NHS
Northamptonshire
Clinical Commissioning Group

PRIOR APPROVAL SCHEME

April 2020

Document Version Control

NAME	CHANGES	DATE
Northamptonshire CCGs	Update of Policy	29/01/2019
Northamptonshire CCGs	Update of policy following provider comments / update of version control (Final Draft V3)	13/03/2019
Northamptonshire CCGs	Update of policy following provider discussions	14/03/2019
Northamptonshire CCG	Reviewed on transition to single CCG	01/04/20

Target Audience	Providers, Primary Care, Commissioners, Contracting, prior approval team and informatics
Brief description	Principle and guidance underpinning all procedures of limited clinical value including the process for approval and payments
Action Required	Following approval contracting will ensure that the policy and related process as in appendix 1 is incorporated into relevant provider contracts and commissioner disseminate the policy to all General Practitioners, Commissioning, Community Contracting, all providers (acute, community and primary care)
Related policies	Secondary Care Initiated referral policy (updated April 2019)
Applicable Age Range	Patients and service users of all ages, to include adults and children
Date for Review	April 2022

INTRODUCTION

This document is designed to provide guidance to clinicians on the overarching principles and processes which underpin a group of policies relating to the commissioning of services or procedures of lower clinical value by NHS Northamptonshire Clinical Commissioning Group (the CCG).

Through these policies, the CCG aims to ensure that the services or procedures commissioned are:

1. Clinically Effective

   Compliance with the policies will ensure that the care we commission is based on best clinical evidence as derived from authoritative sources such as the National Institute for Health and Clinical Effectiveness (NICE).

2. Cost Effective

   The policies take into account the cost-effectiveness of different healthcare interventions in order to maximise the benefit for the population as a whole.

3. Equitable

   The policies will underpin a process by which we commission and provide health care services based solely on clinical need, within the resources available to us. We will not discriminate between individuals or groups on the basis of age, sex, sexuality, race, religion, lifestyle, occupation, social position, financial status, family status (including responsibility for dependants), intellectual/cognitive functioning or physical functioning.

Prior Approval was formally launched in April 2012 by Dr Roger Perry, Planned Care Lead for Nene Commissioning, who advised local GPs at each of the localities that the process was designed "to ensure that the local health resources that we have available are used for our patients in the most effective way". That ethos continues with this policy revision.

DEFINITONS

This document should be read in conjunction with the NHS Standard Contract in use at the time of reading and will not constitute a variation or dilution of these terms. Guidance from NICE may also be considered as appropriate. For clarity, the NHS Standard Contract 2017/18 and 2018/19, Service Conditions SC29.21 to 29.27, state that:

Prior Approval Scheme

29.21 Before the start of each Contract Year, the Co-ordinating Commissioner must notify the Provider of the terms of any Prior Approval Scheme for that Contract Year. In determining whether to implement any new or replacement Prior Approval Scheme

or to amend any existing Prior Approval Scheme, the Commissioners must have regard to the burden which Prior Approval Schemes may place on the Provider. The Commissioners must use reasonable endeavours to minimise the number of separate Commissioner-specific Prior Approval Schemes in relation to any individual condition or treatment. The terms of any Prior Approval Scheme may specify the information which the Provider must submit to the Commissioner about individual Service Users requiring or receiving treatment under that Prior Approval Scheme, including details of the scope of the information to be submitted and the format, timescale and process for submission (which may be paper-based or via specified electronic systems).

29.22 The Provider must manage Referrals in accordance with the terms of any Prior Approval Scheme. If the Provider does not comply with the terms of any Prior Approval Scheme in providing a Service to a Service User, the Commissioners will not be liable to pay for the Service provided to that Service User.

29.23 If a Prior Approval Scheme imposes any obligation on a Provider that would operate contrary to the NHS Choice Framework:

29.23.1 that obligation will have no contractual force or effect; and

29.23.2 the Prior Approval Scheme must be amended accordingly; and

29.23.3 if the Provider provides any Service in accordance with the Prior Approval Scheme as amended in accordance with SC29.23.2 the relevant Commissioner will be liable to pay for that Service in accordance with SC36 (Payment Terms).

