healthcare NHS Foundation Trust
Benign	Does not invade surrounding tissue or spread to other parts of the body; it is not a cancerous.

TERM	MEANING
Binocular vision	Vision in both eyes
Body Mass Index (BMI)	A measure that adults can use to see if they are a healthy weight for their height.
BWH	Birmingham Women's Hospital NHS Foundation Trust.
Cataract	When the lens of an eye becomes cloudy and affects vision.
CCG	Clinical Commissioning Group. CCGs are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.
Cholecystectomy	Removal of the gall bladder.
Chronic	Persistent.
Co-morbidities	Other risk factors alongside the primary problem.
Congenital	Present from birth.
Conservative treatment	The management and care of a patient by less invasive means, these are usually non-surgical.
Depilation	Removal; for example hair depilation.
DOH	Department of Health.
Eligibility/Threshold	Whether someone qualifies. In this case, the minimum criteria to access a procedure.
Exceptional clinical circumstances	A patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients, with the same medical condition and at the same stage of progression as the patient.
Functional health problem/difficulty/impairment	Difficulty in performing, or requiring assistance from another to perform, one or more activities of daily living.
Ganglion	A non-cancerous, fluid filled, lump.
GP	General Practitioner.
Gynaecomastia	Benign enlargement of the male breast.
Haemorrhoidectomy	A procedure to cut away haemorrhoids; sometimes called piles.
HEFT	Heart of England NHS Foundation Trust.
Histology	The structure of cells or tissue under a microscope.
Hyperhidrosis	Excess sweating.
Hysteroscopy	A procedure used to examine the inside of the womb (uterus) using a hysteroscope (a narrow telescope with a light and camera at the end). Images are sent to a monitor so your doctor or specialist nurse can see inside your womb.
Individual Funding Request (IFR)	A request received from a provider, or a patient with explicit support from a clinician, which seeks funding for a single, identified patient, for a specific treatment.
Irreducible	Unable to be reduced (made smaller).
Iterative process	A means of coming to a conclusion by undertaking repeated tests; in the context of PLCV, this means continuously reviewing the policies to ensure they are up to date.
Labiaplasty	A procedure to reduce and/or reshape the labia.
Lipomata	Fat deposits under the skin.
Liposuction	A procedure using a suction technique to remove fat from specific areas of the body.

TERM	MEANING
Malignant/malignancy	Something which is harmful.
Mastopexy	A reconstructive procedure to lift the breast.
Menorrhagia	Abnormally heavy or prolonged bleeding at menstruation.
Monocular vision	Vision in one eye only.
Multi-disciplinary	Involving several professional specialisms for example in a Multi-Disciplinary Team (MDT).
NICE guidance	The guidance published by the National Institute for Health and Care Excellence.
Not routinely funded (a procedure)	This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves there is an exceptional clinical need and that this treatment is supported by the CCG.
NSAIDS	Non-steroidal anti-inflammatory drugs – medication that reduces pain, fever and inflammation.
Paediatric(ian)	Medical care concerning infants, children and adolescents, usually under 18.
Pathology/pathological	The way a disease or condition works or behaves. This may, for example, include examination of bodily fluids or tissue e.g. blood testing.
PCT	Primary Care Trust (PCTs were abolished on 31 March 2013, and replaced by Clinical Commissioning Groups).
Pinnaplasty	A procedure to pin or correct deformities the ear.
PLCV	Procedures of Lower Clinical Value; routine procedures that are of value, but only in the right circumstances.
Precipitates	Brings about/triggers.
Primary care	A patient's first point of interaction with NHS services e.g. a GP surgery.
Prophylactic	Something which is a preventative or prevention.
Rationale	Explanation of the reason why.
Restricted (a procedure)	This means CCG will fund the treatment if the patient meets the stated clinical threshold for care.
Rhinophyma	A condition causing development of a large, bulbous, ruddy (red coloured), nose.
Rhinoplasty	A procedure to shape the size and/or shape of the nose.
Rhytidectomy	A procedure to restore facial appearance or function. These are sometime called face or brow lifts.
Secondary care	Services provided by medical specialists, who generally do not have the first contact with a patient e.g. hospital services.
Stakeholders	Individuals, groups or organisations who are / will be affected by this engagement e.g. patients who current use the service, carers, specific patient groups etc.
Symptomatic	Something causing or exhibiting symptoms.
Tonsillectomy	A procedure to remove the tonsils (two masses of tissue either side of the root of the tongue).
UHB	University Hospital Birmingham NHS Foundation Trust.
Vaginoplasty	A procedure to reconstruct the vaginal canal.

Executive summary

The purpose of this engagement exercise was to ask local people, wider stakeholders and NHS staff their views on proposals to harmonise a set of commissioning policies that had been defined as being Procedures of Lower Clinical Value (PLCV); routine procedures that are of value, but only in the right circumstances.

The reason for reviewing these policies was to make them more consistent and fairer for patients across the Clinical Commissioning group (CCG) areas across the West Midlands.

21 policies were reviewed in total, in accordance with national guidance and evidence from the PLCV working group[1]. These policies were also reviewed to incorporate the most up-to-date published clinical evidence to ensure funded treatments are proven to have a clinical benefit for patients.

Three CCGs; Birmingham CrossCity, Birmingham South Central and Solihull, decided to undertake a period of public engagement to ensure that patients and other stakeholders had the opportunity to give their views on the proposed new harmonised policies.

Public engagement

The engagement was led by Midlands and Lancashire Commissioning Support Unit (CSU) in partnership with Birmingham CrossCity, Birmingham South Central and Solihull CCGs, and involved a number of our secondary care partners[2].

A series of meetings took place from **November 2015** until the formal engagement started on the **1 February 2016**. This helped the project team develop the documents needed to support the engagement, including the development of a survey. The documents were distributed widely and made available both in hard copy and online.

The formal engagement period ran from **1 February** until **14 March 2016**. There were **two** public meetings events and a further **127** contacts between the engagement team, the general public and stakeholder organisations. There was also significant media marketing including social media. In total there were **75** responses to the survey.

Conclusion and key findings

Respondents indicated there was significant support for the six objectives underpinning the review of the 21 PLCV policies:

1. To ensure that procedures and treatments are offered consistently and fairly to patients;
2. To end the 'postcode lottery; which currently exists, by having the same eligibility criteria for treatments;
3. To ensure that policies meet the latest national clinical guidance and are supported by robust clinical evidence;

[1] The CCGs in the harmonisation working group were: Birmingham CrossCity, Birmingham South Central, Solihull, Wolverhampton, Sandwell and West Birmingham and Walsall.

[2] The University Hospitals Birmingham NHS FT, Heart of England NHS FT, Birmingham Children's Hospital NHS FT, Royal Orthopaedic Hospital NHS FT, Birmingham Women's Hospital NHS FT and Birmingham Community Healthcare NHS FT;

4. To stop using treatments that do not have any benefits for patients, or have a very limited evidence base;
5. To prioritise treatments which provide the greatest benefits to patients; and
6. To stop offering cosmetic treatments e.g. Botox injections, liposuction, face lift, repairs of ear lobes and thigh lift.

However, there was mixed support from the public survey for the individual policies under review. Of the 21 policies produced for consideration, **eleven** produced neutral. results from the survey, with no significant levels of support or disagreement. For **seven** policies the largest proportion of survey respondents disagreed or strongly disagreed with the proposed policies; only **three** policies saw significant support from survey respondents.

It is important to note that the assessment of policies felt to be procedures of limited clinical value is an ongoing, iterative, process. For this reason all policies will be continuously reviewed to ensure they are both up to date and fit for purpose.

Background

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

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

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

Subsequently, a working group was established which included clinicians (including general practitioners) and commissioning managers from the six CCGs, along with colleagues from local authorities and public health.

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

The CCGs in the harmonisation working group were:

- Birmingham CrossCity;
- Birmingham South Central;
- Solihull;
- Wolverhampton;
- Sandwell and West Birmingham; and
- Walsall.

In summary the, harmonisation project involved:

- The establishment of a joint working group across Birmingham, Solihull and Black Country;
- The formation of multi-disciplinary working groups including, Public Health, Medicines Management in addition to commissioning and clinical leads from each CCG;
- Agreement of a list of 21 policies for review (covering 45 procedures);
- Equality Impact Assessments (EIAs) for each policy; and
- Engagement with patients, the general public, interested clinicians and other bodies.

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

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

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

Approach to engagement

Phase 1: Pre-engagement

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

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

Solihull Patient Voice Panel meeting

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

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

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

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

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

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

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

For the policies on knee and hip replacement, where BMI is a consideration, it was felt it would be useful to signpost patients towards local weight loss services commissioned by the CCG and Solihull Council. However, it was felt that using BMI as part of the threshold criteria was suitable and appropriate.

The panel felt that both disability and lifestyle are aspects that should be looked at in connection with the policy for cataracts.

Patient engagement meeting – Birmingham

Birmingham South Central CCG and Birmingham CrossCity CCG held a joint public engagement meeting on **11 December 2015**. The meeting was attended by seven people.

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

Attendees were asked to comment on three of the draft policies; cataracts surgery, and hip and knee replacement and make suggestions for how these could be communicated more widely to local people. As noted above, the decision to focus on these particular policies resulted from the Equality Impact Assessment (EIA) which had highlighted that these policies were felt to be the most relevant as they potentially had the greatest impact.

Views were also sought on a draft survey which was to be used as the main channel for feedback on the policies.

Key feedback from pre-engagement events:

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

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

Phase 2: Engagement

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

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

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

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

Recommendations from the Solihull and Birmingham Joint Health and Social Care Overview and Scrutiny Committee

a) Commissioners need to strengthen engagement and communication with the public around PLCV, so that there is a clearer understanding of what this means in practice and demonstrates more clearly what the implications are likely to be;

b) Primary Care staff (including GPs) need to be engaged as part development of new polices to enable the development of referral pathways;

c) Health and Wellbeing Board need to be involved in leading and having overview of these proposals;

d) That case study information and information in Plain English is more widely disseminated to the public about PLCV;

e) That the Scrutiny Committee receives a final copy of the engagement report; and

f) That the Scrutiny Committee consider proposals for implementing PLCV at a future meeting (suggested date June 2016) with a focus on considering implications for service users.

Public Sector Equality Duty (PSED)

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

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

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

Communication & engagement

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

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

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

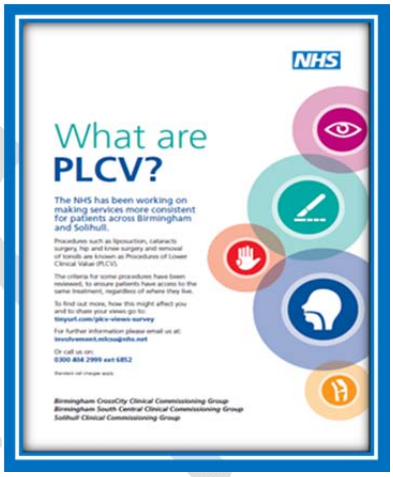
Key messages:

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

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

Information & communications material

Patient leaflet and other material



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

The leaflet provided details about the different PLCVs, gave examples of the treatments covered by the policies, explained why they were being harmonised and how patients could get involved and also provide feedback through the online survey.

Posters were also provided and distributed for display in GP practices and pharmacies. Digital images for display on GP practice TV screens were also produced, where available. A copy of the patient leaflet is at **Appendix 7**.

PLCV webpages

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

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

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

Stakeholder communications

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

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

- **79** local third sector voluntary and community organisations, including Birmingham and Solihull Healthwatch, Birmingham Voluntary Service Council (BVSC) and Birmingham LGBT;

- **136** local councillors and **12** Members of Parliament (MPs);

- Letters, meetings and briefing for both Birmingham and Solihull Health and Social Care Overview and Scrutiny Committees (HOSCs); and

- A range of patients, support groups, CCG public and patient panels and networks.

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

Furthermore, emails were sent to the West Midlands Academic Health Science Network (WMAHSN), Age UK, RNIB, the Birmingham Voluntary Services Council (BVSC) and Healthwatch Birmingham to publicise the engagement via their own newsletters, e-bulletins, social media and respective websites. The voluntary organisations contacted were asked to cascade information to their own networks, via their newsletters, bulletins and websites. This significantly increased the reach of the publicity.

Briefings were also included in Local Authority member bulletins and sent to MPs, who were asked to raise awareness by including details on their websites and in regular constituency newsletters.

Details of the engagement could also be found on *Birmingham Be Heard*, Birmingham City Council's engagement database for the public.

Details of all the stakeholders communicated with are highlighted in **Appendix 6**.

Media

A pro-active approach to the media was adopted, including identifying and training a clinical spokesperson to act on behalf of all CCGs.

Press releases were issued prior to and at the launch of the engagement [3] and to promote the public engagement events. There was, however, no media interest during the engagement period. Examples of the press releases can be found in **Appendix 8**

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

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

[3] Press releases were issued on the 19 January, 2 February and 3 March 2016.

Social media

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

Collectively, the CCGs have approximately 1300 Facebook 'Likes' and over 18,000 Twitter followers[4]. Throughout the engagement period tweets and Facebook posts were issued by the individual CCG accounts, using both pre-agreed and organic content.

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

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

Examples of social media can be found in **Appendix 8**.

Providers and clinical engagement

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

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

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

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

- Royal College of Surgeons; and
- Chartered Society of Physiotherapists.

[4] Numbers accurate at the time of writing.

Online survey

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

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

The survey questions were formulated to allow respondents to give a full range of information when responding to the survey. The survey was a mixture of closed format and multi-option questions (both to gather quantitative data), with additional open questions to gather qualitative data and allow respondents to make any additional comments in support of their responses.

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

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

- Have you had this treatment / procedure?
- To what extent do you agree with the proposed criteria of the policy?[5]

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

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

The full survey report is available at **Appendix 3**.

Events

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

These events were held on:

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

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

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

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

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

Feedback

Feedback was received from the following:

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

Demographics

- Of those responding, **90%** were between the ages of 35 and 74. The majority of respondents were found in the in the 55 – 64 age group (**29.7%**) and 45-54 age group (**28.4%**);

- **68.5%** identified themselves as female with **31.5%** identifying themselves as male. There were no Trans or Intersex respondents;

- **79.7%** stated they were 'heterosexual', **5.4%** as 'gay or lesbian', **2.7%** 'bisexual' and a **single** respondent stated 'other';

- **79.5%** describe themselves as 'white'. **6.85%** describe themselves as 'Caribbean' and **4%** as 'Indian'. Of the remaining respondents, there was a single respondent from a 'Gypsy & Irish Traveller', 'Irish', 'Mixed/Multiple ethnic' and 'Any other ethnic' backgrounds (each **1.37%**);

- **61.6%** identified themselves as Christian. Others stated they were Atheist (**8%**) Hindu or Agnostic (both **2.7%**) or Muslim (**1.4%**). Almost a tenth (**9.6%**) identified themselves as following a religion not offered as an option in the survey, with **13.7%** preferring not to say if they followed a religion or faith;

- **65%** of respondents came from Birmingham and **16%** from Solihull;

- When asked if their day to day activities were limited by a health problem or disability, the majority of respondents (**71.2%**) responded 'No', with **4%** preferring not to say. Of those who were affected, **5.5%** felt their activities were limited 'a lot' with a further **19.2%** feeling they were limited 'a little'.

Key themes from the survey

- Survey responses indicate there is significant support for the six objectives underpinning the review of the 21 PLCV policies (Question 1).

For example:

1. **90.7%** of respondents agreed of strongly agreed with the objective '*To ensure that procedures and treatments are offered consistently and fairly to patients*'.
2. **86.7%** of respondents agreed of strongly agreed with the objective '*To end the 'postcode lottery; which currently exists, by having the same eligibility criteria for treatments*'.
3. **85.3%** of respondents agreed of strongly agreed with the objective '*To ensure that policies meet the latest national clinical guidance and are supported by robust clinical evidence*'.
4. **84%** of respondents agreed of strongly agreed with the objective '*To stop using treatments that do not have any benefits for patients, or have a very limited evidence base*'.
5. **78.7%** of respondents agreed of strongly agreed with the objective '*To prioritise treatments which provide the greatest benefits to patients*'.
6. **74.7%** of respondents agreed of strongly agreed with the objective '*To stop offering cosmetic treatments e.g. Botox injections, liposuction, face lift, repair of ear lobes and thigh lift*'.

This was also apparent in the discussions held at the two public events;

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

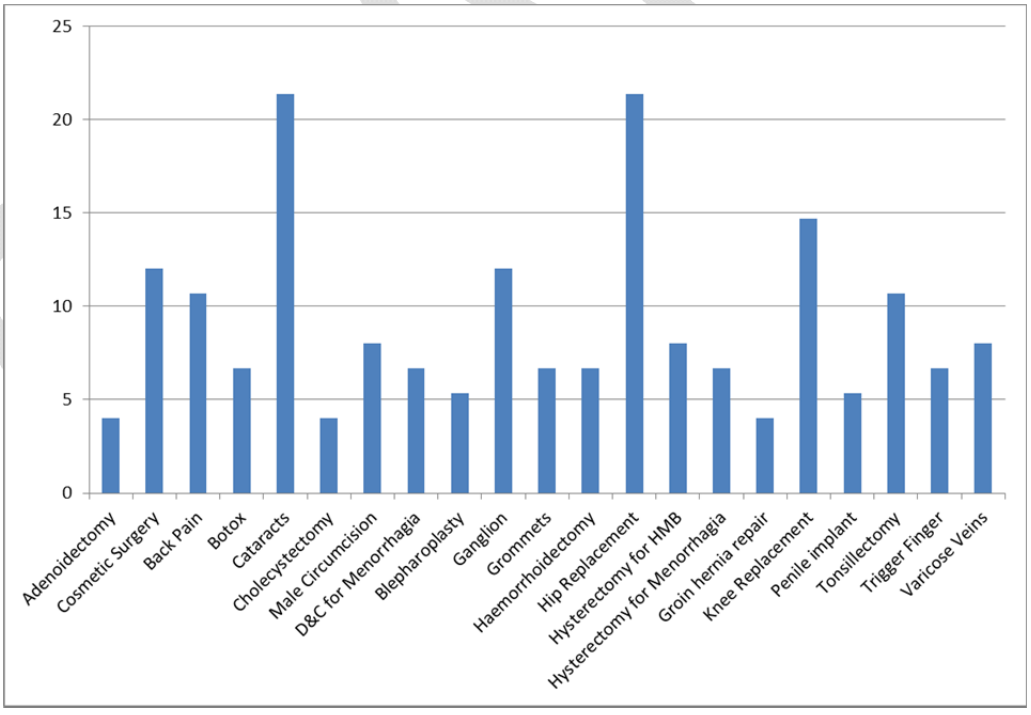


Fig 1: Table of total number of respondents by policy.

- The three policies with the most responses in the survey are Hip Replacement (**21.33%** of the total), Cataracts (**21.33%**) and Knee Replacement (**14.67%**);

- Of the 21 policies, the largest proportion of respondents to the survey agreed or strongly agreed to the proposed criteria for the following **3** policies: Botulinum Toxin

(Botox) for Hyperhidrosis (**60%**), Cholecystectomy for Asymptomatic Gallstones (**66.7%**) and Tonsillectomy (**50%**);

- In the case of **7** policies, the largest proportion of survey respondents disagreed or strongly disagreed with the proposed policies. These were: Non Specific, Specific and Chronic Back Pain (**50%**), Ganglion (**55.6%**), Hip Replacement Surgery (**56.3%**), Hysterectomy for Heavy Menstrual Bleeding (**50%**) and Menorrhagia (**60%**), Knee Replacement Surgery (**63.6%**), and Penile Implants (**50%**);

- In the case of **3** policies, the largest proportion of survey respondents neither agreed nor disagreed with the proposed policy change. These were: Male Circumcision (**50%**), Eyelid Surgery (Upper and Lower) Blepharoplasty (**50%**) and Trigger finger (**60%**);

- For each policy, respondents were asked whether they had the treatment or procedure before. For **19** of the policies, the majority of respondents **did not** have experience of the procedure they were commenting on. In the case of **4** (Botulinum Toxin – Botox - for Hyperhidrosis, Eyelid Surgery, Groin Hernia Repair and Penile Implants) none of the respondents had experience of the procedure being commented on.

- In the case of the Varicose Vein policy, exactly **half** of the 6 respondents had undergone this procedure. The Adenoidectomy policy was the only policy where the majority of respondents (**66.7%**) had direct experience of the procedure.

- Taking into account the views of survey respondents, the discussions held at the public engagement events and from feedback received from providers and other organisations, there was a clear belief in the need for criteria to consider the broader impact of a condition on a patient's quality of life.

  For example, responses from the NHS England West Midlands Local Eye Network and RNIB welcomed the reduction in the Visual Acuity threshold for cataract surgery, but also stated that the wider impact on an individual's lifestyle should be considered in determining access to treatment:

  > "*We welcome the proposal for CCGs across Birmingham and Solihull to lower the visual acuity threshold from 6/12 to 6/9. We believe the change will enhance accessibility to cataract surgery and will in turn significantly benefit those patients whose cataract is impacting on their day to day activities. Once a patient is diagnosed as having cataract surgery, their vision will only worsen and they will be forced to live with sight loss unnecessarily. Sight loss can lead to depression, social isolation and fall-related hip fractures which can be costly to commissioners in the long-term. Enabling patients to access cataract surgery will enable them to remain independent. RNIB believes that patients should be eligible for cataract surgery if they experience disabling visual symptoms attributable to their condition*";

  In this regard Commissioners have noted that NICE is currently reviewing its Clinical Guidance for 'Cataracts in adults: management'. NICE is currently planning to issue this guidance in **April 2018**.

- Respondents also noted that whilst lifestyle could be a major contributor to the development of other illnesses, and that it was also true that a medical condition can in itself lead to the development of other illnesses.

  For example, the Chartered Society of Physiotherapists in their response refer to back pain as a "*gateway*" condition where pain: "*can significantly increase physical or mental health issues.*" Feedback on the Aesthetic policy strongly supports the need to take account of the psychological impact on individuals of living with a physical problem. An example cited by Heart of England Foundation Trust (HEFT) is Pinnaplasty ('Ear Pinning'), which can help schoolchildren avoid serious emotional distress. Another example cited was delaying treatment for varicose veins, which may then result in surgery being needed in the future;

- The treatments covered by harmonisation are perceived as disproportionately affecting the elderly. For example one respondent noted "*They seem to be directed at treatments affecting the* elderly". This was a significant theme at the events, at which many participants commented that this gives the impression that the elderly have been 'targeted';

- This was exacerbated by the term Procedures of Lower Clinical Value. At the events concern was expressed about the use of 'Lower Clinical Value'. Participants questioned why they were considered to be of lower value if they were clinically appropriate for some people, one respondent referring to back surgery noted "*As back pain is one of the major causes of time off work etc., its treatment should not be considered of lower clinical value*";

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

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

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

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

  > "*Referring patients to hip and knee surgery only if their BMI is below 35 could affect a number of people, and the average prevalence of severe knee osteoarthritis is 6.8% across the population covered by the six CCGs:*
  >
  > *- The British Orthopaedic Association (BOA) challenges the decision of the CCGs to include hip and knee replacements in a list of procedures of lower clinical value, considering the low QALY cost of the procedures;*

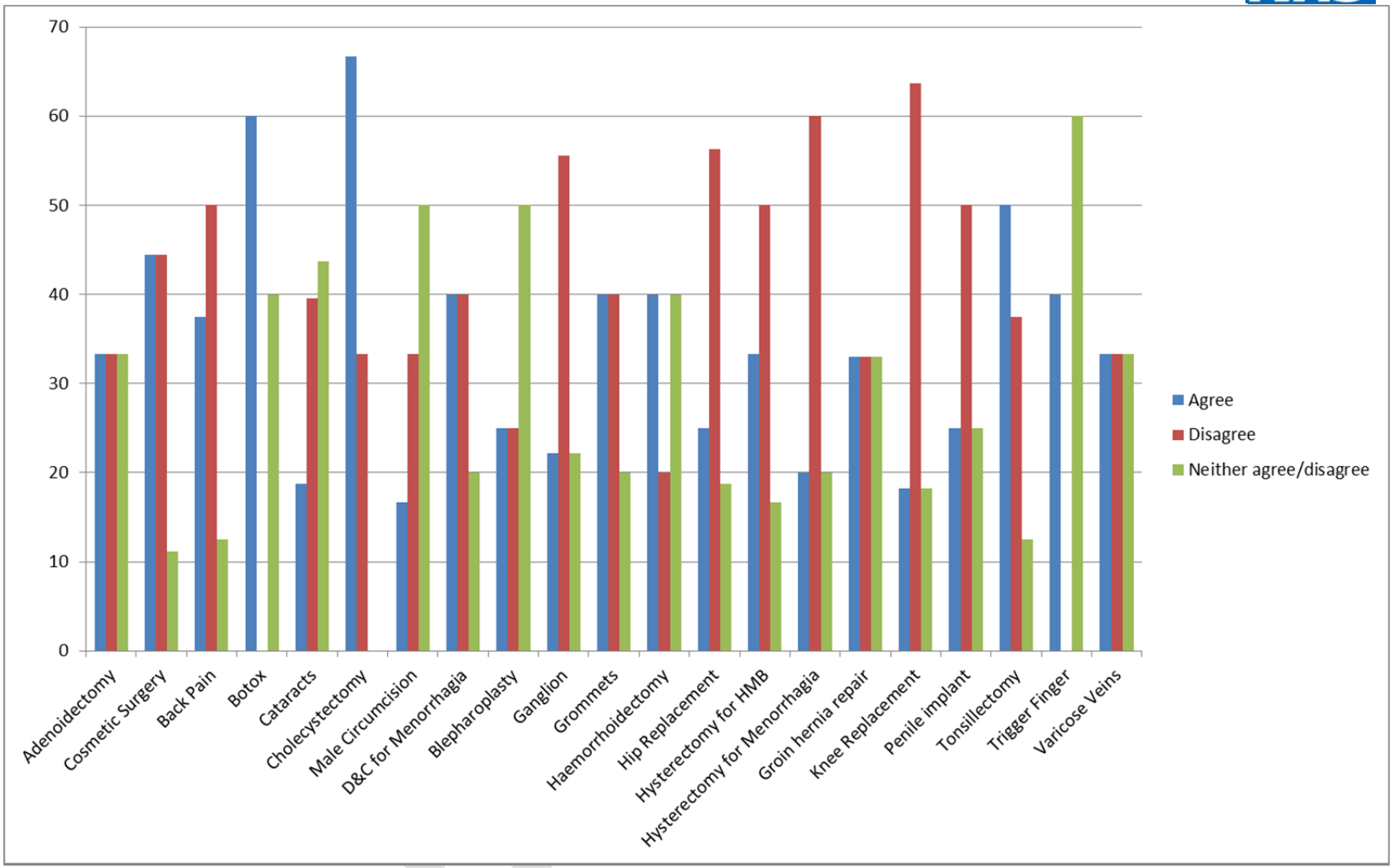


Fig 2: Table of respondent opinion towards each policy. Respondents who 'Strongly Agreed' or 'Agreed' have been combined into the new value 'Agree', those who 'Disagreed' or 'Strongly Disagreed' have been combined into the new value 'Disagree'. The value for 'Neither agree nor disagree' has remained the same.

