Policy and Procedure for Individual Funding Requests (IFRs) and the management of restricted treatments and procedures concerning Clinical Commissioning Groups

Version control

Date	Approved By	Activity	Amended by
November 2010	NHS Southampton Clinical Leadership Board	Changes to Policy title to 'Individual Funding Requests' and **first joint** policy covering NHS Hampshire and NHS Southampton City with joint Panel structure.	Chris Ashdown
12 January 2011	For NHS Hampshire PAC (not convened)	Housekeeping of document to take account of changes to application form which will include reference to potential service development Re-arrangement of exclusions list to separate between: i. Core list of interventions that are "not normally funded". ii. Criteria-based commissioning for procedures of limited clinical value (PLCV) using the Prior Approval Tool iii. Volume thresholds/ quota-based commissioning	Chris Ashdown
15/02/11	NHS Hampshire PAC / Management Committee	Finalising of 'new' procedures of limited clinical value, addition of procedure codes and ordering into 'don't dos' and 'may dos'. Inclusion of revised application form and guidance notes for use in primary care only. (Current application still to be used in secondary care)	Chris Ashdown/ Cathy Price/ Marie-Claire Lobo
May – June 2011	NHSH/ PAC	Amendment to criteria in Dupuytren's contracture, trigger finger and carpal tunnel surgery to align with Map of Medicine pathways. Amendment to bone-anchored hearing aid criteria to cover single-sided hearing loss	CA/ GPC West leads
Mar 2012	BoCC (for information)	Amendments for 2012-13 contract re prior approval procedures including removing the need for prior approval for skin lesions, ganglia, cholecystectomy and hallux valgus surgery. Shift from restricted procedures (tranche 2) to clinical variation (tranche 3 monitoring only).	CA
May 2012	Board of Clinical	Formal endorsement of finalised policy in line	Stuart Ward/ CA

	Commissioners	with above changes	
Feb 2013	CCG clinical execs	Amendments to a headline policy for NHS South CSU for adoption/variation by individual CCGs Removal of cholecystectomy from 'thresholds list' Shift ganglions from 'thresholds' to 'restrictions' with clear criteria Hallux valgus criteria amended Skin lesions criteria amended Changes to management of prior approval for tonsillectomy All NHSCB-designated specialised services as well as dentistry **removed** from exclusions and restrictions lists	CA
March 2013	CCG clinical execs	Amendments to policies on adult and children grommet insertions	CA
May 2013	NICE Technology Appraisal 279	Kyphoplasty and vertebroplasty removed from exclusions/ restrictions lists provided NICE criteria met	CA
	CCG clinical execs	Amendment to hallux valgus pathway (podiatry not essential as long as MSK triage in place)	
January 2014	CSU	Amendments to update CCG Priorities Committee details, ethical framework and prior approval arrangements	CA/ SE Hants, Ports and F&G CCGs
February 2014	SE Hants, Ports and F&G CCGs	Removal of dilatation & curettage and sympathectomy from appendix 2	CA
December 2014	Hampshire CCGs	Draft revised criteria in appendix 2 and revised description of prior approval arrangements	CA/CCG Boards
March 2015	P/SE/F&G CCGs	Updated p.13 table, p17 re response times and criteria re septo-rhinoplasty	
Dec 2015	SHIP8	Draft changes to PLCVs – appendix 2 Inclusion of penile prosthesis – appendix 1	To CCGs
Jan 2016	CCGs and CSU leads	Some re-wording of preamble, new policy title and criteria changes to both appendices 1 and 2. Clarification of exclusions and restrictions criteria	To CCG clinical executives
Feb 2016	CCG clinical execs	Minor amendments to criteria re tonsillectomy and high BMI hip and knee replacements	To contracts
April 2016	CCG clinical execs/Board	Implementation of Priorities Committee policy statements related to hip arthroscopy, continuous glucose monitoring, functional electrical stimulation, intensive decongestive therapy, adenoidectomy, surgery for 'snoring' and arthroscopy in knee pain. Amendment to clarify inguinal hernia policy changing 'all' to 'one' criteria to be met	To contracts