29.24 The Co-ordinating Commissioner may at any time during a Contract Year give the Provider not less than one month's notice in writing of any new or replacement Prior Approval Scheme, or of any amendment to an existing Prior Approval Scheme. That new, replacement or amended Prior Approval Scheme must be implemented by the Provider on the date set out in the notice, and will only be applicable to Referrals made after that date.

29.25 Subject to the timely provision by the Provider of all of the information specified within a Prior Approval Scheme, the relevant Commissioner must respond within the Prior Approval Response Time Standard to any request for approval for treatment for an individual Service User. If the Commissioner fails to do so, it will be deemed to have given Prior Approval.

29.26 Each Commissioner and the Provider must use all reasonable endeavours to ensure that the design and operation of Prior Approval Schemes does not cause undue

delay in Service Users accessing clinically appropriate treatment and does not place at risk achievement by the Provider of any Quality Requirement.

29.27 At the Provider's request in case of urgent clinical need or a risk to patient safety, and if approved by the Commissioner's medical director or clinical chair (that approval not be unreasonably withheld or delayed), the relevant Commissioner must grant retrospective Prior Approval for a Service provided to a Service User.

In addition, the NHS Standard Contract 2017/18 and 2018/19 Technical Guidance states that:

42.10 The commissioner should notify the provider of any Prior Approval Schemes before the start of the contract year. Schemes can be amended and new Schemes introduced in-year with one month's notice. Where this happens, commissioners must ensure that they set reasonable expectations about the applicability of the Scheme in relation to patients who have been referred or have already commenced assessment or treatment.

42.11 Where patients have a legal right of choice of provider, any Prior Approval Scheme which simply restricts that choice is void and cannot be used to restrict payment for activity carried out by the provider.

VALUE BASED INTERVENTIONS

Within this policy is the list of interventions given on the CCG's website considered to have a lower priority for NHS resources in certain or all circumstances and therefore will only be funded when the patient meets the criteria defined within the relevant policy and where prior approval is sought and granted before the treatment commences.

The aim of this process is to disinvest in services or treatments where there is:

a) Poor or unproven clinical effectiveness;

b) Poor or unproven cost effectiveness;

c) Availability of more appropriate treatment alternatives; or

d) Incompatibility with the core purposes and priorities of the NHS.

The evidence supporting the reason for considering the service or procedure to have a lower priority for NHS resources is discussed and referenced within the relevant policy.

Prior Approval is part of NHS England's NHS RightCare Programme which seeks to maximise

- The value that the patient derives from their own care and treatment; and
- The value the whole population derives from the investment in their healthcare.

"Value in any field must be defined around the customer, not the supplier. Value must also be measured by outputs, not inputs. Hence it is patient health results that matter, not the volume of services delivered. But results are achieved at some cost. Therefore, the proper objective is… patient health outcomes (outputs) relative to the total cost (inputs). Efficiency, then, is subsumed in the concept of value." Source: What is Value in Health Care? Harvard Business School. Porter ME. (2008).

The challenge for the NHS is to secure the best value within the finite financial envelope available. To do this, the NHS needs to shift from lower value interventions to higher value interventions.

RED & AMBER PROCEDURES

To support the process, the CCG has classified the relevant services or procedures into two main categories as follows:

- Red – services or procedures that should not be carried out, unless the eligibility criteria are met, and approval has been granted by the CCG Prior Approval Panel (PAP); and
- Amber – services or procedures which can only be provided without seeking Prior Approval if the relevant criteria as stipulated by the policy are met by an individual patient

The criteria are described in the relevant policies which are available on the CCG website and GP Portal system:

- Northamptonshire CCG website http://www.northamptonshireccg.nhs.uk
- GP Portal system http://gp.neneccg.nhs.uk/

Prior Approval must be sought in the following scenarios:

a) During a consultation, the GP suggests a service or procedure which requires prior approval (Red or Amber criteria not met). The GP informs the patient and seeks approval. There are clear cases where prior approval must be sought, for example for hip and knee referrals, plastic surgery referrals and tonsillectomy. If prior approval has not been sought prior to referral, the secondary care teams may send these referrals back to the GP to seek the appropriate prior approval;

b) During a consultation, the GP decides that additional information or an opinion is required regarding the need for a service or procedure, and refers their patient to a Consultant. The GP will notify the patient that the outcome of the onward referral may result in a Consultant deciding that a specific treatment is required that may be subject to prior approval.