- There is evidence that prolonging the wait for total hip replacement in patients with severe pain and reduced mobility results in poorer outcomes from surgery, and this is outlined in NICE guidance for osteoarthritis; and

- According to the BOA, there is no consistent evidence that patients with a high BMI who undergo hip replacement surgery, for example, do better or worse than other patient groups".

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

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

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

"*The document makes extensive reference to guidance published by the RCS and surgical specialty associations (SSAs) in setting out new commissioning policies on thresholds to referral to surgical procedures. Policies for some procedures reference RCS and SSA guidance which is subsequently ignored or cited out of context, thereby presenting the policies as if they are supported by clinically-evidenced guidance, but that in places contravene it".*

Likewise, the criteria for treatment of Adenoids was also questioned, in particular the approach of only undertaking an Adenoidectomy at the same time as a Tonsillectomy:

"*The RCS does not agree with a policy of only referring patients for the procedure if undertaken at the same time as grommets or tonsillectomy. It seems particularly unusual to insist on performing a tonsillectomy at the same time if a patient requires an adenoidectomy, as this may increase surgical risk for the patient who may only need an adenoidectomy to treat sleep-disordered breathing*".

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

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

The full survey report is available in **Appendix 3**. Full details of all comments and feedback received through the online survey, events and direct correspondence are set out in **Appendix 4**.

Appendix 6 provides details of stakeholders communicated with as part of the engagement process.

Conclusion

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

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

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

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

Table 1: Assessment of the level of support for the stated objectives of the PLC engagement

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

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

For **seven** policies, the largest proportion of survey respondents disagreed or strongly disagreed with the proposed policies. For **three** policies, the largest proportion of people agreed or strongly agreed with the proposed polices.

Table 2: Survey results

Policy	Agree (%)	Disagree (%)	Neither agree / disagree (%)	Total respondents	Support for policy
Adenoidectomy	33.3	33.3	33.3	3	Neutral
Cosmetic Surgery	44.4	44.4	11.1	9	Neutral
Back Pain	37.5	50	12.5	8	No
Botox	60	0	40	5	Yes
Cataracts	18.8	39.5	43.8	16	Neutral
Cholecystectomy	66.7	33.3	0	3	Yes
Male Circumcision	16.7	33.3	50	6	Neutral
D&C for Menorrhagia	40	40	20	5	Neutral
Blepharoplasty	25	25	50	4	Neutral
Ganglion	22.2	55.6	22.2	9	No
Grommets	40	40	20	5	Neutral
Haemorrhoidectomy	40	20	40	5	Neutral
Hip Replacement	25	56.3	18.8	16	No
Hysterectomy for HMB	33.3	50	16.7	6	No
Hysterectomy for Menorrhagia	20	60	20	5	No
Groin hernia repair	33	33	33	3	Neutral
Knee Replacement	18.2	63.6	18.2	11	No
Penile implant	25	50	25	4	No
Tonsillectomy	50	37.5	12.5	8	Yes
Trigger Finger	40	0	60	5	Neutral
Varicose Veins	33.3	33.3	33.3	6	Neutral

Additional themes

As noted previously, whilst each question gave a set number of options, the survey gave respondents the opportunity to provide their own opinion regarding the policies under consideration. This is known a qualitative data. Qualitative data is an important facet of our analysis, and helps us build upon the set questions provided in the survey, which is known as quantitative data. Feedback from public meeting also fed into this.

When analysing this additional feedback, it was clear that a number of themes were emerging from our respondents. These key themes were:

- It was noted that some respondents felt the procedures/treatments listed as being of 'lower clinical value' disproportionally affected the elderly.

- It was also highlighted that not all respondents agreed with the terminology for procedures of clinical value, with both members of the public and healthcare professionals noting this was highly subjective and that the conditions treated by these treatments/procedures could lead to further complications affecting both mental and physical health.

- Many respondents felt the blanket application of criteria was inappropriate and that decisions on treatment should be for the clinician and the individual to decide on whether a treatment should go ahead;

- Several professional bodies, including the Royal College of Surgeons (RCS), did not agree that the clinical evidence and guidance available supported all of the new policies, particularly for grommets, knee replacement surgery and tonsillectomies. The RCS in particular felt that its guidelines had been misrepresented or cited out of context.

It is important to note that the assessment of policies felt to be procedures of limited clinical value is an ongoing, iterative, process. For this reason all policies will be continuously reviewed to ensure they are both up to date and fit for purpose.

You said, we did

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

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

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

   We responded: We do not seek to restrict outpatient referrals for specialist opinion. In Solihull and Birmingham specialist advice and support can also be received via e-referral and through 'Consultant Connect' in a range of clinical specialties which might ultimately mean that a GP referral is no longer required.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. **The RNIB said:** the proposal to lower the visual acuity threshold for cataract surgery is welcomed, as the change will enhance accessibility and will in turn significantly benefit those patients whose cataract is impacting on their day-to-day activities. Patients should be eligible for cataract surgery, if they experience disabling visual symptoms attributable to their condition.

   We responded: although visual acuity is a useful component of the assessment of visual disability from cataract, cataract surgery should be considered in the first eye or second eye, of a patient who has disabling visual symptoms attributable to cataract. Therefore we now propose removing the linkage between a visual acuity of 9/6 or worse **and** other disabling visual symptoms linked cataracts.

10. **The Royal College of Surgeons said:** there is evidence that prolonging the wait for total hip replacement in patients with severe pain and reduced mobility, results in poorer outcomes from surgery. There is also no consistent evidence that patients with a high

BMI who undergo hip replacement surgery, for example, do better or worse than other patient groups.

We responded: there is not sufficient or unequivocal evidence either to include or not include a particular BMI for hip replacement. The criteria has been amended and does not have a set BMI, but emphasises the need for surgeons/anaesthetists to carefully assess the clinical risk of surgery for higher BMI patients.

Policy feedback

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

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

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

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

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

2. **Cosmetic Surgery**

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

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

    Gynaecomastia. It was agreed for there to be further clarification that the option remained for a Children's acute provider to make an IFR application in 'exceptional' cases e.g. unilateral gynaecomastia if the treating clinician deemed surgery necessary.

    Ear Reconstruction (BAHI - Bone Anchored Hearing Implants). Regarding BCH's comments on BAHIs these are commissioned by NHS England (NHSE) Specialised Services (assessment, implantation and rehabilitation). NHSE has not specified whether any incidental ear reconstruction would be funded by them England.

Therefore, pending further clarification from NHS England Specialised Services, it cannot be confirmed that any such additional surgery could be applied for through the IFR process.

Pinnaplasty (Children). Further clarification that the option remains to make an IFR application in 'exceptional' cases.

Repair of Ear Lobes. Regarding 2-5 year olds and 12-17 year olds, we believe the examples cited could be covered with an amplification of the policy treatment to say:

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

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

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

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

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

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

3. Non Specific, Specific and Chronic Back Pain

Clarification that draft policy is based on current Map of Medicine and the British Pain Society (BPS) guidance which recognised the need to develop easy-to-use, succinct pathways for clinicians.

We have reflected that regarding non-pharmacological or non-invasive first line treatment for 'non-specific back pain' that the policy needed to emphasise more strongly the following pre-surgical options:

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

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

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

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

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

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

Clarification that:

- Functional Restoration Programme was one of a number of nationally recommended options at an Intermediate level of care (this could be delivered in both acute and non-acute settings).
- The policy should/will reflect the clinical management journey: Primary / Intermediate / Secondary care rather than between non-specific/specific/chronic back pain.

- Epidurals and nerve root injections for radicular pain are a recognised treatment (ref:http://bja.oxfordjournals.org/content/111/1/112.short). This policy currently is restricted to the Back Pain rather than Radicular Back Pain pathway. During 2016/17 this policy will be cross-referenced and updated where appropriate to the current Birmingham and Solihull Scheduled Care SRG pathfinder project on Spinal Surgery and Back Pain. At that stage Radicular (nerve pressure) Back Pain will be incorporated into this policy.

- FRP has been formally commissioned by Birmingham Crosscity CCG and will be expanded in 16/17 financial year.

- Currently 12 hours of combined physical and psychological therapy are commissioned. Further NICE guidance will be published in September 2016 and this will be reviewed and the policy amended where appropriate.

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

4. Cataract Surgery

We felt that purely undertaking cataract surgery on relatively subjective lifestyle factors would lead to further growth, over and above trend demographic growth, that might mean that patients receive cataract surgery when not yet clinically necessary. Therefore the working group were not minded to change the current draft with the linkage of visual acuity **and** disabling life factors before NICE publish their guideline for the diagnosis and management of cataracts in April 2018 (https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0741).

Several textual changes proposed by UHB were agreed, namely:

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

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

Significant improvements in visual symptoms and visual function may occur following cataract surgery even where the preoperative visual acuity is 6/6 or better. However, it is important to note that the risk of worse visual acuity after surgery also increases where the

preoperative visual acuity is very good, so surgery should be considered at this level of visual acuity only where the patient is experiencing significant symptoms attributable to cataract.

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

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

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

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

5. Eyelid Surgery (Upper and Lower) – Blepharoplasty

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

The policy document will be amended to reflect this clarification.

Confirmation that the existing draft policy allowed for surgical treatment of congenital ptosis (drooping eyelid) occurring from birth.

6. Ganglion

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

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

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

7. Groan Hernia Repair

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

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

8. Grommets

We agree that the policy title needs to explicitly state this is for patients >3 years and <12 years and therefore clarify that this policy would not impede grommets for under 3s prior to Cochlear Implantation or children aged 12+ with speech development problems.

We have re-reviewed NICE CG60 - Otitis media with effusion in under 12s - and agree that surgery does not include a requirement for '5 or more episodes of glue ear in a child before referral.' This requirement should be removed from the draft policy. It was included in the older SIGN – Clinical Guidance 66: Diagnosis and management of childhood otitis media in primary care.

9. Haemorrhoidectomy

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

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

Note:

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

10. Hip or Knee Replacement Surgery

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

introduction to emphasise the importance of engaging with local Lifestyle Management services.

11. Male Circumcision

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

12. Penile Implants

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

13. Tonsillectomy

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

14. Trigger Finger

We reflected on the feedback given regarding diabetic patients and noted that The British Society for Surgery of the Hand (BSSH) in its 2011 guidance comments: people with insulin-dependent diabetes are especially prone to triggering, **but** most trigger digits occur in people without diabetes.

GP members of the working group commented that most diabetic or non-diabetic patients with Trigger Finger are in fact treated by steroidal injection rather than surgery and that there was no need in the draft policy to separately identify insulin dependent patients as the clinical protocol for pre-surgical treatment and surgical treatment apply to diabetic and non-diabetic patients.

15. Varicose Veins

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

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

Appendix 1: policies under consideration

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

As a result of feedback received we are proposing to make the following changes to the draft Commissioning Policies which we engaged on:

Aesthetics

Policy	Treatment
Aesthetics	Abdominoplasty / Apronectomy
Aesthetics	Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat
Aesthetics	Liposuction
Aesthetics	Breast Augmentation
Aesthetics	Breast Reduction
Aesthetics	Breast Lift (Mastopexy)
Aesthetics	Inverted Nipple Correction
Aesthetics	Gynaecomastia (Male Breast Reduction)
Aesthetics	Labiaplasty
Aesthetics	Vaginoplasty
Aesthetics	Pinnaplasty
Aesthetics	Repair of Ear Lobes
Aesthetics	Rhinoplasty
Aesthetics	Face Lift or Brow Lift (Rhytidectomy)
Aesthetics	Hair Depilation (Hirsutism)
Aesthetics	Alopecia / Hair Loss
Aesthetics	Removal of Tattoos / Surgical correction of body piercings and correction of respective problems
Aesthetics	Removal of Lipomata
Aesthetics	Medical and Surgical Treatment of Scars and Keloids
Aesthetics	Botox Injection for the Ageing Face
Aesthetics	Viral Warts
Aesthetics	Thread / Telangiectasis / Reticular Veins
Aesthetics	Rhinophyma
Aesthetics	Other Cosmetic Procedures
Aesthetics	Revision of Previous Aesthetic Surgery Procedures

Other Procedures

Policy
Adenoidectomy
Non Specific, Specific and Chronic Back Pain
Botulinum Toxin for Hyperhidrosis
Cataracts
Cholecystectomy for Asymptomatic Gallstones
Male Circumcision
Dilation and Curettage (D&C) for Menorrhagia
Eyelid Surgery (Upper and Lower) - Blepharoplasty
Ganglion
Grommets
Haemorrhoidectomy
Hip Replacement Surgery
Hysterectomy for Heavy Menstrual Bleeding
Hysteroscopy for Menorrhagia
Groin Hernia Repair
Knee Replacement Surgery
Penile Implants
Tonsillectomy
Trigger Finger
Varicose Veins

Appendix 2: notes from pre-engagement activity

Procedures of lower clinical value (PLCV)

BXC and BSC CCG patient engagement meeting

Friday 11 December, 1pm – 3.30pm at Bartholomew House

Notes

Dr Ahmed provided an overview of what procedures of lower clinical value (PLCV) are, what procedures of higher clinical value are and why the policies are being reviewed. He also explained the role of the Individual Funding Request (IFR) panel.

Preetpal Channa gave the group some background about the review and talked about what engagement has already taken place and plans for future engagement to promote the survey.

Q&A

Q: You say that if it is not bothering someone, then you don't need to do a procedure but it must be bothering them for them to speak to the GP.

A: People often find out they have a particular condition incidentally e.g. whilst having an x-ray/scan for one thing, gallstones might be discovered. The patient has no symptoms from the gallstones but because they now aware they have them, they want a procedure to remove them. In this case, the procedure probably wouldn't be funded as the surgery could cause more risk than living with the gallstones. Obviously if in the future, the patient experiences symptoms caused by the gallstones, the surgery could be considered.

There is always the opportunity for a patient's case to be put to the individual funding request panel (IFR) if the GP and patient feel there are exceptional circumstances.

Q: Is there the opportunity for plenty of discussion between the patient and GP before the decision of whether a patient should have a procedure is made?

A: Yes, decisions like these aren't made in minutes.

Dr Ahmed also made the group aware that the review of PLCV has been discussed for the past three years and that these policies are only draft.

Group work

The group divided into two smaller groups to discuss three strategies; cataracts, which is a new policy and hips and knees, which both have changes to the criteria.

Hips and knees feedback

- Use of the word BMI: the group felt that not everyone will know what BMI stands for, and even if they do, they may not know what their own BMI is
- The group thought it would be helpful to use a different word for BMI and/or to include a BMI chart or link to the NHS BMI tool so patients can work out their BMI if they don't know it.
- The language in both policies needs to be simplified for patients to be able to understand e.g. 'conservative means'

Cataracts

- Similarly to the hips and knees policy, the group felt that the language and medical terminology was complex and needs to be made more patient friendly
- The group felt that the variation in the examples used in the section on lifestyle factors was too broad and subjective. Therefore they couldn't make a considered judgment.
- They also questioned if a patient would know if there eyesight was 6/9 or worse.

Other comments

- The group felt there should be a glossary for the names of the procedures e.g. what are aesthetic procedures?
- There was some discussion about how the NHS were working with opticians to offer patients a higher-quality service and better experience.
- Some policies are inconsistent e.g. the word Botox is used in some places and botulism toxin in others
- Typo on page four of cataract strategy (counteract?)

Survey feedback

Introduction: needs to include what CCGs are

Q1: needs to say 'which policy **or policies**…' so people are clear that they can comment on more than one.

Q2: The different procedures need explaining or writing in plain English e.g. few people will know what procedures would be considered 'aesthetic'

Q3: More criteria are needed e.g. 'concerned about a family member or friend' and 'generally interested'

Q4: Need to show what the change in criteria is for each policy

Q5: No comments

Q6: No comments

Q7: No comments

Questions from the group on the survey

- Will there be easy-read, patient friendly versions of each policy?
- Are you able to save what you have done so far so you can return to the survey at a later date?
- Will CCGs contact PPG chairs to let them know when the survey will be published and then when it is online?
- Could the survey be advertised on TV screens in hospitals?

Actions

- The list of procedures on the PowerPoint slide is in a different order to the list we handed out which someone said made it harder to follow

- We need to prompt clinicians to avoid saying ‘postcode lottery’ (use services vary depending where patients live), and words like ‘harmonise’ and ‘thresholds’ which are difficult for patients and public to understand

- Discuss with project group the need for patient friendly versions of policies

- Review policies for consistency of terms e.g. Botox and botulism toxin

- Rearrange timetable at end of presentation so actions in March 2016 are together

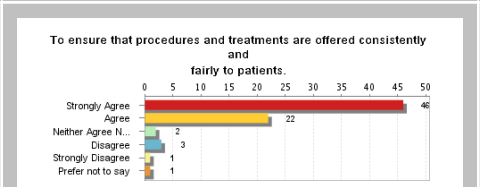
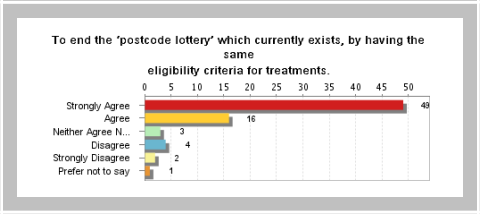
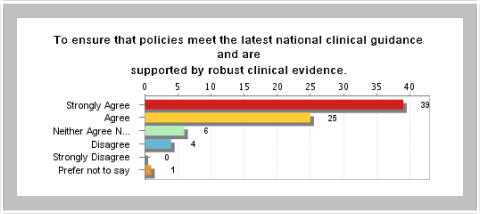
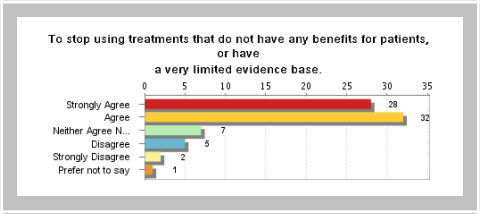
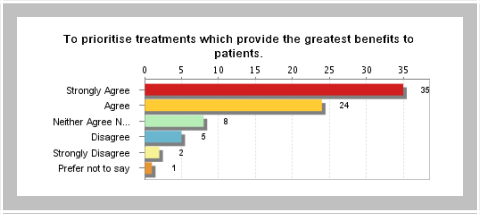
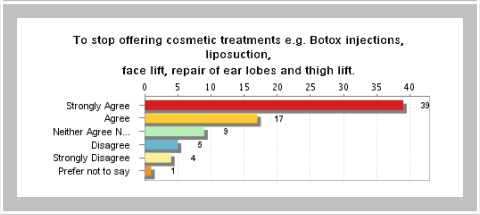
Appendix 3: survey results report

Seeking your views on Procedures of Lower Clinical Value (PLCV) Report

The information you supply will be stored and processed by Midlands and Lancashire Commissioning Support Unit (MLCSU) in accordance with the Data Protection Act 1998 and will be used to analyse the consultation responses, check the analysis is fair and accurate, and help us to consult more effectively in the future. Any reports published using this information will not contain any personally identifiable information. We will provide anonymised responses to the consultation to Birmingham CrossCity Clinical Commissioning Group, Birmingham South Central Clinical Commissioning Group and Solihull Clinical Commissioning Group. The information you provide in your response may be subject to disclosure under the Freedom of Information Act 2000 which allows the public access to information held by MLCSU. This does not necessarily mean that your response will be made available to the public as there are exemptions relating to information provided in confidence and information to which the Data Protection Act 1998 applies. The information collected will be kept until Wednesday 14th September 2016 it will then be confidentially destroyed.		**Response Percent**	**Response Total**
(*) Please tick to confirm you have read		100%	75
I do not confirm		0%	0

Total # of respondents **75**.
Statistics based on **75** respondents; **0** filtered; **0** skipped.

1) (*) The policies for PLCV treatments that are available in Birmingham and Solihull have been reviewed to meet the following objectives. To what extent do you agree with these objectives?

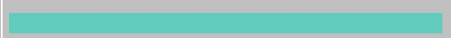
	A	B	C	D	E	F		Response Total
To ensure that procedures and treatments are offered consistently and fairly to patients.	61.33 % (46)	29.33 % (22)	2.67 % (2)	4 % (3)	1.33 % (1)	1.33 % (1)		75
To end the 'postcode lottery' which currently exists, by having the same eligibility criteria for treatments.	65.33 % (49)	21.33 % (16)	4 % (3)	5.33 % (4)	2.67 % (2)	1.33 % (1)		75
To ensure that policies meet the latest national clinical guidance and are supported by robust clinical evidence.	52 % (39)	33.33 % (25)	8 % (6)	5.33 % (4)	0 % (0)	1.33 % (1)		75
To stop using treatments that do not have any benefits for patients, or have a very limited evidence base.	37.33 % (28)	42.67 % (32)	9.33 % (7)	6.67 % (5)	2.67 % (2)	1.33 % (1)		75
To prioritise treatments which provide the greatest benefits to patients.	46.67 % (35)	32 % (24)	10.67 % (8)	6.67 % (5)	2.67 % (2)	1.33 % (1)		75
To stop offering cosmetic treatments e.g. Botox injections, liposuction, face lift, repair of ear lobes and thigh lift.	52 % (39)	22.67 % (17)	12 % (9)	6.67 % (5)	5.33 % (4)	1.33 % (1)		75

Total # of respondents **75**.
Statistics based on **75** respondents; **0** filtered; **0** skipped.

Legend for Rank Grid table:1) (*) The policies for PLCV treatments that are available in Birmingham and Solihull have been reviewed to meet the following objectives. To what extent do you agree with these objectives?

Columns:

A	Strongly Agree
B	Agree
C	Neither Agree Nor Disagree
D	Disagree
E	Strongly Disagree
F	Prefer not to say

2) (*) Below are the 21 PLCV policies that have been reviewed by the CCGs. CCGs have reviewed the criteria for 21 PLCV policies – these are used to determine whether a treatment is available to a patient. You can find out what the differences are between the current policies and the proposed policies by clicking on the links below. Solihull CCG Policies comparison document Birmingham CrossCity CCG comparison document Birmingham South Central CCG Policies comparison document We also recommend you read the introduction: Policy for Procedures of Lower Clinical Value - introduction You can review each policy by clicking on its name. This will open the policy document in a new window. If you then want to comment on the policy, please tick the box of all the policies you would like to provide feedback on.		Response Percent	Response Total
Adenoidectomy		4%	3
Cosmetic Surgery (For example liposuction, repair of ear lobes, botox injection for the ageing face)		12%	9
Non Specific, Specific and Chronic Back Pain		10.67%	8
Botulinum Toxin for Hyperhidrosis		6.67%	5
Cataracts		21.33%	16
Cholecystectomy for Asymptomatic Gallstones		4%	3
Male Circumcision (for medical reasons)		8%	6
Dilation and Curettage (D&C) for Menorrhagia		6.67%	5
Eyelid Surgery (Upper and Lower) - Blepharoplasty		5.33%	4
Ganglion		12%	9
Grommets		6.67%	5
Haemorrhoidectomy		6.67%	5
Hip Replacement Surgery		21.33%	16
Hysterectomy for Heavy Menstrual Bleeding		8%	6
Hysteroscopy for Menorrhagia		6.67%	5
Groin Hernia Repair		4%	3
Knee Replacement Surgery		14.67%	11
Penile Implants		5.33%	4
Tonsillectomy		10.67%	8
Trigger Finger		6.67%	5
Varicose Veins		8%	6
I do not want to specifically comment on any of the individual policies		56%	42
		Total # of respondents **75**. Statistics based on **75** respondents; **0** filtered; **0** skipped.	