CONTENTS

1 INTRODUCTION

This document sets out the Policy and Procedure with respect to treatments not routinely commissioned or restricted to clinical criteria for the following Clinical Commissioning Groups (CCGs) in Hampshire

Fareham & Gosport CCG
North Hampshire CCG
North East Hampshire & Farnham CCG
Portsmouth CCG
Southampton CCG
South Eastern Hampshire CCG
West Hampshire CCG

The function for addressing individual funding requests lies with the NHS South, Central & West Commissioning Support Unit (CSU) which acts on behalf of CCGs. These may be treatment requests or referrals made either to an NHS provider outside the local health economy; to a provider where there is no contract in place; generally for a treatment/ procedure that is excluded or to a non-NHS provider i.e. the private sector. These referrals will, for the purposes of the Policy, be known as Individual Funding Requests (IFRs).

The NHS Confederation document "Priority setting: managing individual funding requests." was drafted for Primary Care Trusts and remains relevant today. It gives a clear definition of an individual funding request as follows:-

"A request to a PCT to fund healthcare for an individual who falls outside the range of services and treatments that the PCT has agreed to commission.

There are several reasons why a PCT may not be commissioning the healthcare intervention for which funding is sought.

- *It might not have been aware of the need for this service and so has not incorporated it into the service specification*
- *It may have decided to fund the intervention for a limited group of patients that excludes the individual for whom the request is made*
- *It may have decided not to fund the treatment because it does not provide sufficient clinical benefit and/or does not provide value for money*
- *It may have accepted the value of the intervention but decided it cannot be afforded in the current year*

Such requests should not be confused with

- *Decisions that are related to care packages for patients with complex healthcare needs*
- *Prior approvals which are used to manage contracts with providers"*

2 REFERRALS TO BE DEALT WITH UNDER THE POLICY - EXCEPTIONALITY

The NHS Confederation guide 'Priority setting: managing individual funding requests' 2008 clarifies exceptionality as:

In making a case for special consideration, it needs to be demonstrated that:

- *the patient is significantly different to the general population of patients with the condition in question, and*
- *the patient is likely to gain significantly more benefit than might be normally expected for patients with the same condition*

The fact that the treatment is likely to be efficacious for a patient is not, in itself, a basis for exceptionality.

This statement still provides a rationale for decision-making as much now as it did then. Since 2008, further guidance was issued by the then NHS Commissioning Board (now NHS England) in preparation for new

commissioning structures from 2013-14. This is quoted as follows from the draft generic commissioning policy used by NHS England Area Teams in addressing specialised services IFRs.

The UK Faculty of Public Health has published a statement describing the concept of exceptionality[1]:

> *".. an individual funding request arises when a treatment is requested for which the [commissioning organisation] has no policy. This may be because:*
>
> - *it is a treatment for a very rare condition for which the [commissioners have] not previously needed to make provision or*
> - *there is only limited evidence for the use of the treatment in the requested application or*
> - *the treatment has not been considered by the [commissioners] before because it is a new way of treating a more common condition. This should prompt the development of a policy on the treatment rather than considering the individual request unless there is grave clinical urgency."*
>
> *In practice, all requests for funding for an individual patient have been called Individual Funding Requests (IFRs) but these sub-categories of request should be recognised'.*

In the event that an IFR is approved, this does not necessarily set any precedent and relates to the individual patient treatment for which funding has been granted.

3 POLICY SCOPE

. In general this policy covers
- Priorities Committee recommendations
- healthcare not normally purchased
- drugs and devices outside of national tariff

IFRs are addressed by a lead manager and team, commissioning colleagues, public health and medicines management colleagues and a clinically-led Referral Panel.

Treatments that require Prior Approval for funding due to either their high cost or uncertain clinical benefit may be dealt with by the same team. However, it is expected that the CCGs will hold specific conditions whereby prior approval is sought before referral or treatment. Where there is uncertainty as to whether those conditions are met then they may be dealt with by the IFR process. A list of treatments excluded from funding and thus will require application can be found at Appendix 2.