   After assessment of the patient by the Consultant, the Consultant feels that treatment would be beneficial and advises the GP accordingly. Where that treatment is subject to Prior Approval, the Consultant then applies for that approval.

   In instances where that opinion is sought via Advice and Guidance, the GP will retain responsibility for securing prior approval at the point a referral is made as stated at point a above; and

c) A Consultant who wishes to undertake a procedure covered by a Prior Approval policy must seek funding approval in the same way and using the same criteria as their GP colleague. This process applies regardless of the hospital at which the patient may be treated and only applies to NHS commissioned secondary care.

Where a Referral Management Service (RMS) is implemented that covers referrals for procedures that are subject to a Prior Approval policy, responsibility for applying for approval will be agreed on an RMS service-specific basis.

The expectation is on the provider to ensure that this policy and approval process is either communicated to or readily available to the relevant frontline staff.

OPCS

All individual policies define the procedure(s) they cover by reference to the relevant operating procedure code supplements (OPCS). Please see the list of all the policies covered by the Prior Approval Scheme provided on the CCG's website and GP portal system:

- Northamptonshire CCG website http://www.northamptonshireccg.nhs.uk
- GP Portal system http://gp.neneccg.nhs.uk/

PROCESS

A. Clinician

The 'relevant clinician' is the clinician who should make the appropriate funding application identified in the scenarios above. This includes GP and secondary care clinicians

The relevant clinician should:

- Check policies which can be accessed on:

  Northamptonshire CCG website http://www.northamptonshireccg.nhs.uk
  GP Portal system http://gp.neneccg.nhs.uk/

- Does the procedure appear on the list?

  No – Follow best practice and peer review referral as appropriate. If unsure, check with the Prior Approval Team on telephone number 0121 611 0644 or ifr.northants@nhs.net, or the CCG Contracting Team.

  Yes – Note whether procedure is RED or AMBER and assess the patient against the prior approval pro-forma (if required check the policy for additional information)

- Does the patient meet the criteria within the policy?

  Yes, Amber – refer patient and include reference to criteria in your referral

  Yes, Red – requires prior approval before referral for procedure

  - Complete the relevant prior approval form, all of which are available on the CCG's website and on the GP Portal (http://gp.neneccg.nhs.uk/) as a pro-forma or word document template;
  - Please add any supporting clinical information;
  - Explain the process to the patient so that treatment expectations are not raised; and
  - Send the completed Prior Approval form via secure nhs.net email account to ifr.northants@nhs.net. Applications for prior approval will only be accepted by this route.

  No, Amber or Red – if the patient does not meet the criteria in the policy, the CCGs will not fund the procedure.

  - Please do not refer the patient for the procedure or an opinion
  - Explain the criteria and evidence base for this policy to the patient

B. Prior Approval Team

i. Acute Trust Prior Approval Requests

The CCG has a 4 working day turnaround for all Acute Trust requests made via email to ifr.northants@nhs.net.

If a reply is not received in this timescale it can be assumed that full approval has been given and the provider will be fully funded for all aspects of care, as per NHS Standard Contract Terms and Conditions. If the Provider requests Prior Approval in accordance with a Prior Approval Scheme the relevant Commissioner must respond within the time period specified in the Prior Approval Scheme. If the Commissioner fails to do so it will be deemed to have given Prior Approval.

If the application is approved you will receive a copy of the application with an assigned approval number which will be valid for 12 months. Beyond this point the procedure will be included in the data challenge.

ii. Primary Care Prior Approval Requests

The CCG has a 10 working day turnaround for all turnaround for all Primary Care requests. For the purposes of patient confidentiality, emails and requests should be sent from secure NHS email accounts to ifr.northants@nhs.net.