Adenoidectomy3) (*) Have you had this treatment / procedure?		Response Percent	Response Total
Yes		66.67%	2
No		33.33%	1
Prefer not to say		0%	0

Total # of respondents **75**.
Statistics based on **3** respondents; **0** filtered; **72** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?		Response Percent	Response Total
Strongly agree		0%	0
Agree		33.33%	1
Neither agree nor disagree		33.33%	1
Disagree		33.33%	1
Strongly disagree		0%	0

Total # of respondents **75**.
Statistics based on **3** respondents; **0** filtered; **72** skipped.

5) Please provide any additional comments in the box below		Response Total
		2

Total # of respondents **75**.
Statistics based on **2** respondents; **0** filtered; **73** skipped.

Aesthetics3) (*) Have you had this treatment / procedure?		Response Percent	Response Total
Yes		22.22%	2
No		66.67%	6
Prefer not to say		11.11%	1

Total # of respondents **75**.
Statistics based on **9** respondents; **0** filtered; **66** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?		Response Percent	Response Total
Strongly agree		22.22%	2
Agree		22.22%	2
Neither agree nor disagree		11.11%	1
Disagree		33.33%	3
Strongly disagree		11.11%	1

Total # of respondents **75**.
Statistics based on **9** respondents; **0** filtered; **66** skipped.

5) Please provide any additional comments in the box below	Response Total
	5

Total # of respondents **75**.
Statistics based on **5** respondents; **0** filtered; **70** skipped.

Non Specific, Specific and Chronic Back Pain3) (*) Have you had this treatment / procedure?	Response Percent	Response Total
Yes	37.5%	3
No	62.5%	5
Prefer not to say	0%	0

Total # of respondents **75**.
Statistics based on **8** respondents; **0** filtered; **67** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?	Response Percent	Response Total
Strongly agree	12.5%	1
Agree	25%	2
Neither agree nor disagree	12.5%	1
Disagree	12.5%	1
Strongly disagree	37.5%	3

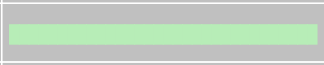
Total # of respondents **75**.
Statistics based on **8** respondents; **0** filtered; **67** skipped.

5) Please provide any additional comments in the box below	Response Total
	6

Total # of respondents **75**.
Statistics based on **6** respondents; **0** filtered; **69** skipped.

Botulinum Toxin for Hyperhidrosis3) (*) Have you had this treatment / procedure?	Response Percent	Response Total
Yes	0%	0
No	100%	5
Prefer not to say	0%	0

Total # of respondents **75**.
Statistics based on **5** respondents; **0** filtered; **70** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?		Response Percent	Response Total
Strongly agree		40%	2
Agree		20%	1
Neither agree nor disagree		40%	2
Disagree		0%	0
Strongly disagree		0%	0

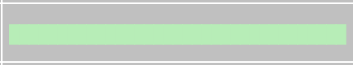
Total # of respondents **75**.
Statistics based on **5** respondents; **0** filtered; **70** skipped.

5) Please provide any additional comments in the box below		Response Total
		4

Total # of respondents **75**.
Statistics based on **4** respondents; **0** filtered; **71** skipped.

Cataracts3) (*) Have you had this treatment / procedure?		Response Percent	Response Total
Yes		25%	4
No		75%	12
Prefer not to say		0%	0

Total # of respondents **75**.
Statistics based on **16** respondents; **0** filtered; **59** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?		Response Percent	Response Total
Strongly agree		6.25%	1
Agree		12.5%	2
Neither agree nor disagree		43.75%	7
Disagree		18.75%	3
Strongly disagree		18.75%	3

Total # of respondents **75**.
Statistics based on **16** respondents; **0** filtered; **59** skipped.

5) Please provide any additional comments in the box below		Response Total
		14

Total # of respondents **75**.
Statistics based on **14** respondents; **0** filtered; **61** skipped.

Cholecystectomy for Asymptomatic Gallstones3) (*) Have you had this treatment / procedure?		Response Percent	Response Total
Yes		33.33%	1
No		66.67%	2
Prefer not to say		0%	0

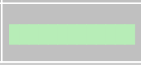
Total # of respondents **75**.
Statistics based on **3** respondents; **0** filtered; **72** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?		Response Percent	Response Total
Strongly agree		33.33%	1
Agree		33.33%	1
Neither agree nor disagree		0%	0
Disagree		0%	0
Strongly disagree		33.33%	1

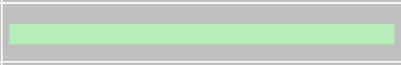
Total # of respondents **75**.
Statistics based on **3** respondents; **0** filtered; **72** skipped.

5) Please provide any additional comments in the box below		Response Total
		3

Total # of respondents **75**.
Statistics based on **3** respondents; **0** filtered; **72** skipped.

Male Circumcision3) (*) Have you had this treatment / procedure?		Response Percent	Response Total
Yes		0%	0
No		83.33%	5
Prefer not to say		16.67%	1

Total # of respondents **75**.
Statistics based on **6** respondents; **0** filtered; **69** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?		Response Percent	Response Total
Strongly agree		16.67%	1
Agree		0%	0
Neither agree nor disagree		50%	3
Disagree		16.67%	1
Strongly disagree		16.67%	1

Total # of respondents **75**.
Statistics based on **6** respondents; **0** filtered; **69** skipped.

5) Please provide any additional comments in the box below		Response Total
		5

Total # of respondents **75**.
Statistics based on **5** respondents; **0** filtered; **70** skipped.

Dilation and Curettage (D&C) for Menorrhagia3) (*) Have you had this treatment / procedure?		Response Percent	Response Total
Yes		20%	1
No		60%	3
Prefer not to say		20%	1

Total # of respondents **75**.
Statistics based on **5** respondents; **0** filtered; **70** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?		Response Percent	Response Total
Strongly agree		20%	1
Agree		20%	1
Neither agree nor disagree		20%	1
Disagree		0%	0
Strongly disagree		40%	2

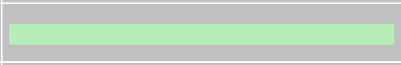
Total # of respondents **75**.
Statistics based on **5** respondents; **0** filtered; **70** skipped.

5) Please provide any additional comments in the box below		Response Total
		4

Total # of respondents **75**.
Statistics based on **4** respondents; **0** filtered; **71** skipped.

Eyelid Surgery (Upper and Lower) - Blepharoplasty3) (*) Have you had this treatment / procedure?		Response Percent	Response Total
Yes		0%	0
No		100%	4
Prefer not to say		0%	0

Total # of respondents **75**.
Statistics based on **4** respondents; **0** filtered; **71** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?		Response Percent	Response Total
Strongly agree		25%	1
Agree		0%	0
Neither agree nor disagree		50%	2
Disagree		25%	1
Strongly disagree		0%	0

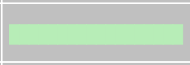
Total # of respondents **75**.
Statistics based on **4** respondents; **0** filtered; **71** skipped.

5) Please provide any additional comments in the box below		Response Total
		3

Total # of respondents **75**.
Statistics based on **3** respondents; **0** filtered; **72** skipped.

Ganglion3) (*) Have you had this treatment / procedure?		Response Percent	Response Total
Yes		33.33%	3
No		66.67%	6
Prefer not to say		0%	0

Total # of respondents **75**.
Statistics based on **9** respondents; **0** filtered; **66** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?		Response Percent	Response Total
Strongly agree		0%	0
Agree		22.22%	2
Neither agree nor disagree		22.22%	2
Disagree		22.22%	2
Strongly disagree		33.33%	3

Total # of respondents **75**.
Statistics based on **9** respondents; **0** filtered; **66** skipped.

5) Please provide any additional comments in the box below		Response Total
		8

Total # of respondents **75**.
Statistics based on **8** respondents; **0** filtered; **67** skipped.

Grommets3) (*) Have you had this treatment / procedure?	Response Percent	Response Total
Yes	40%	2
No	60%	3
Prefer not to say	0%	0

Total # of respondents **75**.
Statistics based on **5** respondents; **0** filtered; **70** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?	Response Percent	Response Total
Strongly agree	20%	1
Agree	20%	1
Neither agree nor disagree	20%	1
Disagree	20%	1
Strongly disagree	20%	1

Total # of respondents **75**.
Statistics based on **5** respondents; **0** filtered; **70** skipped.

5) Please provide any additional comments in the box below	Response Total
	4

Total # of respondents **75**.
Statistics based on **4** respondents; **0** filtered; **71** skipped.

Haemorrhoidectomy3) (*) Have you had this treatment / procedure?	Response Percent	Response Total
Yes	20%	1
No	80%	4
Prefer not to say	0%	0

Total # of respondents **75**.
Statistics based on **5** respondents; **0** filtered; **70** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?	Response Percent	Response Total
Strongly agree	20%	1
Agree	20%	1
Neither agree nor disagree	40%	2
Disagree	20%	1
Strongly disagree	0%	0

Total # of respondents **75**.
Statistics based on **5** respondents; **0** filtered; **70** skipped.

5) Please provide any additional comments in the box below		Response Total
		4

Total # of respondents **75**.
Statistics based on **4** respondents; **0** filtered; **71** skipped.

Hip Replacement Surgery3) (*) Have you had this treatment / procedure?		Response Percent	Response Total
Yes		0%	0
No		93.75%	15
Prefer not to say		6.25%	1

Total # of respondents **75**.
Statistics based on **16** respondents; **0** filtered; **59** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?		Response Percent	Response Total
Strongly agree		12.5%	2
Agree		12.5%	2
Neither agree nor disagree		18.75%	3
Disagree		25%	4
Strongly disagree		31.25%	5

Total # of respondents **75**.
Statistics based on **16** respondents; **0** filtered; **59** skipped.

5) Please provide any additional comments in the box below		Response Total
		14

Total # of respondents **75**.
Statistics based on **14** respondents; **0** filtered; **61** skipped.

Hysterectomy for Heavy Menstrual Bleeding3) (*) Have you had this treatment / procedure?		Response Percent	Response Total
Yes		16.67%	1
No		83.33%	5
Prefer not to say		0%	0

Total # of respondents **75**.
Statistics based on **6** respondents; **0** filtered; **69** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?		Response Percent	Response Total
Strongly agree		16.67%	1
Agree		16.67%	1
Neither agree nor disagree		16.67%	1
Disagree		33.33%	2
Strongly disagree		16.67%	1

Total # of respondents **75**.
Statistics based on **6** respondents; **0** filtered; **69** skipped.

5) Please provide any additional comments in the box below		Response Total
		4

Total # of respondents **75**.
Statistics based on **4** respondents; **0** filtered; **71** skipped.

Hysteroscopy for Menorrhagia3) (*) Have you had this treatment / procedure?		Response Percent	Response Total
Yes		20%	1
No		80%	4
Prefer not to say		0%	0

Total # of respondents **75**.
Statistics based on **5** respondents; **0** filtered; **70** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?		Response Percent	Response Total
Strongly agree		20%	1
Agree		0%	0
Neither agree nor disagree		20%	1
Disagree		40%	2
Strongly disagree		20%	1

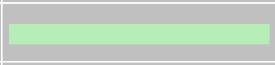
Total # of respondents **75**.
Statistics based on **5** respondents; **0** filtered; **70** skipped.

5) Please provide any additional comments in the box below		Response Total
		4

Total # of respondents **75**.
Statistics based on **4** respondents; **0** filtered; **71** skipped.

Groin Hernia Repair3) (*) Have you had this treatment / procedure?		Response Percent	Response Total
Yes		0%	0
No		100%	3
Prefer not to say		0%	0

Total # of respondents **75**.
Statistics based on **3** respondents; **0** filtered; **72** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?		Response Percent	Response Total
Strongly agree		33.33%	1
Agree		0%	0
Neither agree nor disagree		33.33%	1
Disagree		33.33%	1
Strongly disagree		0%	0

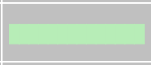
Total # of respondents **75**.
Statistics based on **3** respondents; **0** filtered; **72** skipped.

5) Please provide any additional comments in the box below		Response Total
		2

Total # of respondents **75**.
Statistics based on **2** respondents; **0** filtered; **73** skipped.

Knee Replacement Surgery3) (*) Have you had this treatment / procedure?		Response Percent	Response Total
Yes		0%	0
No		90.91%	10
Prefer not to say		9.09%	1

Total # of respondents **75**.
Statistics based on **11** respondents; **0** filtered; **64** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?		Response Percent	Response Total
Strongly agree		9.09%	1
Agree		9.09%	1
Neither agree nor disagree		18.18%	2
Disagree		45.46%	5
Strongly disagree		18.18%	2

Total # of respondents **75**.
Statistics based on **11** respondents; **0** filtered; **64** skipped.

5) Please provide any additional comments in the box below	Response Total
	10

Total # of respondents **75**.
Statistics based on **10** respondents; **0** filtered; **65** skipped.

Penile Implants3) (*) Have you had this treatment / procedure?	Response Percent	Response Total
Yes	0%	0
No	100%	4
Prefer not to say	0%	0

Total # of respondents **75**.
Statistics based on **4** respondents; **0** filtered; **71** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?	Response Percent	Response Total
Strongly agree	0%	0
Agree	25%	1
Neither agree nor disagree	25%	1
Disagree	50%	2
Strongly disagree	0%	0

Total # of respondents **75**.
Statistics based on **4** respondents; **0** filtered; **71** skipped.

5) Please provide any additional comments in the box below	Response Total
	3

Total # of respondents **75**.
Statistics based on **3** respondents; **0** filtered; **72** skipped.

Tonsillectomy3) (*) Have you had this treatment / procedure?	Response Percent	Response Total
Yes	37.5%	3
No	62.5%	5
Prefer not to say	0%	0

Total # of respondents **75**.
Statistics based on **8** respondents; **0** filtered; **67** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?	Response Percent	Response Total
Strongly agree	12.5%	1
Agree	37.5%	3
Neither agree nor disagree	12.5%	1
Disagree	12.5%	1
Strongly disagree	25%	2

Total # of respondents **75**.
Statistics based on **8** respondents; **0** filtered; **67** skipped.

5) Please provide any additional comments in the box below	Response Total
	6

Total # of respondents **75**.
Statistics based on **6** respondents; **0** filtered; **69** skipped.

Trigger Finger3) (*) Have you had this treatment / procedure?	Response Percent	Response Total
Yes	20%	1
No	80%	4
Prefer not to say	0%	0

Total # of respondents **75**.
Statistics based on **5** respondents; **0** filtered; **70** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?	Response Percent	Response Total
Strongly agree	20%	1
Agree	20%	1
Neither agree nor disagree	60%	3
Disagree	0%	0
Strongly disagree	0%	0

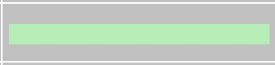
Total # of respondents **75**.
Statistics based on **5** respondents; **0** filtered; **70** skipped.

5) Please provide any additional comments in the box below	Response Total
	4

Total # of respondents **75**.
Statistics based on **4** respondents; **0** filtered; **71** skipped.

Varicose Veins3) (*) Have you had this treatment / procedure?		Response Percent	Response Total
Yes		50%	3
No		50%	3
Prefer not to say		0%	0

Total # of respondents **75**.
Statistics based on **6** respondents; **0** filtered; **69** skipped.

4) (*) To what extent do you agree with the proposed criteria of this policy?		Response Percent	Response Total
Strongly agree		33.33%	2
Agree		0%	0
Neither agree nor disagree		33.33%	2
Disagree		33.33%	2
Strongly disagree		0%	0

Total # of respondents **75**.
Statistics based on **6** respondents; **0** filtered; **69** skipped.

5) Please provide any additional comments in the box below		Response Total
		5

Total # of respondents **75**.
Statistics based on **5** respondents; **0** filtered; **70** skipped.

6) (*) Would you like to be involved in developing policies like these in 2016? This may involve being part of an online/virtual group to review, comment on and shape similar policies in future.		Response Percent	Response Total
Yes		45.33%	34
No		54.67%	41

Total # of respondents **75**.
Statistics based on **75** respondents; **0** filtered; **0** skipped.

Contact Details		Response Total
(*) Name		34
(*) Telephone		34
(*) Email Address		34

Total # of respondents **75**.
Statistics based on **34** respondents; **0** filtered; **41** skipped.

7) About you To help make sure our consultations reflect the views of the diverse UK population, we aim to monitor the types of responses we receive to each consultation and over a series of consultations. Although we will use this information in the analysis of the consultation response, it will not be linked to your response in the reporting process. a) What is your age category?		Response Percent	Response Total
15 or under		0%	0
16 to 24		0%	0
25 to 34		4.05%	3
35 to 44		12.16%	9
45 to 54		28.38%	21
55 to 64		29.73%	22
65 to 74		20.27%	15
75 to 84		4.05%	3
Over 85		0%	0
Prefer not to say		1.35%	1
		Total # of respondents **75**. Statistics based on **74** respondents; **0** filtered; **1** skipped.	

b) How would you describe your gender?		Response Percent	Response Total
Male		31.51%	23
Female		68.49%	50
Trans (any part of a process, including thoughts or actions, to bring your physical sex appearance, and/or your gender role, more in line with your gender identity)		0%	0
Intersex		0%	0
Other (Please state)		0%	0
		Total # of respondents **75**. Statistics based on **73** respondents; **0** filtered; **2** skipped.	

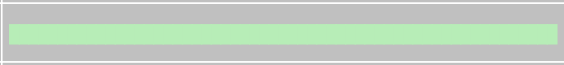
c) Which of the following options best describes how you think of yourself?		Response Percent	Response Total
Heterosexual/Straight		79.73%	59
Gay/Lesbian		5.41%	4
Bisexual		2.7%	2
Other		1.35%	1
Prefer not to say		10.81%	8
		Total # of respondents **75**. Statistics based on **74** respondents; **0** filtered; **1** skipped.	

d) What is your ethnic group/background?		Response Percent	Response Total
White		0%	0
English, Welsh, Scottish, Northern Irish, British		79.45%	58
Irish		1.37%	1
Gypsy or Irish Traveller		0%	0
Any other White background		1.37%	1
Mixed/Multiple ethnic groups		0%	0
White and Black Caribbean		0%	0
White and Black African		0%	0
White and Asian		0%	0
Any other Mixed/Multiple ethnic background		1.37%	1
Asian/Asian British		0%	0
Indian		4.11%	3
Pakistani		0%	0
Bangladeshi		0%	0
Chinese		0%	0
Any other Asian background		1.37%	1
Black/African/Caribbean/Black British		0%	0
African		0%	0
Caribbean		6.85%	5
Any other Black/African/Caribbean background		0%	0
Any other ethnic group		0%	0
Arab		0%	0
Prefer not to say		4.11%	3
Other ethnic background, please describe		0%	0

Total # of respondents **75**.
Statistics based on **73** respondents; **0** filtered; **2** skipped.

e) What is your religion/faith?		Response Percent	Response Total
Christian (including Church of England, Catholic, Protestant and all other Christian denominations)		61.64%	45
Buddhist		0%	0
Hindu		2.74%	2
Jewish		0%	0
Muslim		1.37%	1
Sikh		0%	0
Pagan		0%	0
Atheist		8.22%	6
Agnostic		2.74%	2
Prefer not to say		13.7%	10
Any other religion, please describe		9.59%	7

Total # of respondents **75**.
Statistics based on **73** respondents; **0** filtered; **2** skipped.

f) Are your day-to-day activities limited by a health problem or disability which has lasted, or is expected to last, over 12 months? The Equality Act 2010 defines a person as disabled if they have a physical or mental impairment, which has a substantial and long-term (ie has lasted or is expected to last at least 12 months) and adverse effect on the person's ability to carry out normal day-to-day activities.		Response Percent	Response Total
Yes, limited a lot		5.48%	4
Yes, limited a little		19.18%	14
No		71.23%	52
Prefer not to say		4.11%	3

Total # of respondents **75**.
Statistics based on **73** respondents; **0** filtered; **2** skipped.

8) (*) Where do you live?		Response Percent	Response Total
Birmingham		65.33%	49
Solihull		16%	12
Worcestershire		6.67%	5
Warwickshire		2.67%	2
Staffordshire		1.33%	1
Other - Please Specify		8%	6

Total # of respondents **75**.
Statistics based on **75** respondents; **0** filtered; **0** skipped.

9) (*) Please provide your postcode. This is collected for administrative purposes only and will not identify you in any way.		Response Total
		75

Total # of respondents **75**.
Statistics based on **75** respondents; **0** filtered; **0** skipped.

10) (*) Where is your GP situated?		Response Percent	Response Total
Birmingham		65.33%	49
Solihull		17.33%	13
Worcestershire		6.67%	5
Warwickshire		1.33%	1
Staffordshire		0%	0
Other - Please Specify		9.33%	7

Total # of respondents **75**.
Statistics based on **75** respondents; **0** filtered; **0** skipped.

Appendix 4: comments and feedback

General feedback

Respondent	Comment	CCG Clinical Working Group Response
Solihull and Birmingham Joint Health Overview and Scrutiny Committee	DRAFT recommendations from the Solihull and Birmingham Joint Health Overview and Scrutiny Committee a). Commissioners need to strengthen engagement and communication with the public around PLCV so that there is a clearer understanding of what this means in practice and demonstrates more clearly what the implications are likely to be. b). GP/Primary Care need to be engaged as part development of new polices to enable the development of referral pathways. c). Health and Wellbeing Board need to be involved in leading and having overview of these proposals. d). That case study information and information in Plain English is more widely disseminated to the public about PLCV. (iii). That the Scrutiny Committee receives a final copy of the	To date local CCGs see the February/March 2016 as the start of a wider process of Public Engagement as we start work on the second phase of harmonising local commissioning policies. This is therefore only a beginning, not the end. Local CCGs ensured that GPs were actively part of the policy process but are planning more regular engagement with each CCGs' Primary Care membership meetings in 2016 Local CCGs through meeting with Birmingham and Solihull Health and Wellbeing Boards respectively in June 2016 will seek views on the level of scrutiny and oversight HWBs believe is necessary and appropriate. Once we have the final draft of each policy with the help of patient panel reps we will start to work on 'Plain English' leaflets for each policy. This work is commencing in June 2016 and will take some time due to the number of policies being harmonised and making sure that patient panel input is carefully considered and reflected in the final product. This document once finalised will be shared during summer 2016 including the 'You Said, We Did' elements.