Commissioners comply with mandatory Technology Appraisal Guidance published by the National Institute for Health and Clinical Excellence (NICE)

This Policy does not address therapies provided purely as a part of clinical research. Research is funded through designated research monies and has a separate management and governance framework. Research & Development should not be supported from allocations intended for provision of mainstream health services, except where agreed and negotiated via the Research Management and Governance consortium and in line with national policy**.**

Conditions for submission to the IFR panel
The patient should be registered with a GP practice belonging to the relevant CCG or, if not registered with any GP, lives within the geographical responsibility of the CCGs and is eligible for NHS treatment. If this is not clear then the Responsible Commissioner guidance from NHS England applies
https://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf
- The provider can meet the quality standards as per Healthcare Assurance Standards / Care Quality Commission guidelines

[1] Faculty of Public Health. FPH Position Statement. Describing exceptionality for funding panels. 2012. Available from: http://www.fph.org.uk/policy_reports. Accessed 11/12/12.

- **Only an NHS GP, NHS Consultant or consultant in a Treatment Centre holding an NHS contract** can make a funding application. Allied health professionals and specialist nurses can also make referrals though these should normally be endorsed by a GP or consultant.
- The procedure/treatment is not already purchased under existing service agreements.
- Patient Choice guidelines will apply where relevant.
- For a treatment covered under this policy and the CCGs hold a contract covering a relevant specialty, the referral should be made by a consultant of the same specialty to a provider with whom the CCGs hold a contract.

Where an IFR is required, referrers are asked to consult with the CSU to see if there is a contract in place with the provider.

The CSU would only consider a specialist referral on the recommendation of a local clinician from the relevant specialty, where there was no appropriate NHS provision or where local NHS resources were no longer able to meet the needs of the patient. Treatment in the private sector will only be considered where there is evidence that NHS provision has been fully explored and exhausted.

Private treatment - If a patient has opted to pay for treatment and/or procedures privately, these will **not** be funded retrospectively and would not normally include future treatment offered by the private provider.

4 PRIORITIES FRAMEWORK AND DECISION-MAKING

History - up until February 2013, the Priorities Committee in Hampshire worked on behalf of its constituent commissioners to develop and agree clinical policies using an ethical decision making framework and standard procedures, supported by Solutions for Public Health Their recommendations were advisory but became active policy following consultation with the constituent CCGs and endorsement by the former Cluster PCT's Board of Clinical Commissioners. An index of policy statements can be found on the Commissioning Support Unit's website http://www.southcsu.nhs.uk/documents/ifr. This includes all relevant inherited policies, the IFR Policy and Procedure together with application forms.

The policy statements will remain in place where appropriate and extant. The priorities framework has been reviewed and a CCG Priorities Committee was re-launched during 2014 to offer advice and support to CCGs in Hampshire in order to ensure clinical policy remains fit for purpose, up-to-date and rigorously responsive to any challenge. It is an advisory body with the authority to make decisions in commissioning services and clinical policies for their populations remaining with CCGs. They must be shown to act within its powers and reasonably. Decisions can be challenged by Judicial Review in terms of legality, reasonableness or natural justice. There is therefore a decision making framework in place to guide the IFR panel.

Decision-making is based on the document at Appendix 3 – the South Central Ethical Framework which covers the following;

- evidence of clinical and cost effectiveness
- equity
- healthcare need and capacity to benefit
- cost of treatment and opportunity costs
- needs of the community
- policy drivers
- exceptional need

This framework was developed and updated to support robust and transparent ethical decision-making and was agreed and adopted by the 'SHIP8' of clinical commissioners in Hampshire.

Assessing individual cases

The following information should be used by the CSU and Referral Panel to assess individual cases.