C. Approval Given

Primary Care

Once approval has been issued, a referral can then be sent to secondary care in the normal way. Please attach a copy of the funding approval notice with your e-referral and clearly state the prior approval reference number.

If the referral is not complete with the approved application form/approval number, the Secondary Care provider will not be able to carry out the procedure or respond to contractual challenges and can return the referral to the GP.

Secondary Care

The patient can be added to the waiting list for the approved treatment only if prior approval has been received. Patients must not be listed for treatment until prior approval has been sought and approved. The prior approval reference number must be inserted into the patient's electronic record and any paper record.

D. Approval Not Given

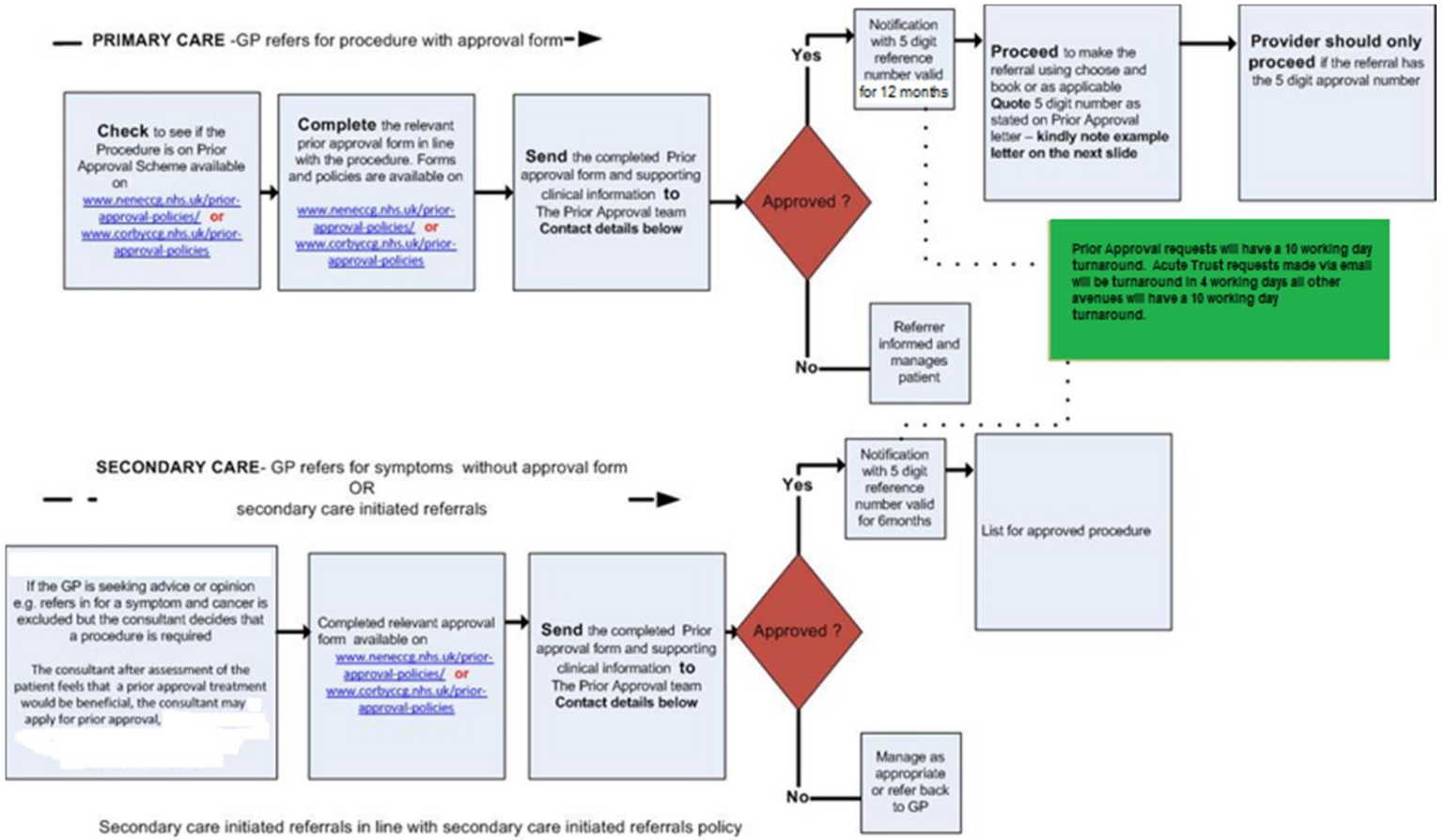
If the application is declined the Prior approval team will send the requesting clinician of the prior approval, an email to explain the decision