	Engagement report. (iv). That the Scrutiny Committee consider proposals for implementing PLCV at a future meeting (suggested date June 2016) with a focus on considering implications for service users.	This is now scheduled for 27th July at the Birmingham Council House.
Birmingham LMC	There are four fundamental principles which the LMC believes must apply to the policy and which we would like to see explicitly reflected in the wording. 1) GPs must retain full clinical freedom to refer for a specialist assessment/opinion whenever they believe it is appropriate; this will include instances where the referral is made because the patient is insistent on a specialist opinion. 2) The policy must not put any additional un-resourced workload on general practice in respect of having to follow any prescribed tick box protocols and pathways prior to referrals- GPs must retain the full clinical freedom to manage patients in the manner they determine appropriate prior to referral- this is in accordance with the definition of essential primary medical services in the GP contractual regulations. 3) Referrals from GPs must never be bounced back without	The harmonised commissioning policies do not seek to restrict outpatient referrals for a specialist opinion in mitigating against the risk of managing patients and their conditions without review and preventing the possibility that sinister lesions / unusual pathology is missed. It should be noted that in Solihull and Birmingham specialist advice and support can be received via e-referral and through (direct GP telephone call to a Hospital Specialist) 'Consultant Connect' in a range of clinical specialties. So far comments from both Consultants and GPs have been encouraging. The policy does not set out any additional work for GPs but instead looks to provide clarity on when a referral is or Is not required. Having a uniform policy across Birmingham, Black Country and Solihull ensures that there is no difference in the patients experience and perception of the service they are receiving. All policies endeavour to include contemporary and evidence based. See above comments. There may be times when it is appropriate for a GP to make an Individual Funding Request and this is allowed for. However in the majority of cases it is normally the hospital specialist who makes the application.

	being seen by a specialist on the basis of the GP not having followed any such prescribed protocol or pathway. 4) Application for special funding must be by the clinician who recommends the procedure. I cannot see therefore that this can be by anyone other than the specialist. As noted above, the referral by the GP is for an assessment/ opinion, not for any particular operation or procedure. Needless to say we would expect all GPs to work in line with accepted good clinical practice and the highest possible standards and not be making any referrals if it were not in their patients' best interests to do so. Concerns were raised during the engagement period by the LMC about the wording in the PLCV leaflet which stated that a patient's GP would make an IFR. It has already been agreed this would be changed to reflect the fact that it will be the hospital consultant in most cases who makes the request for an IFR.	This positive comment is appreciated and is consistent with the document 'Leadership and Management for all Doctors' paragraphs 2G, 79, 80, 81, 84 and particularly 85. Agreed. The electronic version of the PLCV Engagement leaflet on CCG websites was changed to 'reflect the fact that it will be the hospital consultant *in most cases* who makes the request for an IFR.' It was not possible to change the paper version of the leaflet as the printing run had already commenced.
Royal College of surgeons	Patients' access to treatment must be based on clinical assessment and evidence-based practice. The proposals in your engagement document place thresholds to referral on several essential elective surgical procedures spanning six CCGs, and more than 2 million patients in the region, which would act as a barrier to patients receiving necessary clinical treatment. The document makes extensive reference to guidance published by the RCS and surgical specialty associations (SSAs) in setting out new commissioning policies on thresholds to referral to surgical procedures. Policies for some procedures reference RCS	The RCS feedback dated 5 April 2016 was welcomed and has been fully considered by the clinical WG regarding specific areas of concern and where possible and appropriate the draft policy suite has been amended (see individual policy and treatment lines within this appendix). Local CCGs would like to reassure that no absolute referral or treatment block exists because of the shared Individual Funding Request process across Birmingham, Black Country and Solihull since 2013. We would encourage the RCS to continue to work with local CCG commissioners to ensure future commissioning policies are as clinically robust as possible. Whilst the letter sent on 5 April 2016 was

	and SSA guidance which is subsequently ignored or cited out of context, thereby presenting the policies as if they are supported by clinically-evidenced guidance, but that in places contravene it. The RCS and SSAs are keen to work with commissioners to improve patient care. I outline below particular areas of concern and urge you to reconsider your policies.	welcomed the nature and language of the press release issued at the same time did not demonstrate measured engagement and we would urge the RCS to review this aspect of its engagement approach. Notwithstanding this comment the WG has carefully reviewed the RCS feedback and that review and specific policy amendments are reflected in the individual policy and treatment lines within this appendix.
Birmingham Children's Hospital	In early discussions with the Trust, they raised an initial concern that there appears to be no differentiation between adults and children in each of the individual policies and believe that there are fundamental differences between the implementation and effects of certain policies for both adults and children	A GP member of the WG has had further discussions with the Trust on 6 June 2016 to identify specific areas of concern and where possible and appropriate the draft policy suite has been amended (see individual policy and treatment lines within this appendix).
Event key points	- *Support for ensuring policies reflect latest evidence of good practice* - *Clinician/patient relationship very important in reaching the decision about whether a procedure should go ahead* - *Suspicion that decisions will be made on cost grounds* - *Acknowledgement that NHS should invest in procedures that work* - *More explanation needed on why these were considered 'low value'* - *People reassured that harmonisation wasn't based on lowest common denominator e.g. cataracts policy lowered threshold for treatment* - *People acknowledged that clinical practice changes over time e.g. hysterectomy, tonsillectomy* - *Fairness as a principle supported but must ensure all GPs and Hospital Providers are following policies* - *Support for ensuring policies reflect latest evidence of good practice*	All policies are reviewed with reference to the latest NICE guidance or other clinical pathway guidance from Royal Colleges or recognised medical professional bodies. A clinician/patient discussion about treatment issues will be based on national recommended pathway options, where they exist. None of the draft harmonised clinical policies have been developed on financial grounds. However the NHS in England does operate with finite resources and needs to demonstrate that it is commissioning the clinically evidenced and effective treatments. We agree and that is why some of the procedures in the draft harmonised clinical policies are

	- *Clinician/patient relationship very important in reaching the decision about whether a procedure should go ahead* - *Suspicion that decisions will be made on cost grounds* - *Acknowledgement that NHS should invest in procedures that work* - *More explanation needed on why these were considered 'low value'*	categorised as 'not routinely commissioned' because there is insufficient robust evidence We have acknowledged that the term 'low value' is not always helpful in considering some clinical treatments or procedures, e.g. cataract surgery and we are actively looking at a more appropriate title than PLCV such as 'Clinical Treatment Policies'. Where a treatment [policy] is categorised as 'not routinely commissioned' the policy will seek to explain the reasons based on clinical evidence or even absence thereof. Hospital and GP adherence to each policy will be monitored through the use of a cost-effective software application that is already being trialled by NHS England for the service they commission. The cataract policy seeks to incorporate recommendations in the Royal College of Ophthalmologists 2015 guidance on Cataract Surgery. We would like to reassure patients and the public that there is no intention to include any form of age, gender, faith or sexuality bias into any of our clinical treatment policies. It will be the case that certain policies will relate more to a particular gender or age group within our wider population. Some treatment policies will typically cover younger people and some older and some in the middle
Individual at an event	*Policies not as restrictive/limited as feared: recognition that cataracts policy proposed was less restrictive*	
Individual at an event	Recognition of the need to prioritise NHS treatments	
Individual at an event	They seem to be directed at treatments affecting the elderly	
Individual at an event	Criteria must not be the only means to determine if treatment goes ahead - clinicians and patients must decide ultimately on an individual basis	
Individual at an event	Patients refused a procedure must be able to appeal	

		stages of life. NHS Commissioners are expected to commission treatments on an evidence basis and clinicians will act likewise. Clinical treatment policies cannot cover every possible element of a patient's diagnosis and treatment plan and so clinical judgement will play a part naturally in a final recommended treatment plan in discussion with the patient. All Birmingham, Solihull and Black Country CCG operate the same IFR application and appeal process details of which can be found on each CCG's public website.

ADENOIDECTOMY

Respondent	Comment	CCG Clinical Working Group Response
Survey response	Agreed if provided where needed with tonsillectomy.	The WG considered feedback received and proposed to add the following text to the Adenoidectomy eligibility criteria: • Children or adults with sleep disordered breathing/apnoea confirmed with sleep studies undergo procedure in line with recognised management of these conditions. RCS guidance states: Treatment entails a trial of maximum medical therapy, with surgery reserved for recalcitrant cases, with a diagnosis confirmed by radiology, after an appropriate trial of treatment.
Birmingham Children's Hospital	This is not accepted. Adenoidectomy may be required as part of rhinitis treatment. Treating the anatomical obstruction for rhinitic patient improves their symptoms. Also for very young children with sleep apnoea adenoidectomy alone improves the symptoms and reduces morbidity (by not doing a tonsillectomy as well if not necessary). Adenoidectomy may be required by patients who have previously had their tonsils removed but still have OSA. It is well known how nasal obstruction and poor sleep affects a child's development, growth and concentration at school. Often adenoids do need to be removed without tonsillectomy as large adenoids can cause obstructive sleep apnoea.	

Royal College of Surgeons	The policy is not in line with RCS guidance, as is suggested in the document. The RCS does not agree with a policy of only referring patients for the procedure if undertaken at the same time as grommets or tonsillectomy. It seems particularly unusual to insist on performing a tonsillectomy at the same time if a patient requires an adenoidectomy, as this may increase surgical risk for the patient who may only need an adenoidectomy to treat sleep-disordered breathing. We strongly urge you to reconsider your position on the points of concern outlined above. Aspects of the policy amount to rigid thresholds which would act as a barrier to essential elective surgical procedures. The RCS has produced clear guidance, accredited by NICE, and this should be fully taken into account in CCGs' commissioning policies. In this case, our guidance has been misrepresented and incorrectly referenced in many places.	There is over 5 fold variation in procedure rates for sinus surgery per 100,000 population by CCG across England. Therefore the WG proposed that the linkage with tonsillectomy is removed and replaced with the following text: • 'As nationally there is a more than 5 fold variation in procedure rates for sinus surgery per 100,000 population by CCG across England secondary and primary care clinicians should ensure they undertake maximum medical therapy following the RCS High Value Care Pathway for Rhinosinusitis, with surgery reserved for recalcitrant cases, with a diagnosis confirmed by radiology, after an appropriate trial of treatment.'

COSMETIC SURGERY

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

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

Respondent	Comment	CCG Clinical Working Group Response
Survey response	The criteria are too harsh in respect of children or issues such as ear pinning, facial marks and for all in respect of abnormal facial hair growth. Failure to address these issues can result in isolation, mental health issues, bullying and children in particular who are damaged for life.	No local commissioning policy includes mental health criteria because there are no objective measures of psychological distress that can be used. Nevertheless CCGs allow for clinical 'safety net' of the IFR process to be used where in exceptional circumstances an application can be submitted by a suitably qualified clinician which in this case would a Psychiatrist or possibly a Psychologist. Wolverhampton City Council Public Health has undertaken a 'Rapid evidence review: **Surgery to**
Survey response	Any woman with intractable nipple inversion should be allowed correction to enable her to breast feed successfully - isn't it a key public health policy to encourage ALL women to do so. All lacerations are repaired in A&E or referred appropriately ENT etc. Why should a torn pinna be treated any differently?	
Survey response	The majority of criteria set out a number of alternative/pre - treatments. Often patients will either accept the other treatment offered and in some cases decline alternative treatment offers. They will then continue with	

	the pain/discomfort inability to carry out day to day tasks. An example of this is back pain. Whereby the patient may not be able to undertake daily activities; missing work due to pain related sickness; attending work when unwell and risking having an accident; making mistakes; etc. The non-treatment may aggravate other medical issues, including mental health. Therefore, the criteria should look at the person as a whole rather than simply in isolation of delaying the treatment or what may be seen as discouraging the patient from accessing effective treatment. A number of the criteria mention pain (improving pain) and the question would be, how would this be fairly managed in the process? A patient feels a level of pain, then the patient has to quantify this main, the medical practitioner then translates this into a score... Would it not be better to ask questions to support this, i.e. how has this affected your daily routines (walking, standing, work, etc.)?	**correct inverted nipples** in order to promote breastfeeding.' Key Findings: - Inverted nipples are common (approximately 1 in 3 women), but often resolve spontaneously during pregnancy. - Many women with inverted nipples can breastfeed successfully and should be offered additional postnatal advice and breastfeeding support [NICE CG 37] - Surgery to correct inverted nipples can result in damage to the milk ducts which mean that the woman is unable to breastfeed. - Inverted nipples can reoccur (1 in 8) following surgery. Recommendations: Surgery to correct nipple inversion is not an appropriate intervention to promote breastfeeding because the risks associated with surgery outweigh the potential benefits of nipple correction. Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded. An underlying breast cancer may cause a nipple to become indrawn: this must be investigated urgently. The WG agreed that is the context of breast feeding that it remained appropriate to retain the procedure categorisation of 'not routinely commissioned.'
Survey response	If people want this treatment they should pay for it rather than getting it on the NHS or any other mean rather than them paying for the treatment	
Birmingham Children's Hospital	Gynaecomastia Not Accepted - Require Clarification – what about unilateral gynaecomastia during puberty? On 6 June 2016 BCH added bilateral gynaecomastia is generally due to obesity, but unilateral is often due to an endocrine disorder and often they need to correct the gynaecomastia as well as the underlying endocrine disease as the unilateral gynecomastia can cause psychological problems. Labiaplasty - Not Accepted - What about congenital deformities Pinnaplasty – Requires further discussion On 6 June BCH further commented that although Pinnaplasty is not a clinical issue, it was felt the quality of life improves if corrected. Repair of Ear Lobes – Requires further discussion On 6 June 2016 BCH added that In BAHI (bone anchor hearing implant);	

	patients may have a partial or incomplete outer ear and will need this constructing. On 6 June BCH further commented that if it is a congenital split of the earlobe, then they repair it. Also young kids 2-5 years often have their ear pierced and have an earring due to the parents' wishes; the child subsequently pulls it off splitting the earlobe. The specialist argued that it was not the child's decision to have the earring so it should be repaired. Older children 12-17 years who have earrings can sustain a traumatic injury with the earring splitting the earlobe, so the Trust consultant discussed that this should be repaired. Rhinoplasty - Can a classification system be agreed?	**Gynaecomastia.** The WG agreed that option remained for a Children's provider to make an IFR application in 'exceptional' cases e.g. unilateral gynaecomastia if the treating clinician deemed surgery necessary. **Ear Reconstruction (Bone Anchored Hearing Implants).** The WG noted BCH's comments. BAHIs are commissioned by NHS England Specialised Service (assessment, implantation and rehabilitation). It is not specified whether any incidental ear reconstruction would be funded by NHS England. Therefore the WG agreed, pending further clarification from NHS England Specialised Service that any such additional surgery could be applied for through the IFR process. **Pinnaplasty.** The WG agreed that the option remained to make an IFR application in 'exceptional' cases. **Repair of Ear Lobes.** Regarding 2-5 year olds and 12-17 year olds the WG believe the examples cited could be covered with an amplification of the policy treatment to say, *'Repair of split ear lobes are not routinely commissioned except for the following traumatic injury examples:* • *Young children typically under 5 whose parents have their child's ear pierced and the child subsequently pulls it off splitting the*

		earlobe. • *Older children typically 12-17 years who have earrings who sustain a traumatic injury with the earring splitting the earlobe.* **Breast Augmentation/Breast Reduction/Breast Lift/Inverted Nipple Correction.** The commissioning policy for cosmetic surgery allows for Breast reconstructive surgery of the cancer affected breast following full or partial mastectomy. NICE CG80 - Early and locally advanced breast cancer: diagnosis and treatment (2009) and NICE Quality Standard 12 – Breast Cancer (2011) recommend that women should have the choice of whether to have reconstructive surgery at the same time as a mastectomy or at a later date. However NICE does not deal with the issue of contralateral surgery on the other breast not affected by cancer whether symmetrising surgery including: Breast Augmentation/Breast Reduction/Breast Lift/Inverted Nipple Correction. Both HEFT and UHB clinicians have commented on the psychological factors but no Birmingham, Solihull and Black Country commissioning policy includes psychological factors in their clinical access thresholds. This is because there is no objective clinical measurement/standard that commissioners can apply.
HEFT	Dermatology/Plastics - concerns over limits on medical and surgical treatment of scars and keloids. Warts for cryotherapy now referred frequently as not available via primary care. Concern over excluding Facial port wine stains, severe facial acne scars and severe rhinophyma ENT - "Pinnaplasty is disappointing as there can be considerable emotional/ psychological distress in children of school age. Adenoids may be obstructive and merit removal as a sole procedure (very uncommon). If we are not able to treat snoring surgically do we have the licence to refuse referrals?" Breast/Plastics - Treatment (i.e. symmetrisation/augmentation/reduction) of the non-affected breast following breast cancer reconstruction is important psychologically. Medicine - not seen to be applicable in HEFT (awaiting comments from neurology about botulinum toxin use) Gynae - nothing new on list except labia trimming which is not	

	undertaken	However the WG on 29th June proposed that for breast cancer patients facing reconstructive surgery on the cancer affected breast should have the option at the same time reconstructive surgery is being undertaken of contra-lateral surgery on the non-cancer affected breast to include Breast Augmentation, or Breast Reduction, or Breast Lift, or Inverted Nipple Correction surgery. Separate later/subsequent applications for such contra-lateral surgery would not however be routinely commissioned. **Rhinoplasty.** BCH asked whether a classification system be agreed. Commissioners as part of ongoing review and updating of their commissioning policies are prepared to consider a proposal if presented that can be evidenced by NICE, a Royal College or a Specialty Specific Association. **Labiaplasty.** BCH commented on cases of congenital deformity, a very low volume procedure for BCH. The WG agreed that option remained for a Children's provider to make an IFR application in 'exceptional' cases. **Removal of Benign or Congenital Skin Lesions/ Medical and Surgical Treatment of Scars and Keloids/Treatment for Viral Warts/ Rhinophyma.** HEFT comment on fact that policy makes no allowance for psychological issues of

		severe facial acne scars, port wine stain (note: not part of the policy) or severe rhinophyma. WG agreed that option remained to make an IFR application in 'exceptional' cases.

NON SPECIFIC, SPECIFIC AND CHRONIC BACK PAIN

Respondent	Comment	CCG Clinical Working Group Response
Survey Response	Living with back pain is terrible and if the pain is not resolved this can affect a person's ability to work or complete everyday activity	The WG confirmed that the policy is based on current Map of Medicine and the British Pain Society (BPS) guidance which recognised the need to develop easy-to-use, succinct pathways for clinicians. Regarding the RCS comments on: non-pharmacological or non-invasive first line treatment for 'non-specific back pain', the WG reflected that the policy needed to emphasise more strongly the following pre-surgical options: • Structured individual or group exercise programmes • A course of manual therapy, including spinal manipulation, comprising up to a maximum of nine sessions over a period of up to 12 weeks performed by chiropractors and osteopaths, as well as by doctors and physiotherapists who have undergone specialist postgraduate training in manipulation • A course of acupuncture needling comprising up to a maximum of 10 sessions over a period of up to 12 weeks. But not offering injections of therapeutic substances into the back for non-specific low back
Survey response	If pain restricts movement then a patient will not take enough exercise to keep fit and will cost more in the long run	
Survey response	This would end up being a vicious circle. Which has happened to me in the past. Missing days off work, having to take additional leave to attend appointments and treatments, which only reduce the pain and for a minimal period. This means taking more time off work. This can affect other illness, which includes mental health	
Survey Response	I have chronic back pain and I agree in the policy it should also be reported more by doctors or anybody in the Governing Body can be from hurting your back more than once or twice and can hurt more if you put more weight on you should be told that and put in more leaflets about it and should be helped in losing weight if your doctor cannot help in weight management then should be where to seek help.	
Survey response	As back pain is one of the major causes of time off work etc., its treatment should not be considered of lower clinical value. Interventions are, however, not very successful - the prime need is for proper research to be PLANNED and implemented in order to obtain evidence of best practice for prevention and cure of	

	these disabling conditions.	pain. And add the following statement, 'NICE are currently consulting on revised guidance for Non-Specific Bank Pain and Sciatica' and expect to publish updated clinical guidelines in September 2016. At that point this policy will be updated to align with that revised NICE guidance.' It was noted that the draft NICE Clinical Guidance no longer recommends acupuncture for the management of non-specific low back pain (and sciatica). The WG therefore decided that upon final publication of the updated NICE clinical guidance that at that point this policy will be updated to align with that revised NICE guidance. The WG reflected on the RCS comments regarding 'single injection' and agreed that the Specific Pain section of the policy should be re-drafted as follows: 'Lumbar facet joint injections should not be routinely considered for patients with low back pain of up to 12 months duration or moderate to severe depression. Few patients will need referral to secondary care, where this is necessary the CCG will fund this treatment if the high value part of the RCS Low Back Pain pathway can be evidenced as regards to: • Assessment • Injections • Pain Management •Surgery (where other recommended treatments have been exhausted).' With regard to the various queries raised by ROH the
Survey response	Every individual case should be considered based on patient pain.	
HEFT	Pain - Facet joint injections and median branch blocks regularly undertaken after approval	
Chartered Society of Physiotherapists	One of the main challenges for the UK is the growing burden of disability owing to more people living longer with more long-term conditions. In the UK, musculoskeletal (MSK) conditions account for the largest proportion of years living with a disability, with back and neck pain being the most prevalent. The latest NHS England National Health survey data shows that average prevalence of persistent low back pain (>3months) is 17 per cent and for severe low back pain is 10 per cent. MSK conditions are also the biggest cause of workplace sickness absence, causing 27 per cent of total days lost. MSK problems are 'gateway' conditions, where pain and disability significantly increases the likelihood of other physical and mental health issues. These include depression, diabetes, obesity and cardiovascular disease. In many circumstances, these conditions are entirely avoidable through early access to evidence based musculoskeletal physiotherapy. On review of your Policy for Procedures of Lower Clinical Value, we are concerned by the ambiguous language used in the non-specific low back pain section around access to physical treatment programmes. We ask that you confirm that the CCG's position is to support patient access to physiotherapy, providing NICE recommended interventions.	
Royal College of Surgeons	In most cases of back pain, physiotherapy or combined physical and psychological therapy should be the first line of treatment, and patients should only be referred for surgical opinion if they	

	do not respond to this first line of treatment. This pathway is not mentioned in the policy document. RCS guidance does not prescribe a single injection in the circumstances outlined in the policy, and the guidance should not be referenced in this way. According to the BOA, the priority for improving back pain care is implementation in full of the National Pathway of Care for Low Back and Radicular Pain, which is supported by NHS England. Furthermore, it may be sensible for CCGs to delay implementing the proposed policy until after NICE has consulted on Guidance on Low Back Pain and Sciatica13, to ensure the policy is aligned with NICE guidance14. The engagement closes on 5 May.	WG confirmed: • That a Functional Restoration Programme was one of a number of nationally recommended options at an Intermediate level of care (this could be delivered in both acute and non-acute settings). • That the policy should reflect the clinical management journey: Primary/Intermediate/Secondary care rather than between non-specific/specific/chronic back pain. • Epidurals and nerve root injections for radicular pain are a recognised treatment (per http://bja.oxfordjournals.org/content/111/1/112.short) . This policy currently is restricted to the Back Pain rather than Radicular Back Pain pathway. During 2016/17 this policy will be cross-referenced and updated where appropriate to the current Birmingham and Solihull Scheduled Care SRG pathfinder project on Spinal Surgery and Back Pain. At that stage Radicular (nerve pressure) Back Pain will be incorporated into this policy. • There were a number of other specific back pain secondary care management queries which the WG believe are covered by the 2013 RCS/BOA high value pathway for Low Back Pain. • FRP has been formally commissioned by Birmingham Crosscity CCG and will be expanded in 16/17 financial year. • Currently 12 hours of combined physical and psychological therapy are commissioned. Further NICE guidance will be published in September 2016 and this will be reviewed and the policy amended where appropriate. The WG agreed that the policy needed to cross
ROH	Firstly it is very disappointing that our previous comments in response to the “harmonised commissioning policies” dated 14th July 2015 have been ignored. Our previous comments were well reasoned and in line with best practice. The Trust Spinal and MSK Team scrutinise every decision to offer spinal injections and now utilise the FRP for patients presenting with non-specific low back pain with excellent outcomes. It is unclear from the Policy whether FRP is supported and what classification of back pain patients will be funded for this treatment. The classification of low back pain into 'non-specific', 'specific' and 'chronic' does not reflect clinical practice. There is no definition of the difference between specific and chronic low back pain, or clear differentiation of non-specific low back pain (NSLBP). In the discussion on NSLBP the policy states “This is because in the first instance NICE recommends does not recommend non-pharmacological or invasive procedures”, this may indicate the authors	

	don't actually know what NICE states! There is no mention of the spinal task force or pathfinder documents which have superseded the NICE guidelines. From a clinicians perspective these later documents are more widely accepted. The policy indicates that spinal injections will not be funded, as patients should be referred to a "combined physical and psychological treatment programme "(CPP) for 100 hours. Please can the commissioners confirm where they have placed this contract for 100 hours CPP for each patient and how the Trust accesses this service as otherwise the commissioner is asking the Trust to use a treatment that is not available and not to use one that is available. With regard to specific back pain, the policy cites that all patients need MDT agreement before using injections etc. The real impact of this is unworkable. MDT's are very busy discussing patients for surgery and with complex problems. There simply is not enough time to discuss patients for injection without reducing current activity levels in clinics or theatres. The policy also indicates that injections should only be considered if patients have had symptoms for >12 months. This is a major concern as the policy appears to prohibit a young person, off work due to low back pain (non-specific) that fails to settle in 3 months or so, from having any injections for 12 months (facets only then). People with symptoms severe enough to keep them off work who fail to settle with normal conservative treatment may see benefit from a one-off epidural to try and help them maximise the effect of rehab and return to work more quickly. There is very clear evidence that if a patient is off work for more than 3 months with back pain, then their chance of returning to that job drops dramatically. A 12	reference to current/ongoing Birmingham and Solihull Scheduled Care SRG pathfinder project on Spinal Surgery/Back Pain which ROH is a party to (see attached national pathway reference paper). The current draft policy follows the Back Pain element of the national Pathfinder Pathway but not the Radicular (nerve pressure – including sciatica) Back Pain element of the national Pathfinder Pathway.

	month wait for potential treatment will increase long term disability significantly leading to greater reliance on social support/benefits and greater costs . We would also wish the commissioner to clarify that the Trust can continue to offer epidurals and nerve root injections for radicular pain. Within non-specific LBP there are subgroups with a more specific structural potential cause for LBP i.e. spondylolisthesis, single level disc degeneration (and a subgroup of these patients do well with fusion surgery, whereas others do well with FRP). The policy states that FJI will be commissioned if a patient has been trialled on 'max analgesia'. Does this mean exposing older patients to escalating doses of opiates with the risk of debilitating constipation (and the health effects associated) as well as the common side effect of dizziness, drowsiness and consequent falls? The Trust already has an agreed criteria for spinal injections, for example within a diagnosis of mechanical LBP either with or without a specific potential structural identifiable cause, some patients present with a clear extension pattern or weight bearing related pain pattern and facet joint injections should be considered for these patients, if conservative treatment has failed and if the patient is > 65. If there is minimal benefit (measured for instance on a self-reported % improvement, ODI score or walking tolerance improvement), the Trust does not repeat the injection. If there is good improvement for up to 6/12 consider repeat injections (or consider rhizolysis.) If there is good improved but only short term, consider medial branch block/ rhizolysis. There is also empirical evidence that an epidural injection can improve stenotic LBP and therefore should be considered at least as a one off treatment and repeat only if there is significant improvement for up to 6/12.	

	For those patient who have mechanical LBP who do not fulfil the above criteria injection treatment should not be considered and similarly injection treatment should not be considered for those patient with widespread pain, significant distress, external locus of control and other psychosocial factors that might predict a poor prognosis or over reliance on injection treatment. The Trust Team feel that there should be scope for the clinician to be able to offer injection treatment if felt it was clinically appropriate and the patient should have the choice of at least a trial of injection treatment rather than taking large amounts of analgesic and/ or opiates to manage their pain. The patient should be fully counselled on the level of evidence behind injections, risks and anticipated benefits and it should be clearly explained that injections will only be repeated if there is sustained and significant benefit. In addition we note that for chronic back pain, the only treatment considered is radiofrequency lesioning of the facet. Patients with chronic pain (>3/12) often need a kick start and rehabilitation. The use of injections, in appropriate situations, can facilitate this. If introduced in its current format, the commissioners will need to understand that many referrals into spinal surgical services will be returned to the GP without the patient being seen as there will clearly be no option available to the surgeon, once an MRI has excluded serious pathology	

BOTULINUM TOXIN FOR HYPERHIDROSIS

Respondent	Comment	CCG Clinical Working Group Response
Survey Response	I get a lot of night sweating and sweat a lot in the day I have to watch I wear during the day also when I go out when I wear a	Feedback on (i) personal impact of condition; (ii) need to consider impact on an individual's life improvement.

	coat I cannot wear a jumper underneath because it causes me to sweat too much so yes I think this treatment should be as it is and not taken out and should be left as it is.	The WG felt that current policy draft was clinically sound and should not be changed.
Survey response	This should focus on what the outcome (rather than output) has achieved for the person. How has it improved their lives.	
HEFT	Medicine - not seen to be applicable in HEFT (awaiting comments from neurology about botulinum toxin use)	

CATARACTS

Respondent	Comment	CCG Clinical Working Group Response
Survey response	Cataracts ruin the lives of older people by preventing them from pursuing lifetime interests in which they may be highly skilled such as close-up photography and the identification of insects and flowers. The failure to get a close friend of mine's cataracts dealt with ruined the last year of his life and prevented him from contributing to scientific studies. Finally he could not find his way on a sunny day to a lavatory block only 25 yards from where he was sitting on a beach and on another day panicked because he could not see me when 50 yards away. Not only could he do nothing, I could not either because he could not be left for long enough for me to get where I needed to be, creating needless dependency and preventing me from getting even a short break from caring responsibilities to pursue our joint interests.	The WG felt that purely undertaking cataract surgery on relatively subjective lifestyle factors would lead to further growth, over and above trend demographic growth, that might mean that patients receive cataract surgery when not yet clinically necessary. Therefore the WG were not minded to change the current draft with the linkage of visual acuity **and** disabling life factors before NICE publish their guideline for the diagnosis and management of cataracts in April 2018 (https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0741). UHB further commented that: • Final bullet point should read: 'Patients with glaucoma who require cataract surgery to contract control intraocular pressure.' The Working Group meeting on 14th April agreed that policy text should be amended.
RNIB	We agree with the introduction of a harmonised policy across the Birmingham area. RNIB welcomes the aim of ensuring consistency and fairness across the region in regards to access to cataract surgery. These proposals will help to ensure equity of service provision across the region. **Eligibility criteria**: We agree with the stipulated changes in the eligibility criteria as they are based on the recommendations made by the Royal College of Ophthalmologists. We welcome the proposal for CCGs across Birmingham and Solihull to lower the	

Respondent	Comment	CCG Clinical Working Group Response
	visual acuity threshold from 6/12 to 6/9. We believe the change will enhance accessibility to cataract surgery and will in turn significantly benefit those patients whose cataract is impacting on their day to day activities. Once a patient is diagnosed as having cataract surgery, their vision will only worsen and they will be forced to live with sight loss unnecessarily. Sight loss can lead to depression, social isolation and fall-related hip fractures which can be costly to commissioners in the long-term. Enabling patients to access cataract surgery will enable them to remain independent. RNIB believes that patients should be eligible for cataract surgery if they experience disabling visual symptoms attributable to their condition. This is in line with the latest commissioning guidance from the Royal College of Ophthalmologists, which was developed using a NICE accredited process. The guidance notes that: the sole use of visual acuity can underestimate visual disability because it does not take account of symptoms such as glare or reduced contrast sensitivity. It also adds that: although visual acuity remains a useful component of the assessment of visual disability from cataract, cataract surgery should be considered in the first eye or second eye of a patient who has disabling visual symptoms attributable to cataract. For instance, a patient who experiences disabling glare due to cataract when driving may still achieve a visual acuity of better than 6/9 under ideal conditions of illumination RNIB believes that patients should be eligible for cataract surgery if they experience disabling visual symptoms attributable to their condition. This is in line with the latest commissioning guidance from the Royal College of Ophthalmologists, which was developed using a NICE accredited process. The guidance notes that: The sole use of visual acuity can underestimate visual disability because it does not take account of symptoms such as glare or reduced contrast sensitivity.	• The advice that '…but the Ophthalmologist should explain the possibility of total blindness if severe complications occur' is not relevant to a discussion of when cataract surgery should be commissioned and the WG agreed that this text should be deleted. The RC Ophthalmology 2015 Guidance on Cataract Surgery has the following sole comment on blindness. 'Cataract is the presence of visually impairing opacity in the eye's natural lens, which may occur in one or both eyes. Cataract is the leading cause of blindness in the world.' There is no statement in the RC Cataract Surgery guidance to suggest 'the possibility of total blindness if severe complications occur.' The Working Group meeting on 14th April agreed that the above sentence was not consistent with the Royal College guidance and should be removed. The WG meeting of 29th June further reflected on the fact that visual acuity is the most common measurement of visual function as it can be quickly and easily measured. However, the sole use of visual acuity can underestimate visual disability because it does not take account of symptoms such as glare or reduced contrast sensitivity. Significant improvements in visual symptoms and visual function may occur following cataract surgery even where the preoperative visual acuity is 6/6 or better. However, it is important to note that the risk of worse visual acuity after surgery also increases where the preoperative visual acuity is very good, so surgery

Respondent	Comment	CCG Clinical Working Group Response
	It also adds that: Although visual acuity remains a useful component of the assessment of visual disability from cataract, cataract surgery should be considered in the first eye or second eye of a patient who has disabling visual symptoms attributable to cataract. For instance, a patient who experiences disabling glare due to cataract when driving may still achieve a visual acuity of better than 6/9 under ideal conditions of illumination. **Access to second eye cataract surgery** We also welcome the fact that this policy applies to both first and second eye cataract surgery. This is line with the Royal College of Ophthalmologists guidance which states that "there is no evidence that patients are more tolerant of cataract in the second eye than the first eye. There is no justification therefore for routinely applying a higher threshold to the decision to operate for second eye cataract surgery. When removing a cataract from one eye and leaving the other with *a cataract a patient's vision will be out of balance, putting them at risk of falls. This is as a result of cataracts impacting on a patient's depth perception, such as judging the height of a step or curb, therefore, putting a patient's safety at risk.*	should be considered at this level of visual acuity <u>only</u> where the patient is experiencing significant symptoms attributable to cataract. The Royal College of Ophthalmologists' National Ophthalmology Database shows that, for the period 2006-2010, 3%, **5%** and 36% of eyes undergoing cataract surgery have preoperative visual acuities of **better than** or equal to 6/6, **6/9** and 6/12 Snellen indicating that before restrictions on access to cataract surgery based on visual acuity were commonplace, eyes with visual acuities of 6/9 or better accounted for less than 10% of cataract surgery. Although visual acuity remains a useful component of the assessment of visual disability from cataract, cataract surgery should be considered in the first eye or second eye of a patient who has disabling visual symptoms attributable to cataract. For instance, a patient who experiences disabling glare due to cataract when driving may still achieve a visual acuity of better than 6/9 under ideal conditions of illumination. This recommendation is consistent with advice from the Royal College of Ophthalmologists, and where implemented in local Commissioning guidance has been found to be practical and equitable. We also noted that in patients with learning disability or cognitive impairment for other reasons, it may not be possible to measure visual acuity accurately and in these cases, clinicians will need to base the clinical decision to offer cataract surgery on clinical examination findings and information provided by
Survey response	Criteria re driving should be modified I think. 'Unable to drive' - should be changed to 'unable to read road signs clearly'. For drivers, being unable to drive is serious, especially for those like me who have a long term condition that may affect mobility. Cataracts should not be allowed to affect daily living tasks, as in the old days, before they are treated. This would be likely to cause other emotional/social problems.	
Survey response	I am concerned that the criteria are too specific and do not seem to take account of the importance of reading and reading related activities to an individual's quality of life, and if the emotional and	

Respondent	Comment	CCG Clinical Working Group Response
	psychological impact of impaired sight.	carers. Therefore the WG has decided to propose removing the linkage between a visual acuity of 9/6 or worse **and** other disabling visual symptoms linked cataracts.
Survey response	It is unbelievable that in this age we would want people to struggle with poor eyesight, especially when so many health organisations are working to reduce the number of falls in the elderly population. If you do not help people who have impaired sight, you will have an escalation of falls in the elderly which will ultimately prove more costly for the NHS.	
Survey response	People do not seek medical advice until the cataract is causing problems with vision and daily living. A cataract will not resolve by itself. Why wait until it is so bad that it can cause accidents resulting in pain and further problems and also inevitably costs the NHS more?	
Survey response	Whilst a person does not meet the criteria for being blind. The condition when combined with other ailments may have an increased adverse impact on the patient. Therefore, this should not be looked at in isolation. We should be looking at the patient's quality of life and outcomes. Not purely outputs. Again, there should be additional questions.	
Survey response	As I am approaching the age when this could affect me, I am concerned that some elderly people maybe more or less blind before this procedure can be carried out. I have several friends who have had this procedure recently which has been extremely successful. However if you delay the operation until blindness is not far off, quality of life will be severely affected and I don't think this is acceptable.	
Survey response	You have stipulated that the patient now has to have "sufficient cataract to account for the visual symptoms." This does not appear in your "difference" column. I am concerned that this change could potentially affect the access of patients to cataract surgery with reduced VA due to other pathology such as AMD or glaucoma. The cataract may be significant but as it is secondary to another pathology would not be "sufficient to account for visual symptoms". A patient with RP may have dense cataract and intense glare symptoms. Removing the cataract may lessen but not remove the	

Respondent	Comment	CCG Clinical Working Group Response
	symptoms	
Survey response	I have never had cataracts but I know people who have had them and they can be very painful so this treatment/procedure should be left as it is.	
Local Eye Network, NHS England, West Midlands	The Eye Health Network is a multi-disciplinary network hosted by NHS England comprising a range of clinicians from across the eye health and sight loss sector including Ophthalmologists, Optometrists, Orthoptists, Ophthalmic Nurses and others. We have concerns that this change in Cataract PLCV would inappropriately restrict access to cataract surgery for some patients who would significantly benefit from the procedure, and who currently have access to cataract surgery with VA better than threshold because of 'agreed exceptions' within the current PLCV. Although the PLCV documents make reference to Cataract Commissioning Guidance from The Clinical Council for Eye Health Commissioning and Royal College of Ophthalmologists (February 2015), there may have been some misinterpretation. p8 states: "Visual acuity is the most common measurement of visual function as it can be quickly and easily measured. However, the sole use of visual acuity can underestimate visual disability because it does not take account of symptoms such as glare or reduced contrast sensitivity". It goes on to say "Significant improvements in visual symptoms and visual function may occur following cataract surgery even where the preoperative visual acuity is 6/6 or better. However, the risk of worse visual acuity after surgery also increases where the preoperative visual acuity is very good, so surgery should be considered at this level of visual acuity only where the patient is experiencing significant symptoms attributable to cataract". The first paragraph of the proposed change to PLCV for cataracts states: The patient should have sufficient cataract to account for the visual symptoms (6/9 or worse) AND/ OR should affect the	

Respondent	Comment	CCG Clinical Working Group Response
	patient's lifestyle o difficulty carrying out everyday tasks such as recognising faces, watching TV, cooking, playing sport/cards etc. Reduced mobility, unable to drive or experiencing difficulty with steps or uneven ground o Ability to work, give care or live independently is affected. This wording seems to make the assumption that visual symptoms only become affected at an acuity level of 6/9 or worse, but from a clinical perspective, there are certain patients (as indicated above in the extract from Cataract Commissioning Guidance) who experience significantly disabling symptoms with visual acuity better than 6/9, who would benefit from cataract surgery. Historical data from The Royal College of Ophthalmologists' National Ophthalmology Database indicates this number is relatively low, and eyes with visual acuities of 6/9 or better accounted for less than 10% of cataract surgery before thresholds were in place. Whilst the reduction in acuity threshold from 6/12 to 6/9 is welcomed, the wording on the document requiring VA of 6/9 or worse AND impact on lifestyle does not allow for a holistic patient-centred clinical assessment of visual need for the surgery. Instead of using the current wording "The patient should have sufficient cataract to account for the visual symptoms (6/9 or worse) AND should affect the patient's lifestyle..." If 'AND' was replaced by 'AND/OR to give new wording of: "The patient should have sufficient cataract to account for the visual symptoms (6/9 or worse) AND/ OR should affect the patient's lifestyle This small change would allow appropriate clinical input to a decision about cataract surgery based on the patient's need rather than relying on visual acuity. If this wording is changed, those patients who have visually disabling symptoms attributable to cataract with VA better than 6/9 would now have access to surgery if appropriate, and not be restricted by the harmonised PLCV policy. Patients with VA better than 6/9 but	

Respondent	Comment	CCG Clinical Working Group Response
	without visually disabling symptoms would still be restricted by the harmonised PLCV policy. I would be grateful if you would consider these comments so that any changes made to cataract PLCV do not inadvertently restrict those patients who have genuine needs. I would be very happy to have further dialogue to explain this in more detail if required.	

CHOLECYSTECTOMY FOR ASYMPTOMATIC GALLSTONES

Respondent	Comment	CCG Clinical Working Group Response
Survey Response	My gallstones were asymptomatic until my gall bladder turned necrotic and gangrenous, leading to complications when it was removed leaving me with on-going pancreatitis. Therefore the approach of leaving them would seem to me to be a bad one. However as previously stated I am not medically qualified, nor am I aware of the research behind these recommendations. I am therefore not sure of the purpose of this engagement s approach.	The WG response was that the draft policy represented RCS recommended practice and therefore no change to clinical criteria should be made.
Survey response	Leave policy in place	

DILATION AND CURETTAGE (D&C) FOR MENORRHAGIA

Respondent	Comment	CCG Clinical Working Group Response
Survey Response	What affect this has on the patients daily activities? To what extent would the desired outcome be met by the provision of the alternatives on offer, and what impact will these have on the patients' daily activities?	The WG view was that the policy for Commissioners and Providers reflected current NICE guidance and therefore no change to the policy should be made.
Survey response	Impact on ultrasound services is to be expected. Increase in referrals. Is there sufficient capacity locally?	

EYELID SURGERY (UPPER AND LOWER) – BLEPHAROPLASTY

Respondent	Comment	CCG Clinical Working Group Response
Survey Response	I don't agree about this policy because if people want it they should pay for it or prove that it's not for cosmetic reasons	With regard to Chalazion (meibomian cyst) the WG on 29th June was of the view that unless acutely infected, it is harmless and nearly all resolve if given enough time. If conservative therapy fails, chalazia can be treated by surgical incision into the tarsal gland followed by curettage of the retained secretions and inflammatory material under local anaesthetic. The policy document will be amended to reflect this clarification. The WG reiterated that the existing draft policy allowed for surgical treatment of congenital ptosis(drooping eyelid) from birth.
Survey response	I am not medically qualified. As such the presentation of CCG policies to me to comment on is not appropriate. Please reconsider the approach you are taking with the engagement to make the best use of you patient panel	
Birmingham Children's Hospital	Upper Eye Lid Surgery - Does this cover Chalazia? Does this relate to all aged patients? If the visual field is affected [for children] then it should be corrected. Having ptosis with or without visual field defect affects life chances (jobs etc) according to some research.	

GANGLION

Respondent	Comment	CCG Clinical Working Group Response
Survey Response	I think Consultant Surgeons should be able to determine the risk/benefits of surgery in the best interest of the patient. There may be patients (albeit low numbers) that may still be deemed to benefit from the surgery despite them not meeting every criteria for eligibility. There may be specific social/employment factors that the commissioning policy does not take account for. The IFR process is not sensitive enough for this cohort of patients and does not take into consideration social/occupational factors. Ganglions can affect a person's ability to work. The process takes	The ROH commented that it is rare for Ganglions to cause neurology and therefore questioned the merit of a Nerve Conduction Study. The ROH felt that the existing criteria in operation should be adopted, namely: • Surgery for ganglia will be funded where painful lump causing disabling pain on activities of daily living and/or work; • Surgery for mucous cysts will be funded when causing distortion of nail growth and discharge

	too long and early intervention saves pain and discomfort.	predisposing to septic arthritis. The WG considered this feedback and were minded to agree to the above changes as long as ROH could indicate how disabling pain could be objectively/consistently measured. Regarding 'disabling pain' Commissioners have written to the ROH to request support in providing the policy wording to determine/demonstrate an objective measure for disabling pain that clinicians should use.
Survey response	This is certainly not a vital procedure and should be a low priority.	
Survey response	I have never had any treatment for a ganglion and if I have one of these if they stay small then they should left alone and treatment only available if they become bigger.	
Survey response	Pain should be a criterion as it is debilitating and can cost more in the long run. Pain has been removed as an indication for this surgery and should remain. Ganglions can be very painful so should be included in this policy.	
Birmingham Children's Hospital	Carpel Tunnel - further discussion	
ROH	Our specialist hand surgeons have observed that the neurological effect described in the policy is NOT a clinical entity, it is extremely rare for ganglia to cause neurology and even more unlikely to cause positive Nerve Conduction Study (NCS) results, the latter have never been performed for a ganglia! The clinicians are of the view that if this commissioning policy is introduced the Trust would not be able to carry out the optimum treatment for patients with a diagnosis of carpal tunnel and would be returned to primary care for the GP to refer with a positive NCS – which effectively means the Trust would not be referred any patients with a Ganglia! It should be noted that palm ganglia are often very close to the digital nerve and therefore this raises obvious safety concerns regarding the puncture with needle as suggested (aspiration). This policy does not account for recurrent or persistent ganglia causing functional problems and we assume, just presumes they all go away. It should be noted that the wording in the RCS and BSSH is most go away, not all - this has been overlooked 5 We would point out that the previous eligibility criteria were agreed after a serious attempt by the previous commissioners to consult and engage our clinical team and we would recommend the existing criteria shown below are adopted:	

	• Surgery for ganglia will be funded where Painful Lump causing Disabling Pain on Activities of daily living and or work • Surgery for mucous cysts will be funded when causing distortion of nail growth and discharge predisposing to septic arthritis	

GROIN HERNIA REPAIR

Respondent	Comment	CCG Clinical Working Group Response
Survey Response	It should be focused on the patients' desired outcomes. What may be acceptable for one patient may not be for another. An individual's daily activities will depend on a number of criteria including their work and other commitments.	The RCS commented that the draft policy omits RCS guidance which 'suggests that all patients who present with overt or suspect inguinal hernia should be referred for surgical hernia repair.' The WG accepted that a key sentence which had been part of line of an earlier draft had been omitted in error and that it should re-include the following criteria: • 'all patients with an overt or suspected inguinal hernia to a surgical provider except for patients with minimally symptomatic inguinal hernias who have significant comorbidity (ASA grade 3 or 4) **AND** do not want to have surgical repair (after appropriate information provided)'
Royal college of Surgeons	**Hernia repair** RCS guidance has been misrepresented for hernia repair. The policy states that only irreducible or partly reducible inguinal hernias, or those that cause pain that limits daily activity, or are strangulated or obstructed will be funded. RCS/SSA guidance suggests that all patients who present with overt or suspected inguinal hernia should be referred for surgical hernia repair8 Evidence in the European Hernia Society Guidelines shows that delaying inguinal hernia surgery causes the need for later surgery in the vast majority of patients, which can be more difficult in older patients. The British Hernia Society is concerned that the CCGs' policy contradicts available evidence and puts patients at risk	

GROMMETS

Respondent	Comment	CCG Clinical Working Group Response

Survey Response	The policy does not look at quality of life. Having persistent ear infections is painful and requires time off work/school. The procedure is successful and can stop this pain and discomfort. All these changes are more to do with finances and not health and wellbeing.	The WG agreed that the policy title needs to state this is for patients >3 years and <12 years and therefore would not impede grommets for under 3s prior to Cochlear Implantation or children aged 12+ with speech development problems. The WG considered the BCH and RCS comments and commented that this was a restricted procedure that was still available to patient if the clinical criteria were met. The WG agreed to make the policy title more explicit to show that the policy was specifically for children aged 3 and over and under 12. The WG reviewed NICE CG60 - Otitis media with effusion in under 12s: surgery does not include a requirement for '5 or more episodes of glue ear in a child before referral.' This requirement was included in the earlier SIGN – Clinical Guidance 66: Diagnosis and management of childhood otitis media in primary care. The Working Group meeting on 14th April agreed that the above criteria was not consistent with NICE CG60 and should be removed from the draft policy.
Survey response	Advice on managing behaviour as a result of poor hearing is vague. Who will offer advice and what will it be? It should be a specialist able to provide parents with effective tools. Waiting to meet the criteria is a long time and lasting impact on the child's development and behaviour is a risk.	
Birmingham Children's Hospital	This is not accepted. Children with persistent glue ear that require cochlear implantation are usually younger than 3 yrs. The age range is completely inappropriate for our patients. They need grommets prior to cochlear implantation to make the CI surgery safer and also reduce the chance of infection. Plus the age for speech development is 2-3yrs old. A young child with persistent glue and hearing loss should be treated otherwise speech and language development will be delayed. Other children over the age of 12 with other pathologies (Cleft or Downs Syndrome) may also require grommets.	
Royal College of Surgeons	Rationale for a policy to document five or more episodes of glue ear in a child before being referred for grommets treatment is not evidenced in RCS/SSA or NICE guidance. NICE guidance states that the persistence of bilateral otitis media with effusion (glue ear) and hearing loss should be confirmed over a period of three months before intervention is considered, and that the child's hearing should be tested at the end of this period. The CCGs' policy does not mention re-testing and hearing loss, which raises concern as hearing loss often, goes undetected without formal testing. ENT UK also stresses that glue ear that may require intervention with grommet insertion is a chronic disorder and not an episodic acute illness. Such a chronic condition may induce recurrent episodes of acute otitis media as well as hearing loss.	