PRIOR APPROVAL PRINCIPLES

Comments	Principles
Prior approval	Approval is valid for 12 months. If the procedure is not undertaken in 12 months of the initial approval the procedure will be challenged within the context of the data challenge process.
Non-Primary procedure where retrospective payment may be made	Prior approval required for all procedures before undertaking procedures. Only in exceptional cases of urgent clinical need or a risk to patient safety will payment be considered. Where these are "Red Flag" procedures, serious consideration will be given. The provider will need to apply for payment within 24 hours
Internally generated referral (Consultant to Consultant), and that treatment is covered by a Prior approval policy,	Providers seek prior approval
Replacement or amended Prior Approval Scheme (overarching document) or Policy (individual Policy for procedures subject to Prior Approval)	As per service conditions in the standard NHS contract any new, replacement or amended Prior Approval Scheme must be implemented by the Provider on the date set out in the notice, and will only be applicable to Referrals made after that date. For equity of service provision, the Trust will ensure that the revised prior approval scheme is applied to patients whose decision to admit is made after the date set out in the notice; this will ensure that patients by whatever means of referral to the service are treated equally under the policy. In the event of a policy being introduced or updated within year, formal notice of one month will be given to providers before the policy is deemed live and published on the CCG website. For the purpose of data challenges and payment to Acute Trusts, the date from which the referral was made to the Trust will be utilised when changes to prior approvals are made; this will predominately be the

Comments	Principles
	referral date from the GP. With this in mind, the CCG will not challenge a provider and withhold payment on the adherence to policy within the first 180 days of the date set out in the notice.
NHS patients who are a referral from the Private Sector	All NHS patients who have a procedure as listed within the Prior Approval Policy (funded by the CCG) are required to have the appropriate Prior Approval, regardless of where their initial referral is from an NHS or private referrer.

Process by which primary and secondary care should seek Prior Approval



PERFORMANCE MANAGEMENT

Performance management will be at procedure level broken down by practice, locality (primary care) and consultant, speciality level (secondary care). FUNDING

As referred to in Service Condition 28 of the standard NHS Contract, except as permitted under an applicable Prior Approval Scheme, the Provider must not carry out nor refer to another provider to carry out any non-immediate or routine treatment or care that is unrelated to a Service User's original Referral or presentation, without the agreement of the Service User's GP.

- If a provider undertakes treatment following referral for an assessment, and that treatment is covered by a Prior Approval policy but approval was declined, the treatment will not be paid for.

- If a provider undertakes treatment following an internally generated referral (Consultant to Consultant), and that treatment is covered by a Prior Approval policy, then that treatment will only be paid for where prior approval has been sought and given.

The CCG will consider referrals that do not comply with this policy as not chargeable unless relevant Service Conditions 29.23 to 29.27 from the NHS Standard Contract for 2017/18 and 2018/19 apply.

Activity at acute Trusts is monitored against the Prior Approval team database and procedures without approval are challenged via the agreed challenge process so that unapproved activity can be deducted and monies recovered.

Appendix 1 – Prior Approval Procedure list

Individual prior approval procedure policies can be viewed at:
http://www.northamptonshireccg.nhs.uk/prior-approval-policies/

Individual prior approval procedure approval forms can be accessed at
http://www.northamptonshireccg.nhs.uk/prior-approval-policies