HAEMORRHOIDECTOMY

Respondent	Comment	CCG Clinical Working Group Response
Survey Response	This is a miserable condition which responds well to a fairly cheap procedure. Why cause suffering when it is so easy to relieve it? I was grateful to have this procedure as I had been in serious discomfort and it was affecting my quality of life	The WG was satisfied that the draft policy was consistent with national commissioning guidance on the treatment of rectal bleeding. However the WG did feel that it was necessary in the policy to make clearer the eligibility as follows: • Minor text changes to confirm that pre-Haemorrhoidectomy recommended treatments such as Rubber Band Ligation and Injection of a Grade 1 or Grade 2 Haemorrhoid can still be undertaken in a clinic setting. • For Grade 3 or Grade 4 cases replace the term 'surgical treatment ' with 'Haemorrhoidectomy' and replace Roman numerals (III/IV) with standard number. Note: • Grade One: No prolapse • Grade Two: Prolapse that goes back in on its own • Grade Three: Prolapse that must be pushed back in by the patient • Grade Four: Prolapse that cannot be pushed back in by the patient (often very painful)
Survey response	This is totally dependent on the patient's ability to carry out the suggested alternatives (they may not be physically able to reinsert the vein)	
Survey response	Pain (again can be subjective and would suggest that there are further questions/supporting questions relating to carrying out daily activities and also passing motions).	
HEFT	Gen Surgery - no changes noted and accepted. One question- banding of piles in outpatients not mentioned and assumed allowed	

HYSTEROSCOPY FOR MENORRHAGIA

Respondent	Comment	CCG Clinical Working Group Response
Survey Response	Quality of life - having to live with this is terrible. Has anyone given any thought to the Mental health of patients? Given the	The WG concluded that the policy is in line with NICE recommended practice.

	recent media publicity these policies are extremely short sighted. It should be focused on the patients' desired outcomes. What may be acceptable for one patient may not be for another. An individual's daily activities will depend on a number of criteria including their work and other commitments.	
Survey response	Impact on ultrasound services should be affected. Is there sufficient capacity locally?	
Birmingham Women's Hospital	The Trust approved the policies for Hysterectomy and Hysteroscopy in October 2015 and the contract was varied to accept these new versions	

HYSTERECTOMY FOR HEAVY MENSTRUAL BLEEDING

Respondent	Comment	CCG Clinical Working Group Response
Survey Response	Quality of life with heavy bleeding you become anaemic the psychological affect often leads to depression. Not in any of the policies is mental health considered!	The WG concluded that the policy allows for hysterectomy for HMB but not as a first line treatment and that this is in line with NICE recommended practice.
Survey response	Other treatments offer a different range of complications. A woman should be able to choose which treatment and therefore which complications she would prefer to risk. Consideration should also be given to the patients' ability to undertake the alternative methods. They may have a job or disability which would impact on the ability to undertake the alternative methods. Also, would the alternatives achieve the desired outcomes or purely lessen the effects for set periods.	
Birmingham's Women's Hospital	The Trust approved the policies for Hysterectomy and Hysteroscopy in October 2015 and the contract was varied to accept these new versions	

HIP REPLACEMENT

Respondent	Comment	CCG Clinical Working Group Response
Survey Response	Quality of life has not been incorporated into this policy.	The WG discussed at length the BMI criteria set in this

Survey response	I know of two people with very keen natural history interests whose lives were at an end until they got hip replacements. They could also no longer pass on their skills at fieldcraft to students or act as group leaders. At one indoor meeting, one of these people asked me to go 10 yards to fetch a cup of tea for them because they were in too much pain to fetch it for themselves. In other words, they could not cope in a domestic setting with everyday responsibilities before their operation. This cannot be cost-effective when they might easily live another 20 years needing expensive assistance!	policy, and concluded that there is not sufficient or unequivocal evidence either to support/ include or to not include a particular BMI for Hip replacement. The group agreed to amend the criteria and have no set BMI while more strongly emphasising the need for surgeons/anaesthetists to carefully assess the clinical risk of surgery for higher BMI patients where the ASA score exceeds 2. It also agreed that Commissioners should insert new text into main policy suite introduction to emphasise the importance of engaging with local Lifestyle Management services.
Survey response	If the elderly are unable to exercise there will be an escalation of other conditions such as obesity, high blood pressure and cardiac problems which will prove more costly for the NHS to deal with.	
Survey response	I think Consultant Surgeons should be able to determine the risk/benefits of surgery in the best interest of the patient. There may be patients (albeit low numbers) that may still be deemed to benefit from the surgery despite them not meeting every criteria for eligibility. There may be specific social/employment factors that the commissioning policy does not take account for. In addition the reduction in BMI thresholds for Hip replacements does not appear to be backed up by definitive published clinical evidence. The IFR process is completely driven by "exceptionality" and is not sensitive enough to take into consideration the surgeons experience and does not take into consideration social/occupational factors.	
Survey response	Patients are individuals and cannot be categorised by BMI alone. I should be the clinician and patient together who decide risks/benefits of surgery.	
Survey response	The policy on BMI contravenes the first statement: To ensure that procedures and treatments are offered consistently and fairly to patients. GPs are still referring these patients. This is nothing to do with efficacy or safety.	
Survey response	The decision to deny surgery to patients with intolerable arthritic hip pain with a BMI between 35 and 40 is completely unacceptable. It has no evidence base and it is purely a misguided method of attempted cost saving. Although every patient needs to be individually assessed for anaesthetic risk there is no evidence	

	that a blanket ban on surgery for patients with this BMI will do anything other than inflict unnecessary suffering on a particularly unfortunate group of patients. There are many joint replacement surgeons who can demonstrate excellent survivorship of hip replacement patients in spite of routinely operating on patients with a high BMI. If this policy is imposed by the CCG's it should be referred to NICE for clarification as to whether it has any evidence base and NICE should give an opinion on whether patients with a high BMI should be routinely denied surgery. If the CCG wishes to impose this policy then it should also have a policy to allow bariatric surgery for patients with a BMI between 35 and 40. If this is not done there will be a group of patients who cannot have their arthritic pain relieved but equally cannot have their obesity relieved either.	
Survey response	Hip surgery is costly, but effective. There may be a case for calling it of lower clinical value and not offering it for people above a certain age (70?), but maybe here's an opportunity for good public/private cooperation.	
Survey response	The policy on BMI contravenes the first statement: To ensure that procedures and treatments are offered consistently and fairly to patients. GPs are still referring these patients. This is nothing to do with efficacy or safety.	
Survey response	Directorate concerns have been expressed with respect to both Hip Surgery and knee replacement and inclusion of BMI>35 as a limiting factor. It is suggested that the evidence selected to support the limitation is selective and misrepresentative, secondly that there is a plethora of evidence to the contrary suggesting that the quality of life improves regardless of BMI.	
Royal College of Surgeons	Referring patients to hip and knee surgery only if their BMI is below 35 could affect a number of people, and the average prevalence of severe knee osteoarthritis is 6.8% across the population covered by the six CCGs: - The British Orthopaedic Association (BOA) challenges the decision of the CCGs to include hip and knee replacements	

	in a list of procedures of lower clinical value, considering the low QALY cost of the procedures; - There is evidence that prolonging the wait for total hip replacement in patients with severe pain and reduced mobility results in poorer outcomes from surgery, and this is outlined in NICE guidance for osteoarthritis; and - According to the BOA, there is no consistent evidence that patients with a high BMI who undergo hip replacement surgery, for example, do better or worse than other patient groups. In order to improve efficiency, we believe that reviewing local pathways to support early discharge and identify high-risk patients should take priority over implementing thresholds to access. The BOA also stresses that CCGs should ensure that knee arthroscopies are not being performed in the run up to knee replacement	
ROH	The Trust is disappointed that the Commissioner has to date, been unable to present any robust supporting evidence as to why the 'cut-off' for primary hip replacement surgery is to drop from a BMI of 40 to 35. The Commissioner stated intent is not supported by NICE or the British Orthopaedic Association and could be considered discriminatory and would caution the CCG in introducing a policy which does not have any supporting peer reviewed clinical evidence. The Commissioner has not overtly supported the Trusts proposal to extend its non-surgical hip and knee service to support patients with high BMI. The Trust will expect GPs to only refer patients to the Trust that do not evidently fulfil the eligibility criteria. 4 The Trust would recommend that the following additional eligibility criteria are also added.	

	Reference to any co-morbidities should have been appropriately evaluated and control optimised before referral.	

KNEE REPLACEMENT

Respondent	Comment	CCG Clinical Working Group Response
Survey Response	Basically the same as for hip replacements. I had a neighbour who had to walk cross-legged for years with a failed knee and was a new person after it was replaced.	The WG discussed at length the BMI criteria set in this policy, and concluded that there is not sufficient or unequivocal evidence either to support/ include or to not include a particular BMI for Hip replacement. The group agreed to amend the criteria and have no set BMI while more strongly emphasising the need for surgeons/anaesthetists to carefully assess the clinical risk of surgery for higher BMI patients where the ASA score exceeds 2. It also agreed that Commissioners should insert new text into main policy suite introduction to emphasise the importance of engaging with local Lifestyle Management services.
Survey response	If people are not mobile or are held back from having sufficient exercise there will be an escalation in other conditions due to lack of movement and exercise which may prove more costly for the NHS.	
Survey response	I think Consultant Surgeons should be able to determine the risk/benefits of surgery in the best interest of the patient. There may be patients (albeit low numbers) that may still be deemed to benefit from the surgery despite them not meeting every criteria for eligibility. There may be specific social/employment factors that the commissioning policy does not take account for. The IFR process is completely driven by "exceptionality" and is not sensitive enough to take into consideration the surgeons experience and does not take into consideration social/occupational factors.	
Survey response	I am concerned that there appears to be no provision for patients with a BMI>35 who for one reason or another is unable to achieve the required weight loss, but who might be in considerable pain and disability due to their knee pain. Is it expected that a IFR is completed for every patient who does not fulfil the criteria and if the answer to that is yes, will the GP do this in a timely manner to allow treatment to proceed?	
HEFT	Directorate concerns have been expressed with respect to both Hip Surgery and knee replacement and inclusion of BMI>35 as a limiting factor. It is suggested that the evidence selected to support the limitation is selective and misrepresentative, secondly that there is a plethora of evidence to the contrary suggesting that the	

	quality of life improves regardless of BMI.	
RCS	Referring patients to hip and knee surgery only if their BMI is below 35 could affect a number of people, and the average prevalence of severe knee osteoarthritis is 6.8% across the population covered by the six CCGs: - The British Orthopaedic Association (BOA) challenges the decision of the CCGs to include hip and knee replacements in a list of procedures of lower clinical value, considering the low QALY cost of the procedures; - There is evidence that prolonging the wait for total hip replacement in patients with severe pain and reduced mobility results in poorer outcomes from surgery, and this is outlined in NICE guidance for osteoarthritis; and - According to the BOA, there is no consistent evidence that patients with a high BMI who undergo hip replacement surgery, for example, do better or worse than other patient groups. In order to improve efficiency, we believe that reviewing local pathways to support early discharge and identify high-risk patients should take priority over implementing thresholds to access. The BOA also stresses that CCGs should ensure that knee arthroscopies are not being performed in the run up to knee replacement	
ROH	The Trusts Arthroplasty surgeons feel strongly that to refer to Total Knee Replacement as a procedure of “low clinical value” is disingenuous to the significant positive impact that such procedures have on those suffering with disabling arthritis. The surgeons are of the view that there is sufficient evidence that indicates that once a patient with a high BMI gets past the immediate post-operative stage their results are excellent. They are of the view that there should be discretion for the surgeon to determine the risk/benefit of surgery. As stated above, the IFR	

	process is not sufficient to determine this calculation. Once again we will expect GPs to be the gatekeeper and not refer patients to the Trust that do not evidently fulfil the eligibility criteria. The Trust would recommend that the following additional eligibility criteria are also added. Reference to any co-morbidities should have been appropriately evaluated and control optimised before referral.	

MALE CIRCUMCISION

Respondent	Comment	CCG Clinical Working Group Response
Survey Response	Should be looking at overall outcome.	The WG believes the current Medical Circumcision policy contains appropriate clinical criteria. However it agreed that individual CCGs were free to operate a supplementary local policy on Religious Circumcision if their Governing Body elected to.
Survey response	Surely there are no circumstances under which a circumcision for religious reasons should be performed under NHS so why is there any need to add referral to CCG to this policy ?	
Survey response	I am not medically qualified. As such the presentation of CCG policies to me to comment on is not appropriate. Please reconsider the approach you are taking with the engagement to make the best use of you patient panel.	

PENILE IMPLANTS

Respondent	Comment	CCG Clinical Working Group Response
Survey Response	If this is the only treatment available then it should be provided. Definitely none urgent PLCV. It should be focused on the patients' desired outcomes. What may be acceptable for one patient may not be for another.	The WG reflected that in January 2016 NHS England started a engagement on an evidence review of penile prosthesis surgery and its initial conclusion is that 'evidence to support the use of penile prosthesis implantation in men with erectile is predominantly of low level evidence.' NHSE further comment that to date no review of cost effectiveness of the treatment has been undertaken. NICE has not published clinical guidance on
HEFT	Urology - penile prostheses for intractable impotence is important for a small number of patients	

		Erectile Dysfunction (ED) in terms of clinical effectiveness, safety and tolerability and cost effectiveness. If NICE do evaluate treatments of ED, specifically penile prosthesis surgery, Commissioners will review and update this policy.

TONSILLECTOMY

Respondent	Comment	CCG Clinical Working Group Response
Survey Response	GPs need to ensure episodes treated at urgent care / out of hours providers are included in the count. Records are not currently linked leaving parents waiting longer than necessary for a referral to ENT.	The WG agreed that it was appropriate to add a note confirming that Walk in Centre or Out of Hours documented episodes that had been communicated in writing to GP Practices are included in the episode count. The WG at its meeting on 29th June meeting noted the additional comments by BCH but did not consider them to necessitate a change to the draft policy access criteria.
Survey response	There is no mention of other indications for tonsillectomy other than tonsillitis.	
Birmingham Children's Hospital	Tonsillectomy– Requires further discussion On 6 June 2016 BCH added that often renal patients have them removed at the request of the nephrologists as tonsillitis infections can further damage the kidney.	

TRIGGER FINGER

Respondent	Comment	CCG Clinical Working Group Response
Survey Response	This can seriously impact on the use of the hand and again should be considered on individual merit.	The WG reflected on the feedback given and noted that The British Society for Surgery of the Hand (BSSH) in its 2011 guidance comments: people with insulin-dependent diabetes are especially prone to triggering, **but** most trigger digits occur in people without diabetes. GP members of the WG commented that most diabetic or non-diabetic patients with Trigger Finger are in fact treated by steroidal injection rather than surgery and that
Survey response	I think Consultant Surgeons should be able to determine the risk/benefits of surgery in the best interest of the patient. There may be patients (albeit low numbers) that may still be deemed to benefit from the surgery despite them not meeting every criteria for eligibility. There may be specific social/employment factors that the commissioning policy does not take account for. The IFR process is completely driven by "exceptionality" and is not	

	sensitive enough to take into consideration the surgeons experience and does not take into consideration social/occupational factors.	there was no need in the draft policy to separately identify insulin dependent patients as the clinical protocol for pre-surgical treatment and surgical treatment apply to diabetic and non-diabetic patients.
Birmingham Children's Hospital	Trigger Finger – Requires further discussion	
ROH	The eligibility criteria are very similar to that previously agreed following clinical engagement, with the exception that the new PLCV does not refer to Insulin dependent diabetic patients. We would recommend that the following criteria are added: • Insulin dependent diabetic patient with trigger finger	

VARICOSE VEINS

Respondent	Comment	CCG Clinical Working Group Response
Royal College of Surgeons	The policy proposes to only surgically treat more advanced cases of varicose veins. Varicose veins that are not treated at an earlier stage are likely to deteriorate and require later surgery. For instance, patients with complications such as ulceration require additional treatment from other services, and this could have been treated at an earlier stage at a relatively low cost. According to the Vascular Society, this cost-effective treatment is beneficial as varicose veins impact on a patient's quality of life: - There is no real evidence base for the proposed initial treatments, and NICE guidance states that compression hosiery should only be offered as a permanent treatment if no other treatments are suitable; and - It is also of concern that the policy signals that if treatment for varicose veins is necessary, a clinician may first recommend the use of compression stockings for up to six months	The WG has re-reviewed NICE CG168 and agreed to: • Remove reference to compression hosiery pre-surgical treatment as this is not part of NICE CG 168. • Make more explicit NICE recommended pre-surgical options. • Emphasise that for patients who have 'varicose veins that have bled and are at risk of bleeding again' then they should be referred to secondary care immediately. The draft policy has been duly amended to reflect the above.

Survey Response	If you are on the NHS like me you should be given a choice as to what treatment you can haver and it should be up to you as a person what treatment you want e.g. if you want laser then you will be or if you want stripping then you should be given the operation and should not be told you have a choice if your surgeon suddenly jumps in and says you will have laser treatment even though you want surgery but the surgeon thinks you should be given laser treatment because it is cheaper or because it takes less time. So yes I strongly this that this treatment stays in place and the patient has a choice.	
Survey response	These are painful conditions that impact on the elderly who lose quality of life and independence. All GPs would need to offer rapid treatment and try other approaches if not working. This is often not the case.	
Survey response	Varicose veins can be both painful and unsightly. My long-term and more recent experience shows that, even though I suspect I did not fulfil the criteria indicated in the Policy Alignment, I did benefit from their removal. Therefore I suspect that this is a financial reduction of previously available beneficial surgery and not a 'harmonisation' of policy.	

Appendix 5: summary comments from the Birmingham and Solihull public engagement events – March 2016

- Policy criteria should take into account broader life factors impact
- Procedures classed as low value ‘seem’ to affect the elderly more
- Term ‘low value’ is inappropriate: not low value if you need it!
- Support the principle of evidence-based harmonised policies but should be nationwide
- What are the next group of treatment policies CCGs will develop?
- What is meant by ‘cosmetic’ in particular for children?
- Need to present policies in plain English that public understand
- Clinician/patient relationship important in deciding if a procedure should go ahead
- Suspicion that commissioning decisions will be made on cost grounds only
- More explanation needed on why these were considered ‘low value’
- People reassured that harmonisation wasn’t based on lowest common denominator e.g. cataracts policy
- People acknowledged that clinical practice changes over time e.g. hysterectomy, tonsillectomy
- Fairness as a principle supported but must ensure all GPs and Hospital Providers are following policies

Appendix 6: stakeholder communications

Birmingham CrossCity CCG

Stakeholder	Action	Date
People's Health Panel News (January Edition)	Newsletter	29/01/2016
Tweet sent via BXC CCG Twitter account	Social Media	02/02/2016
Patient Council	Email sent	02/02/2016
PPG Chairs' Forum	Email sent	02/02/2016
Action for Service User Groups (AFSUG)	Email sent	02/02/2016
Yardley Forum	Email sent	02/02/2016
Advocacy matters	Email sent	02/02/2016
Birmingham Faith Council	Email sent	02/02/2016
Masjid Hamza (Moseley)	Email sent	02/02/2016
Ghamkol Sharif Mosque	Email sent	02/02/2016
Green Lane Mosque	Email sent	02/02/2016
Representative Council of Birmingham and West Midlands Jewry	Email sent	02/02/2016
West Midlands Faith Forum	Email sent	02/02/2016
Faith Makes a Difference	Email sent	02/02/2016
Bosnia and Herzegovina UK network	Email sent	02/02/2016
Bournville Village Trust	Email sent	02/02/2016
New Hope	Email sent	02/02/2016
Mashriq Women's Resource Centre	Email sent	02/02/2016
SUFI Trust	Email sent	02/02/2016
Nash Dom CIC	Email sent	02/02/2016
Muath Trust- Yemeni Group	Email sent	02/02/2016
MECC Trust Ltd	Email sent	02/02/2016

Stakeholder	Action	Date
Yemeni Community Association	Email sent	02/02/2016
West Midlands Pensioner's Convention	Email sent	02/02/2016
Age UK	Email sent	02/02/2016
Disability Resource Centre	Email sent	02/02/2016
Alzheimer's society	Email sent	02/02/2016
Midlands Mencap	Email sent	02/02/2016
Deaf Cultural Centre	Email sent	02/02/2016
OSCAR Birmingham	Email sent	02/02/2016
SOLO	Email sent	02/02/2016
Parent Support Network for Autism	Email sent	02/02/2016
Forward Carers	Email sent	02/02/2016
Dementia Information Service for Carers (DISC) Crossroads care	Email sent	02/02/2016
ExtraCare Charitable Trust	Email sent	02/02/2016
Smallsteps	Email sent	02/02/2016
Stonewall	Email sent	02/02/2016
Birmingham Pride	Email sent	02/02/2016
Birmingham LGBT Centre	Email sent	02/02/2016
Broken Rainbow	Email sent	02/02/2016
Birmingham City University LGBT+ Society	Email sent	02/02/2016
Birmingham Parents' Support Group	Email sent	02/02/2016
New Road	Email sent	02/02/2016
Gires	Email sent	02/02/2016
FTM Birmingham	Email sent	02/02/2016
Emerge	Email sent	02/02/2016
Outskirts TransGender Group	Email sent	02/02/2016
Significant Others, Family, Friends & Allies (SOFFA)	Email sent	02/02/2016
Women's Consortium	Email sent	02/02/2016

Stakeholder	Action	Date
Mashriq Women's Resource Centre	Email sent	02/02/2016
Women's Aid	Email sent	02/02/2016
Relate	Email sent	02/02/2016
Relate	Email sent	02/02/2016
RSVP	Email sent	02/02/2016
Saheli Hub (Women's group)	Email sent	02/02/2016
Victim Support	Email sent	02/02/2016
Reducing Domestic Violence Project	Email sent	02/02/2016
The Birth Centre-Birmingham Women's Hospital	Email sent	02/02/2016
The Bethel Doula Service	Email sent	02/02/2016
Acorn Birth Services	Email sent	02/02/2016
Acupuncture Pre Birth Treatments & Induction	Email sent	02/02/2016
At One Day Spa - Antenatal Massage	Email sent	02/02/2016
Baby Bump Painting	Email sent	02/02/2016
Pinks and Blues CIC (miscarriage support)	Email sent	02/02/2016
Miscarriage Association	Email sent	02/02/2016
Homegroup (Stonham)	Email sent	02/02/2016
Ashram Housing Association	Email sent	02/02/2016
Stonham Birmingham	Email sent	02/02/2016
St Basils	Email sent	02/02/2016
St. Basil's Board	Email sent	02/02/2016
Birmingham Social Housing partnership	Email sent	02/02/2016
Trident Young Peoples Services	Email sent	02/02/2016
Birmingham Social Housing Partnership	Email sent	02/02/2016
Reach the Charity	Email sent	02/02/2016
BVSC	Email sent	02/02/2016
Citizens Advice Bureau	Email sent	02/02/2016

Stakeholder	Action	Date
Tweet sent via BXC CCG Twitter account	Social Media	10/02/2016
All B'ham MPs and Councillors	Email sent.	11/02/2016
People's Health Panel News (PLCV Bulletin)	Newsletter – Bulletin	23/02/2016
Facebook Post	Social Media	24/02/2016
Email to PPG Chairs' Forum Chair & Vice Chair	Email sent	25/02/2016
Email to Birmingham Council of Faith's Chair	Email sent	25/02/2016
Telephone call to Head of Community Development and Engagement at BID services.	Telephone call	25/02/2016
Follow up email to the Head of Community Development and Engagement at BID services following earlier phone call	Email sent	25/02/2016
Telephone call to the Disability Resource Centre	Telephone call	25/02/2016
Follow up email to the Disability Resource Centre	Email sent	25/02/2016
Telephone call to BLGBT	Telephone call	25/02/2016
Email to St Basil's	Email sent	25/02/2016
X2 Tweet re: PLCV	Social Media	29/02/2016
Article in People's Health Panel News	Newsletter	01/03/2016
Tweet re: PLCV	Social Media	01/03/2016
X2 Tweet re: PLCV	Social Media	02/03/2016
Tweet re: PLCV	Social Media	03/03/2016

PLCV – STAKEHOLDER COMMUNICATIONS RECORD
Solihull CCG

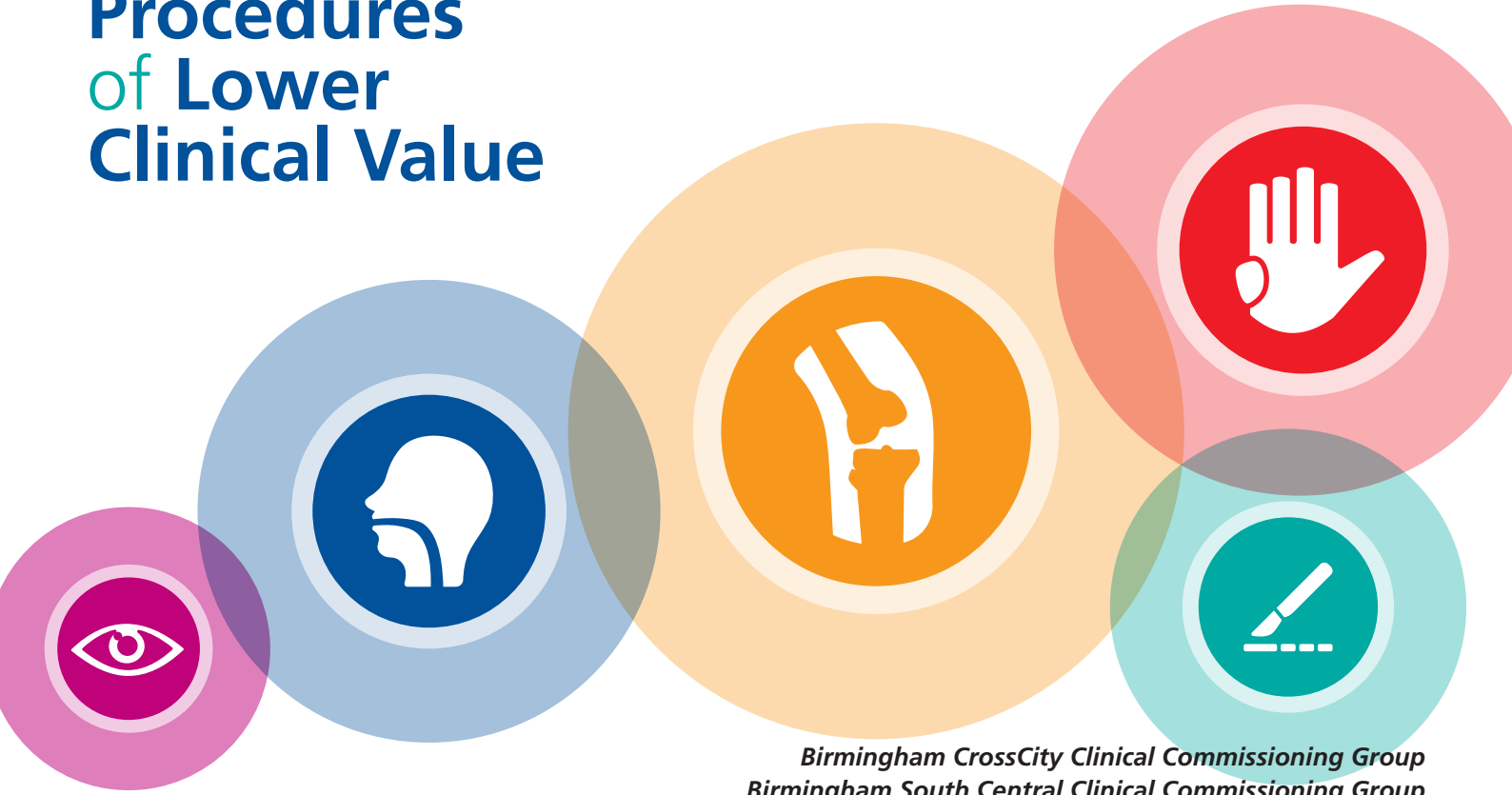
Stakeholder	Action	Date
BBCSol acute trusts	Drafts of harmonised policies shared for further review and clinical feedback	June/July 2015
Patient Voice Panel (PVP)	Briefly discussed as part of commissioning intentions topic	30/9/15
Wider stakeholders (including Your Health Your Voice (YHYV) members)	Item included in e-newsletter report of PVP meeting	5/10/15
GPs, PMs, PNs	Item in e-bulletin for practices	30/10/15
PVP	Focus group session – discussed how to engage/survey questions/3 new policies	17/11/15
Wider stakeholders inc. YHYV members	e-newsletter report of PVP focus group session	23/11/15
CCG staff	Team Brief meeting and inclusion in follow-up notes distributed to all staff and uploaded to intranet	25/11/15
Patient Participation Group (PPG) Network	Mentioned at network meeting	26/11/15
Julian Knight MP	Informed in regular meeting with Chair	27/11/15
Caroline Spelman MP	Informed in regular meeting with Chair	30/11/15
Governing Body GPs	Draft GP briefing shared for feedback	7/1/16
Solihull Metropolitan Borough Council OSC	Letter	8/1/16
GPs, PMs, PNs	Item in e-bulletin for practices	8/1/16
Patients	Leaflets & poster sent to all practices	w/c 18/1/16
Patients	Slide on waiting rooms screens	18/1/16
CCG staff	Team Brief meeting and inclusion in follow-up notes distributed to all staff and uploaded to intranet	26/1/16
PPG Network Wider stakeholders (including Your Health Your Voice (YHYV) members) (reach circa 300 email accounts)	Leaflets taken to network meeting, survey promoted Item as headline item in newsflash	28/1/16 29/02/16

PLCV – STAKEHOLDER COMMUNICATIONS RECORD
Birmingham South Central CCG

Stakeholder	Action	Date
Tweet sent via BXC CCG Twitter account		
GP Practices across BSC patch	Posters and leaflets	
BSC newsletter (February)	Email sent	09/02/16
Opticians in the BSC patch	Leaflets sent	16/03/16
Libraries in the BSC patch	Leaflets sent	16/03/16
BSC newsletter (March)	Email sent	09/03/16
Tweet sent via BSC CCG Twitter account	Social Media	10/02/2016
B'ham MPs within the BSC patch	Email sent.	15/02/16
Birmingham Councillors	Email sent	15/02/16
Newsletter February	Email sent	25/02/2016
X2 Tweet re: PLCV	Social Media	29/02/2016
Tweet re: PLCV	Social Media	01/03/2016
X2 Tweet re: PLCV	Social Media	02/03/2016
Tweet re: PLCV	Social Media	03/03/2016
Tweets re: PLCV events	Social media	07/03/16
Tweets re: PLVC	Social media	09/03/16

Appendix 7: public leaflet

Policy for **Procedures** of **Lower Clinical Value**



Birmingham CrossCity Clinical Commissioning Group
Birmingham South Central Clinical Commissioning Group
Solihull Clinical Commissioning Group

Introduction

Clinical Commissioning Groups (CCGs) across Birmingham, Solihull and the Black Country, have been working together to make a core set of Procedures of Lower Clinical Value (PLCV) consistent across the region.

Birmingham CrossCity, Birmingham South Central, and Solihull CCGs are keen to hear your feedback about changes relating to the criteria of the policies.

What is **PLCV?**

Some routine procedures are now described as 'Procedures of Lower Clinical Value' (PLCV). PLCV refers to procedures that are of value, but only in the right circumstances. The main objective for having PLCV policies is to ensure:

Patients receive appropriate health treatment, in the right place and at the right time.

Treatments with no, or a very limited, evidence base are not used.

Treatments with minimal benefits to health are restricted.

Why are we **looking** at **Procedures** of **Lower Clinical Value?**

At the moment, the criteria for a core set of PLCV may vary between areas. This can cause differences in the availability of some procedures between areas. You may have heard this called "postcode lottery" in the media and it can cause frustrations for both patients and clinicians.

The CCGs across Birmingham and Solihull believe there should be a single, consistent core set of policies which is fairer to patients. General Practitioners (GPs) and CCG staff have been working with colleagues from the local councils and public health to review each of the policies to ensure they are in line with robust clinical evidence and national guidance.

Which **treatments** are **affected?**

Here are some examples of the treatments that are classed as PLCV.

Cosmetic surgery (for example liposuction and breast augmentation)

Cataract surgery

Hip/knee replacement surgery

Removal of tonsils

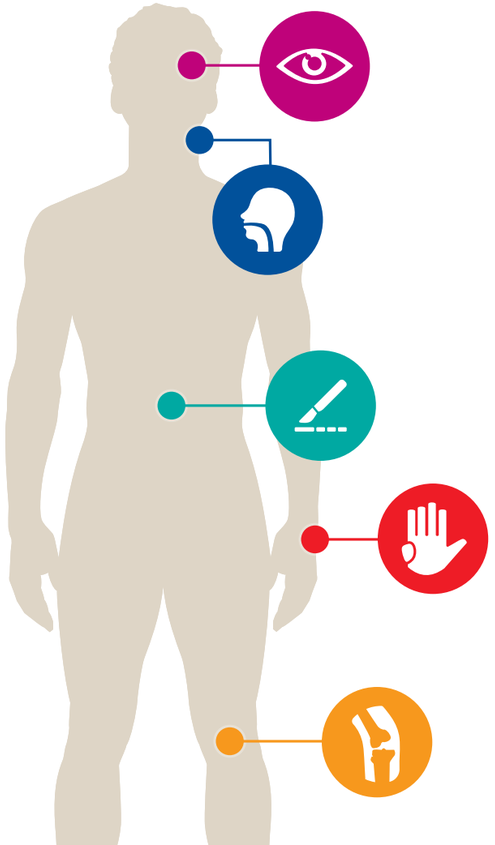
Ganglion cyst removal

A full list of all treatments, applicable exclusions and criteria is available on:

bhamcrosscityccg.nhs.uk

bhamsouthcentralccg.nhs.uk

solihullccg.nhs.uk



What does this **mean for patients?**

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

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

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

Does this mean that these procedures **won't be carried out anymore?**

No. All of the 45 procedures (21 policies) will still be available. However, the clinical access criteria for a procedure may have changed. If a patient doesn't meet the criteria in the policy, but the GP believes that their circumstances are exceptional, the GP can submit a request for the procedure to be paid for through an Individual Funding Request (IFR).

Is this about **saving money?**

No. The quality of care given to patients is the most important factor for these policies, not money. The development of these policies will help to ensure the NHS offers treatments, which are in-line with the latest available evidence.

Whilst we believe that standardising policies across Birmingham and Solihull will help us to deliver a more efficient service, our main priority is for PLCV to be offered fairly and consistently across Birmingham and Solihull.

How can I **have my say?**

You can give us your views by completing the survey at:

tinyurl.com/plcv-views-survey

For any queries email us at:

Involvement.mlcsu@nhs.net

Or call:

0300 404 2999 Ext 6852

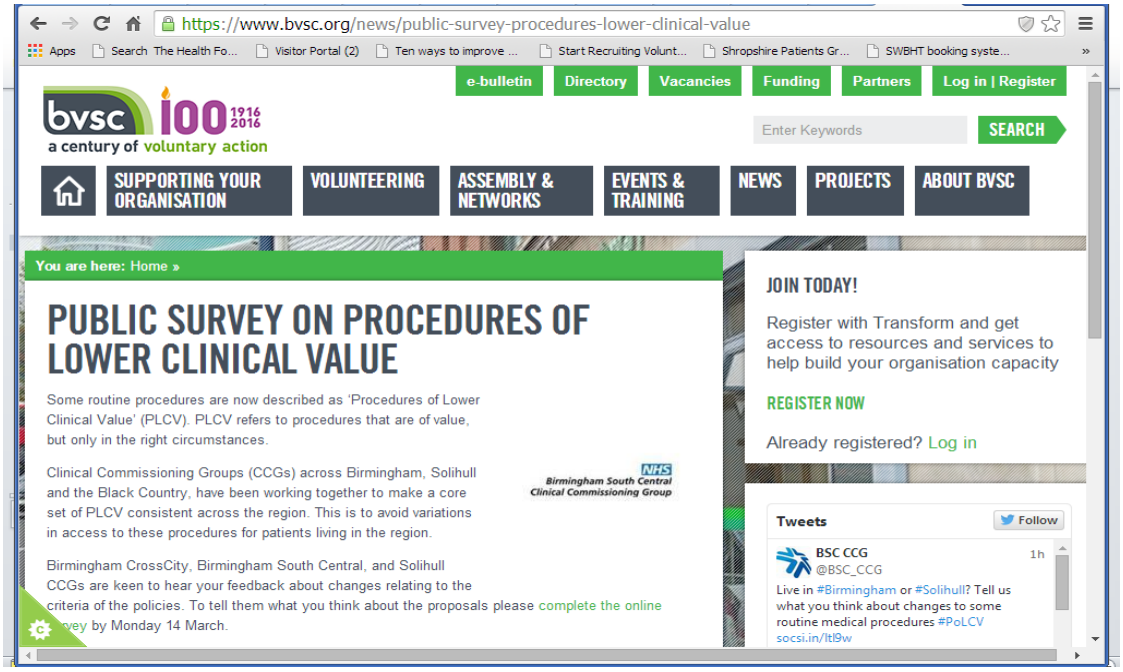
Standard call charges apply

Birmingham CrossCity Clinical Commissioning Group
Birmingham South Central Clinical Commissioning Group
Solihull Clinical Commissioning Group

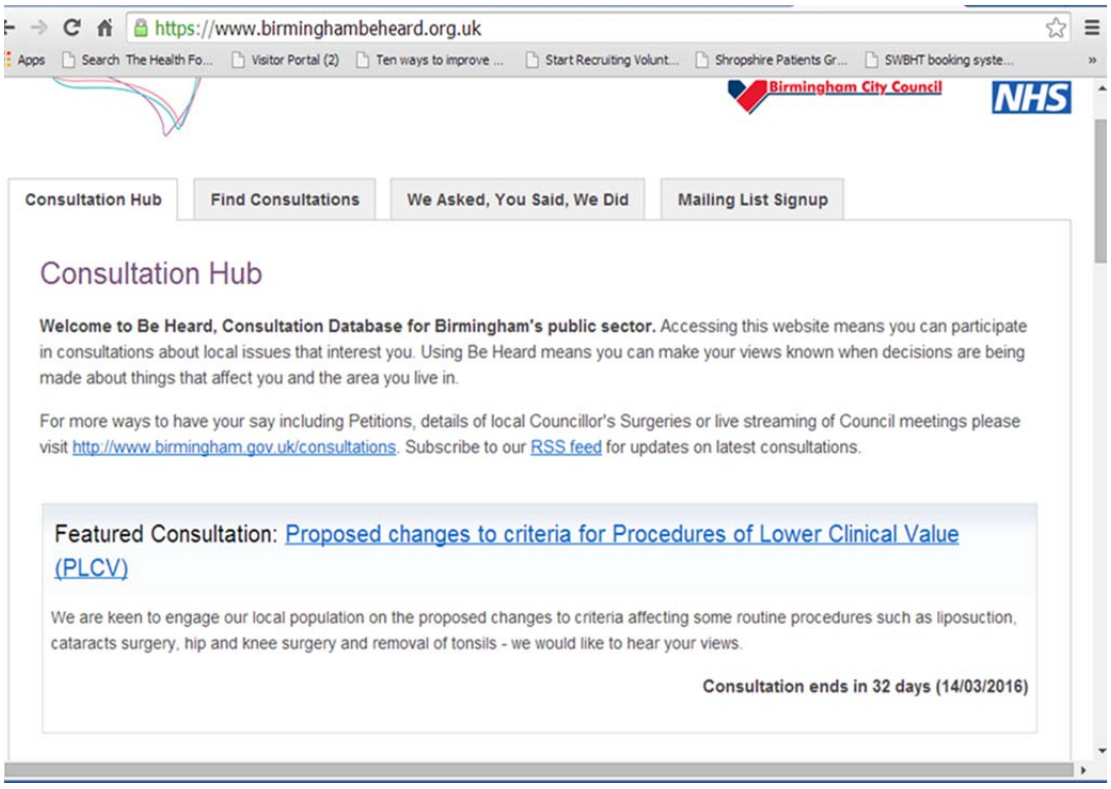
Appendix 8: media, websites and news releases

Websites

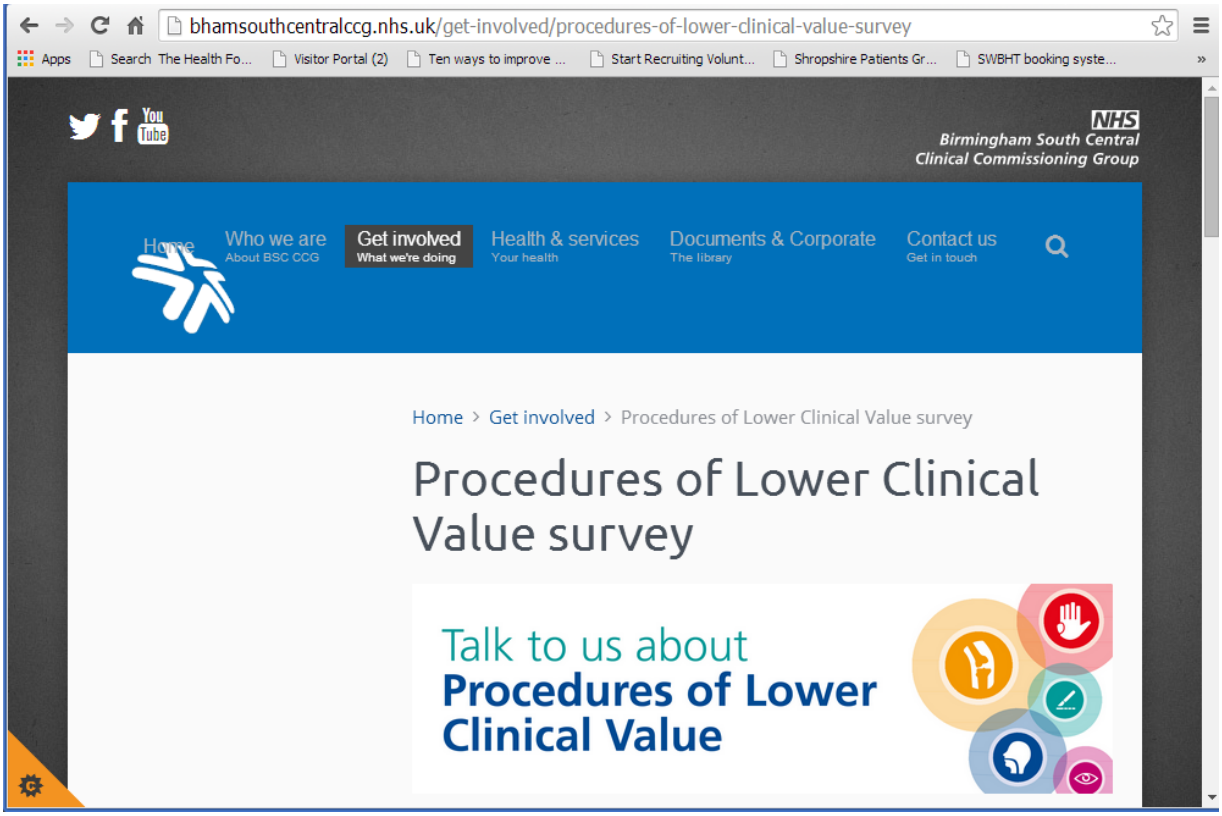
BVSC News article on website linking to the survey and CCG website

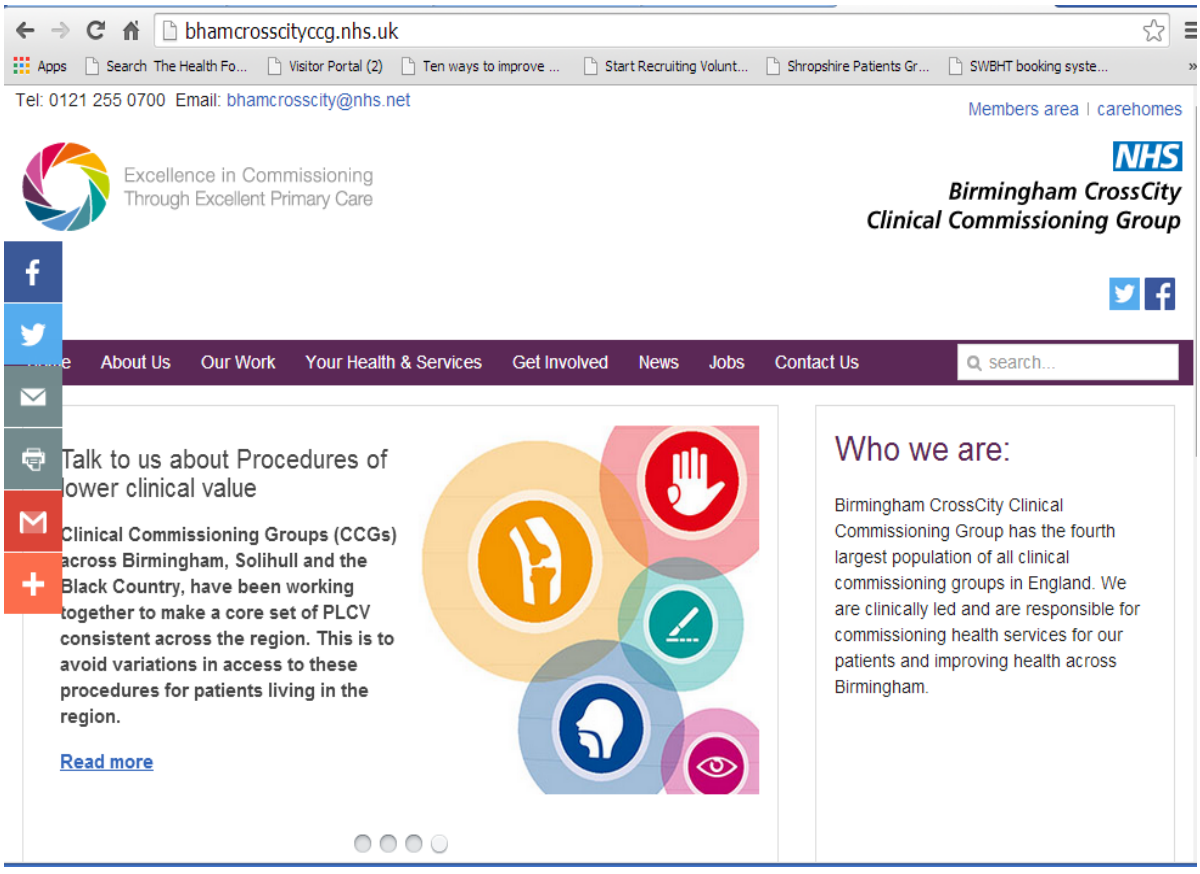


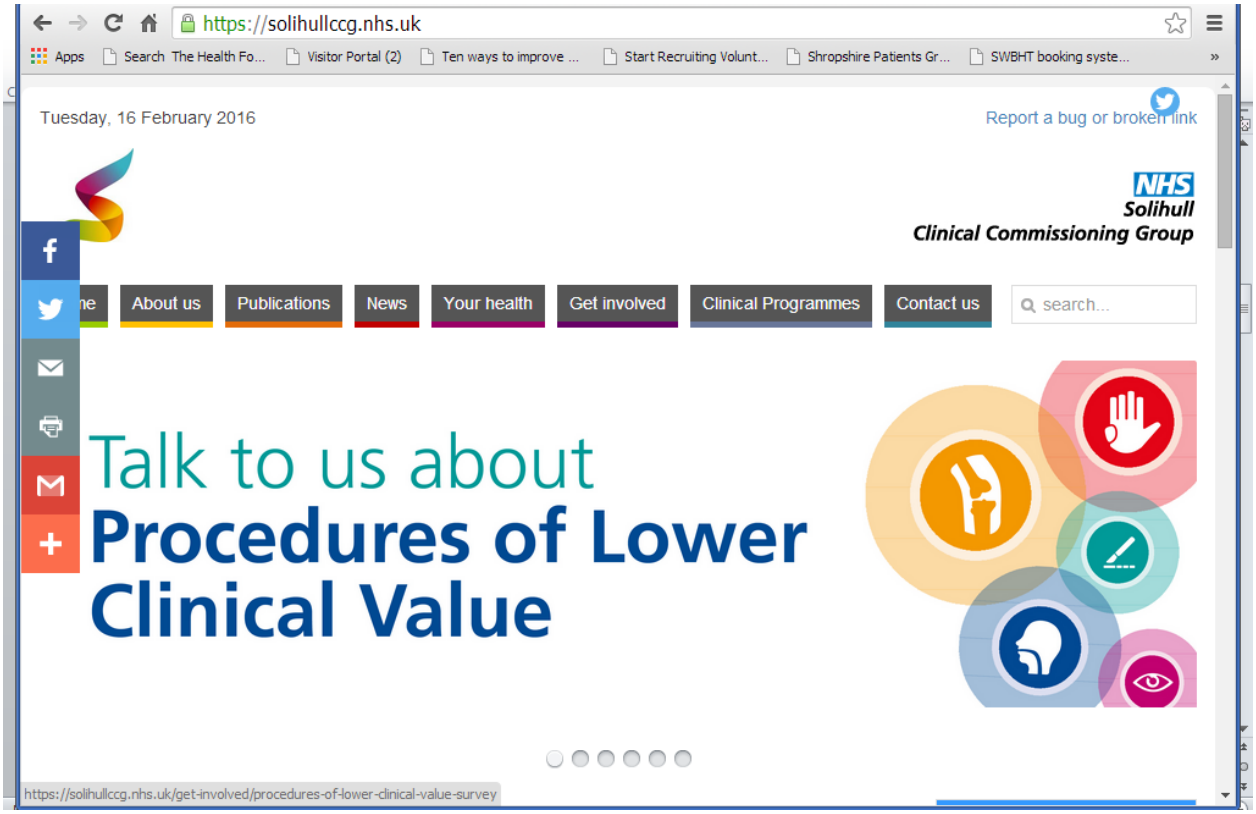
Featured engagement on **Birmingham BeHeard** (citywide engagement platform), also known as Citizen Space.



CCG websites






https://solihullccg.nhs.uk
Apps
Search The Health Fo...
Visitor Portal (2)
Ten ways to improve ...
Start Recruiting Volunt...
Shropshire Patients Gr...
SWBHT booking syste...
Tuesday, 16 February 2016
Report a bug or broken link
NHS
Solihull
Clinical Commissioning Group
About us
Publications
News
Your health
Get involved
Clinical Programmes
Contact us
search...
Talk to us about
Procedures of Lower Clinical Value
https://solihullccg.nhs.uk/get-involved/procedures-of-lower-clinical-value-survey

NEWS RELEASE

Date: 02 February 2016

Patients invited to share their views about Procedures of Lower Clinical Value

The NHS in Birmingham and Solihull would like to talk to patients about Procedures of Lower Clinical Value (PLCV).

PLCV refers to procedures that are of value, but only in the right circumstances. This is to ensure patients receive appropriate health treatment, based on the latest clinical evidence and national guidance. Some treatments under PLCV include procedures such as removal of tonsils, cataract surgery, liposuction, and hip and knee replacement surgery.

The Clinical Commissioning Groups (CCGs), who are responsible for buying health services for people in Birmingham and Solihull, are reviewing the clinical criteria for 21 policies to ensure they are consistent.

Local CCGs are asking the public to give their views on the proposed criteria by taking part in a survey which is available at: http://tinyurl.com/plcv-views-survey.

The survey is also available via the websites of the three CCGs:

Birmingham CrossCity http://bhamcrosscityccg.nhs.uk/
Birmingham South Central http://bhamsouthcentralccg.nhs.uk/
Solihull CCG https://solihullccg.nhs.uk/

The survey is being carried out to ensure that patients are treated fairly across Birmingham and Solihull; currently there are differences between areas.

Dr Waris Ahmad, a local GP and spokesperson on behalf of the PLCV project group, said: “We want to ensure that patients have the same opportunity to access these procedures regardless of which GP they see, or which hospital they attend across Birmingham or Solihull.

“As well developing policies that are up-to-date and include the latest national clinical guidance, we also want people to ensure that local public, patients and clinicians have the opportunity to be informed and comment on this work.”

The survey is open now and continues until Monday 14 March 2016.

ends

Media Enquiries: mediacsu@nhs.net Telephone 0121 612 3888

A second news release was issued on Thursday March 3. Solihull and Birmingham media as well as Birmingham bloggers were contacted.

Date: 04 April 2016

Following a press release issues by the Royal College of Surgeons, a press release was issued in response by the CCGs across Birmingham, Solihull and the Black Country:

A spokesperson on behalf of the Clinical Commissioning Groups (CCGs) across Birmingham, Solihull and the Black Country said:

“Along with a number of key stakeholders, the Royal College of Surgeons (RCS) were asked for their views as part of our Procedures of Lower Clinical Value (PLCV) engagement process; we have only just received their formal feedback.

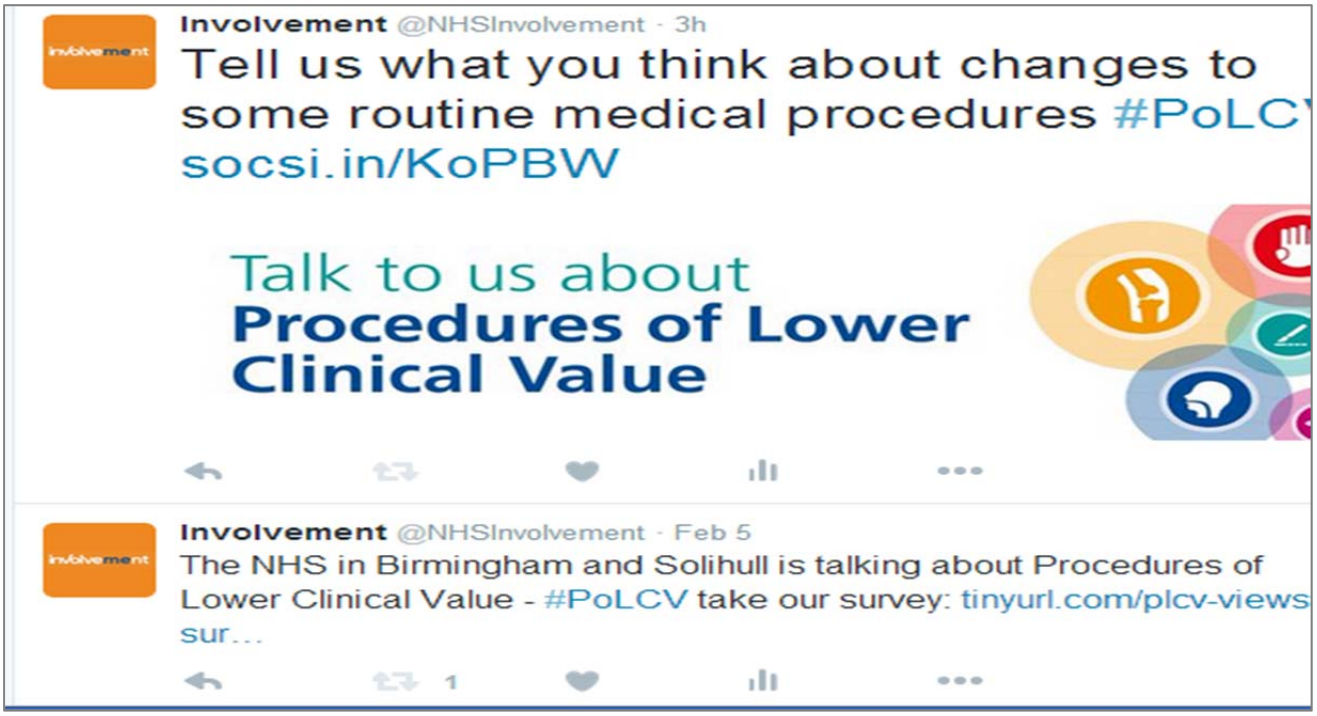
“We have already taken into account many of the valid points raised by the RCS, as part of feedback received through the engagement process, and will continue to do so as we work through each policy.

“Naturally, the review of PLCV policies is very detailed, and includes reviewing all the comments that we have received from our stakeholders to inform our decisions.

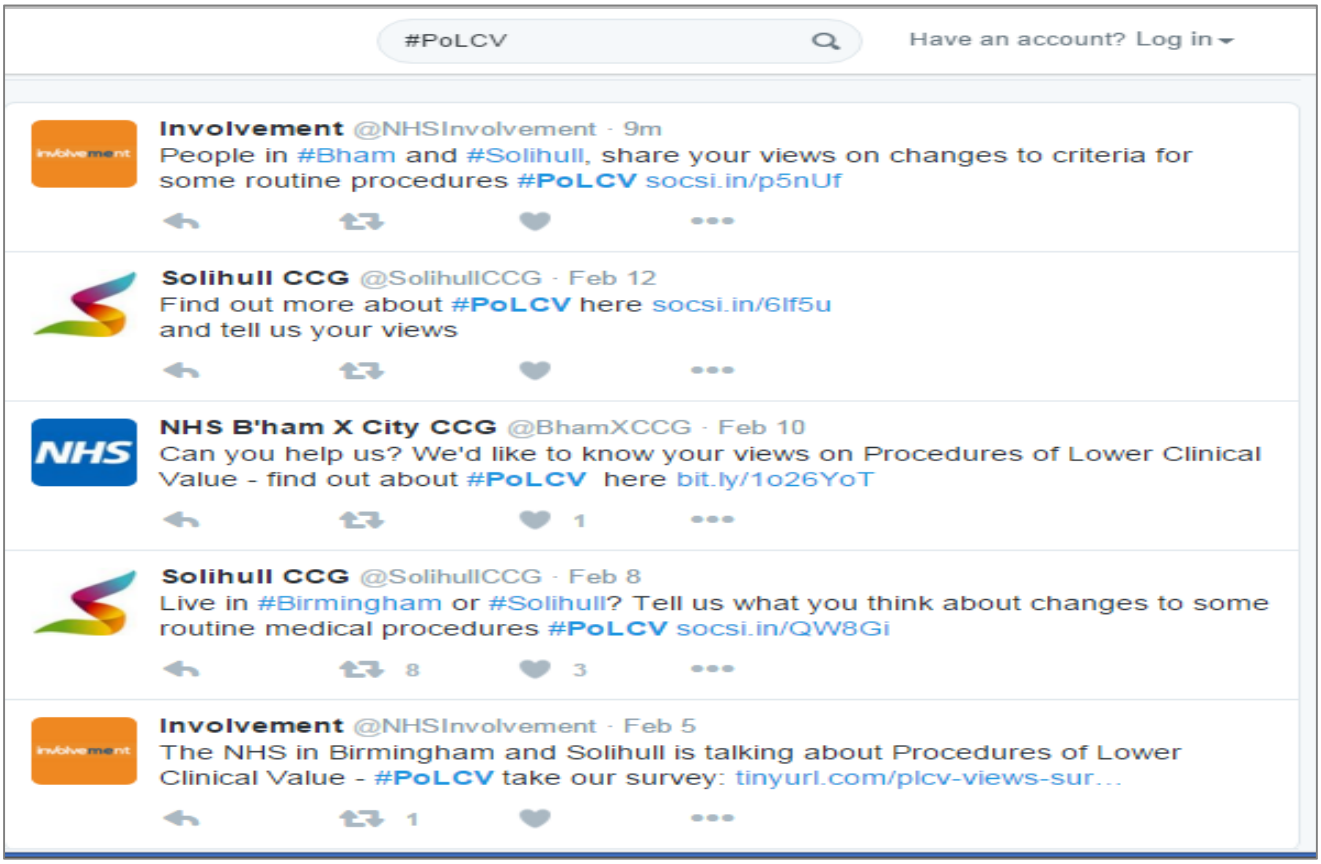
“We are very pleased that the RCS has now formally commented, to enable us to make sure their views are considered fully and appropriately.”

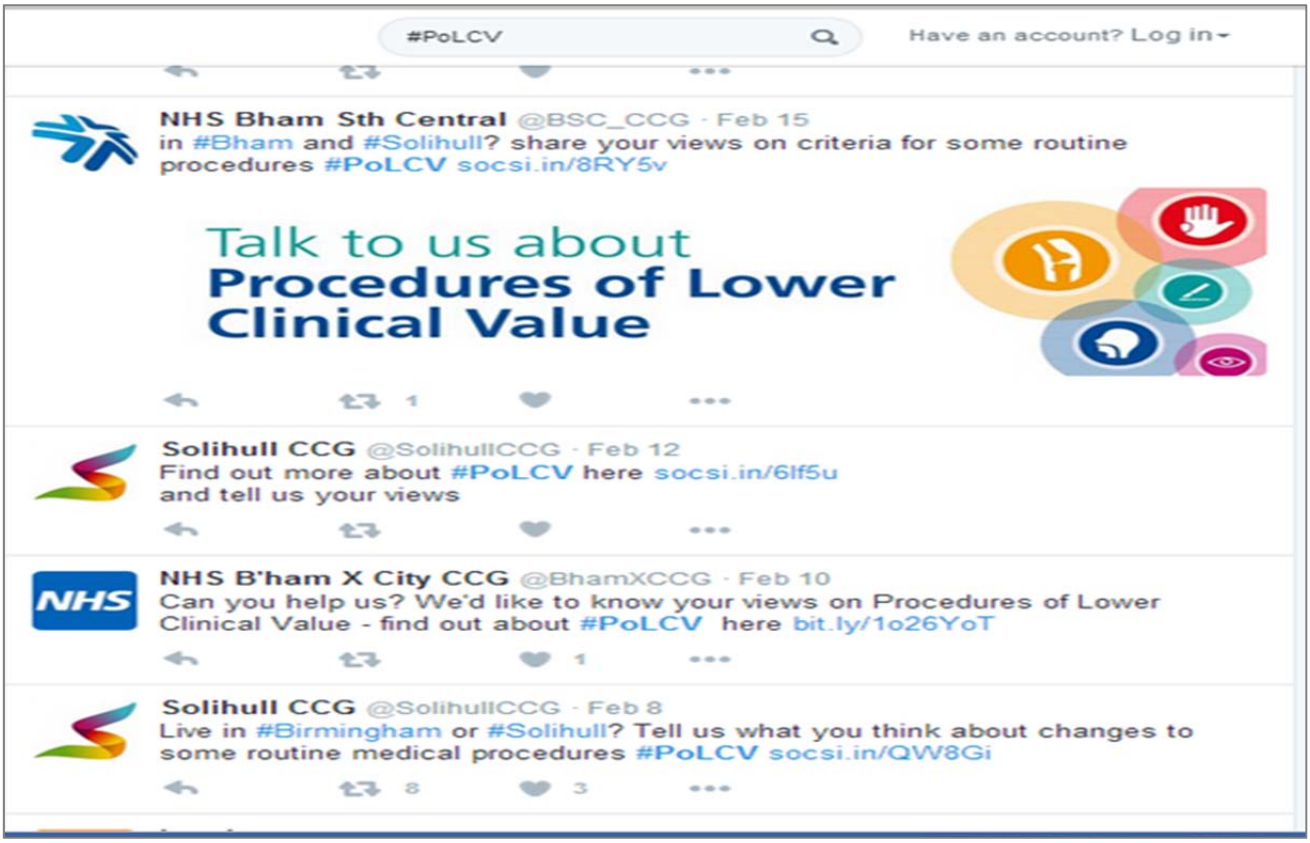
Social media - Twitter

Midlands and Lancashire CSU **@nhsInvolvement** – twitter account

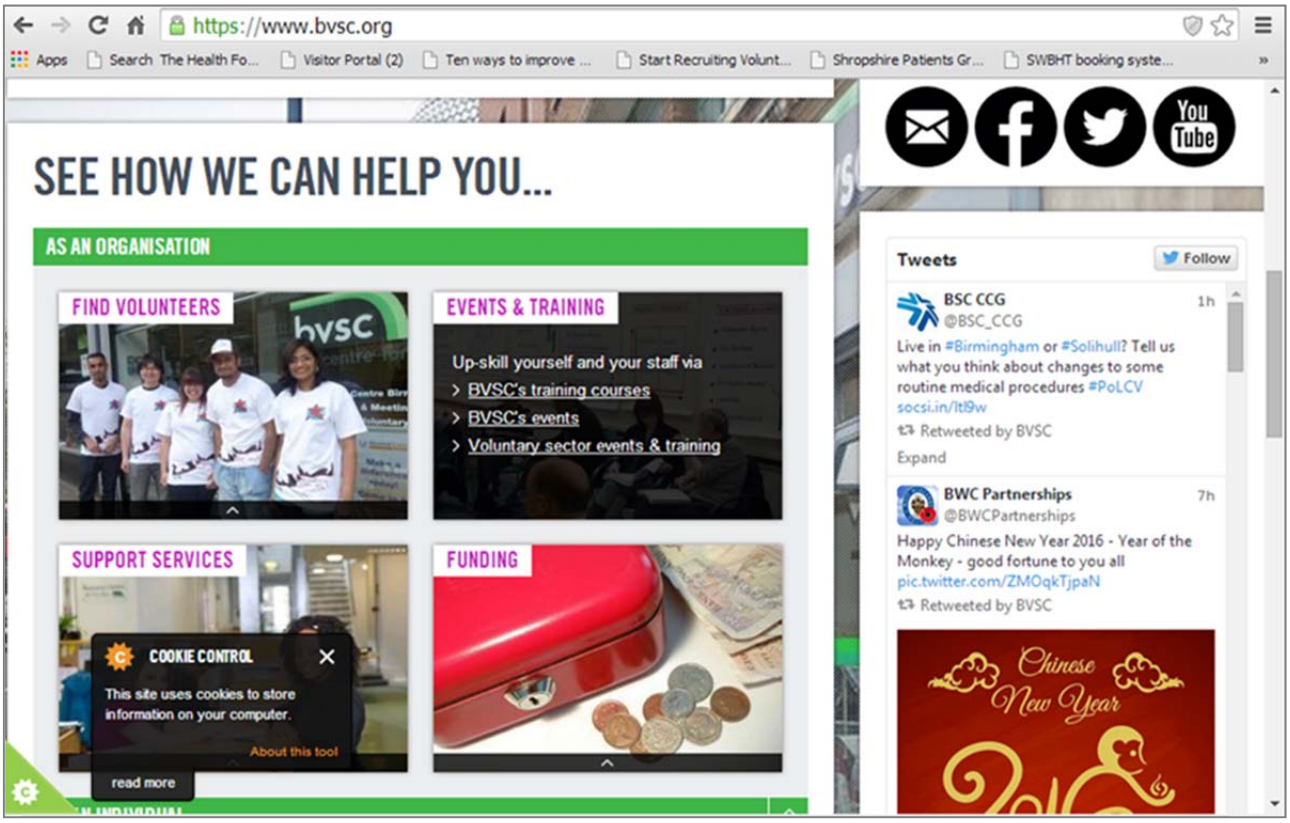


#PoLCV search for latest tweets





Birmingham Voluntary Services Council (**BVSC**): Re-tweets by stakeholders



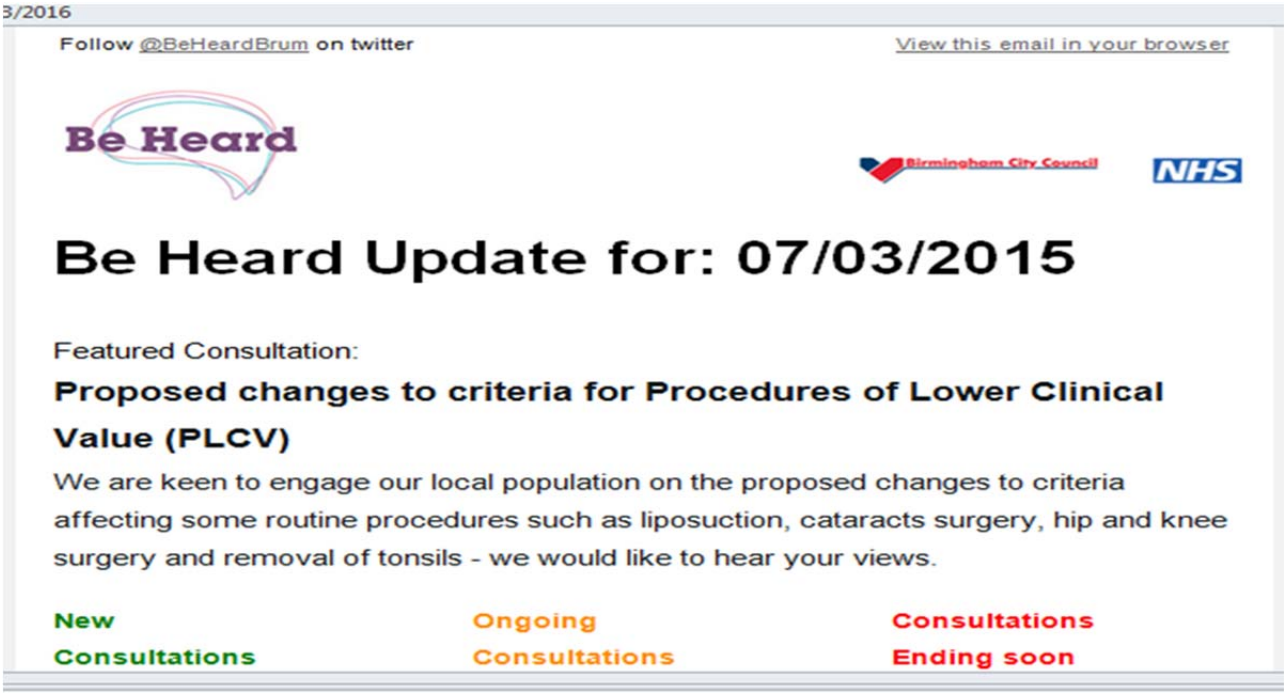
Be Heard Twitter

Facebook


NHS Birmingham CrossCity CCG
10 February
Can you help us? We would like to know your views on Procedures of Lower Clinical Value (PoLCV) - don't know what these are or how you can help?
Read about #PoLCV how you can get involved here:
http://bit.ly/1o26YoT
Talk to us about
Procedures of Lower Clinical Value
Share

E-bulletins

E-shot send to all **BeHeard** users weekly by Birmingham City Council, promoting PLCV


3/2016

Follow @BeHeardBrum on twitter

View this email in your browser

Be Heard

Birmingham City Council

NHS

Be Heard Update for: 07/03/2015

Featured Consultation:

Proposed changes to criteria for Procedures of Lower Clinical Value (PLCV)

We are keen to engage our local population on the proposed changes to criteria affecting some routine procedures such as liposuction, cataracts surgery, hip and knee surgery and removal of tonsils - we would like to hear your views.

New Consultations	Ongoing Consultations	Consultations Ending soon

Article for Birmingham Councillors via E- Bulletin – sent by Birmingham City Council

Engagement on Procedures of Lower Clinical Value (PLCV)

The Clinical Commissioning Groups (CCGs) in Birmingham and Solihull; Birmingham CrossCity, Birmingham South Central and Solihull CCGs are currently undertaking six week public engagement to seek views on changes to the policies for Procedures of Limited Clinical Value (PLCV).

PLCV are routine procedures that are of value, but only in the right circumstances, and are not felt to be necessary to maintain good health.

At the moment, the criteria for these procedures vary between areas which can cause differences in the availability of them. This has happened because the policies were inherited from the predecessor Primary Care Trusts (PCTs), and were adopted by CCGs to ensure patients could continue to access essential clinical services, during the transition from PCTs to CCGs.

The CCGs believe that a standardised set of policies, which are consistent across the area, would deliver a fairer service for patients.

A working group was established, which included colleagues from local authorities and public health. This working group reviewed the 21 policies, in accordance with national guidance and evidence from the PLCV programme review board. They have also been reviewed in light of the most up-to-date published clinical evidence base, to ensure treatments which are funded are proven to have a clinical benefit for patients. From this, a standardised set of 21 policies have been developed.

Although all of the procedures will still be available, making the policies consistent means that the criteria for being accepted to have a procedure may have changed. There may be circumstances where a patient will no longer be able to receive a treatment they would previously have been able to. In these cases, the patient will be supported by their GP to consider alternative treatments available to them, which may be of greater benefit.

The CCGs have now started a period of public engagement. This will run for six weeks from 1 February to 14 March 2016 and builds on previous engagement with patients, during the policy review process.

A comprehensive Equality Analysis has been undertaken, which has identified the people who are most likely to be impacted by these changes. A robust communications and engagement plan is in place to involve and inform them, and the wider public.

The CCG is contacting a broad range of local community stakeholders to let them know about the engagement exercise, including some face-to-face events. Information will also be made available in alternative, accessible formats, upon request.

Full details, are available on the CCG websites:

http://bhamcrosscityccg.nhs.uk/get-involved/engagement s-and-surveys/procedures-of-lower-clinical-value-survey

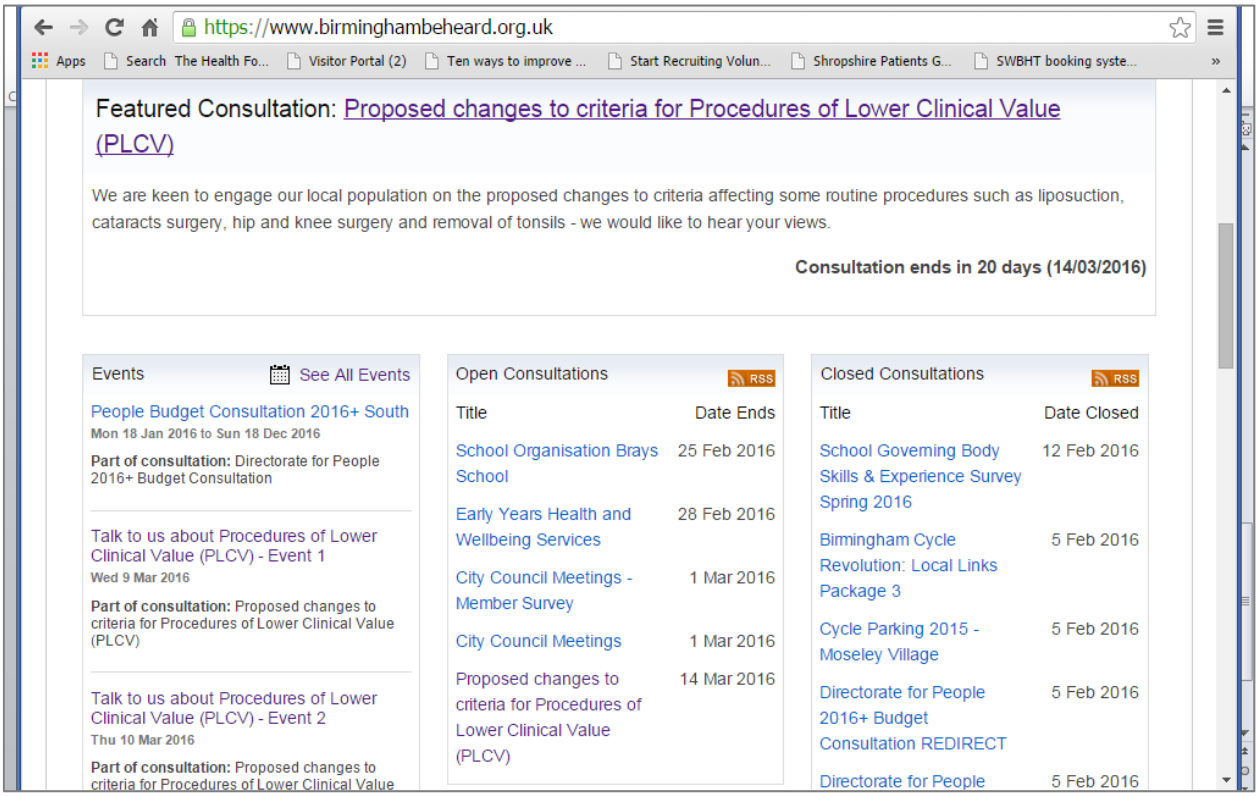
http://bhamsouthcentralccg.nhs.uk/get-involved/procedures-of-lower-clinical-value-survey

https://solihullccg.nhs.uk/get-involved/procedures-of-lower-clinical-value-survey

The CCGs will appreciate any help you can give to raise awareness of the engagement and encourage people to provide feedback using the online survey. A leaflet providing a summary for the public is available here.

Promoting PLCV public events

Beheard Birmingham – events promotion on homepage

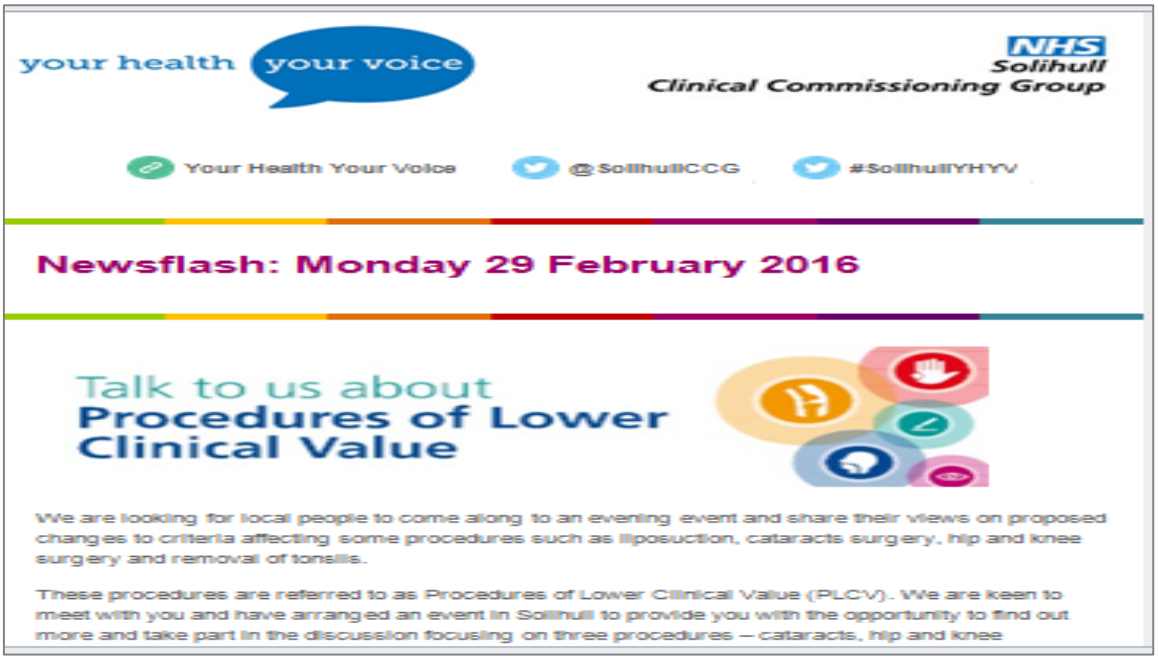


West Midlands Academic Health Science Network (**WMAHSN**) website on 23/02/16 – promoting the 2 events

Birmingham CrossCity CCG – People's Health Panel news bulletin sent to 1871 people on 23/02/16

BVSC website – promotion of 2 public events

Your health, your voice – Solihull CCG newsflash on Monday 29/02/2016



Targeted groups

Emails sent to a wide variety of stakeholders, including: WMAHSN, Age UK, RNIB, BVSC and Healthwatch Birmingham. The purpose of this was to publicise the engagement via their newsletters, e-bulletins, social media and respective websites.

Clinical engagement

The three CCGs used their existing communications channels to inform their members about the PLCV work. During January, this took for the form of Governing Body briefings, information in practice newsletters GP briefing documents, various committees and meetings, clinical networks and practice patient forums.