- Background to the case
- The patient's problem and circumstances of the case
- Previous treatment and funding
- Proposed treatment and provider details
- Consideration of similar cases which have been dealt with in the past (but not as setting of precedents)
- Current contracting arrangements
- Funding
- Contracts and providers
- Exclusions
- Relevant commissioning policies
- Comparison
- Information on what is happening elsewhere (particularly CCGs in neighbouring areas)
- Advice from the priorities framework/process
- Corporate view
- Views and position of interested parties (patient, patient body, carers, health professionals, politicians, media)

Clinicians are involved in the decision making through the Referral Panel and its minutes are reviewed and signed off by the Chair of the Panel.

5 PROCESS

All requests should be in writing using the IFR funding application forms (found at appendices 4 and 5 and available on NHS South CSU's website www.southcsu.nhs.uk/documents/ifr

- a clear description of the exceptional circumstances, based on overriding clinical need,
- copies of any relevant correspondence; and
- other supporting documentation e.g. robust evidence of clinical and cost effectiveness, consultant and other specialist assessments, appropriate costings.

There are specific forms for primary care and secondary care as well as short proforma for prior approvals.

IFRs must be submitted on the form together with all supporting documentation such as relevant clinical history, correspondence from treating specialists and relevant published evidence base. In the first instance, referrers should consider whether the referral is covered by local NHS provision, whether there is a contract in place and that the referral is not contrary to the referral controls set out in this policy.

The referral must be clinically led. In most cases, the GP would be the appropriate clinician making the application. However, where specialist opinion is required to inform the application, we would expect the responsibility for the application to fall upon the specialist clinician.

The CSU will not accept direct patient requests, or routinely enter into any correspondence with patients and/or their families unless as part of the statutorily applied NHS Complaints Procedure. However, the CSU will provide guidance to patients (and their families subject to consent) related to the progress of an application. The referring clinician should act as the patient's representative and responses to funding requests will be made direct to the referrer. Where a request is declined, the CCGs recognise their obligations under the NHS Constitution to explain decisions to the patient but maintain the importance of the referring clinician's role in explaining clinical issues and rationale.

Before reaching the Panel, all requests will be addressed by the IFR team and, in cases where the referral clearly does not meet the exceptional circumstances explained above will be declined with an explanation. The IFR team will approve all referrals that clearly meet the criteria set out in this policy. In cases where the referrer has not made the application on the IFR funding request form and/or has not sent all relevant information plus any supporting documentary evidence, the referrer will be invited to do so, to enable the request to proceed.

Those referrals to be considered by the Panel should be exceptional within the guidelines of current policy. The Panel may also consider cases for a treatment not provided for within the policy and, where the consequences of a decision might have wider implications on commissioning policy may refer such cases back to the CCGs for consideration of future precedence.

All requests, requiring a decision by the Panel together with supporting information will be submitted to the next available meeting. Papers should be circulated at least one week prior to the meeting date.

The IFR team shares its decisions via a monthly report to CCGs.

Referrals leading to a possible policy change, those in an area of contention, or appeals against a Panel decision where no additional information has been provided may be considered by the Appeal Panel for the relevant CCG.

Urgent cases
In exceptional circumstances where an urgent decision is required i.e. treatment cannot be delayed and/or the patient's disease is rapidly progressing it may be necessary for the Panel to consider a case virtually i.e. via e-mail or conference call. Decisions will need to be clearly recorded and conveyed with a final decision based on consensus and Chair's action. Retrospective prior approval may be an option in such events and it is expected that an acute Trust will manage the risk of commencing treatment.

6 IFR REFERRAL PANEL

In order to meet the demand from the volume of referrals, the CSU has a structure of an IFR Referral Panel and 'parent' Appeal Panels for each commissioner.

Panel remit

It is important that all decisions made by Panels are transparent, defendable and consistent, observing CCG corporate principles, available NICE guidance, advice from the priorities framework and the available evidence base. After a decision has been made, a full written explanation will be provided to the referrer and patient.

All referrals should be directed to the IFR team. All referrals received via other routes should be passed to the IFR team. The IFR team will:

- Convey information
- Manage the panel meeting agenda
- Record Panel decisions
- Triage applications

Where the IFR team is unclear how to triage an application as the information may be complex or unclear advice may be sought from a range of expert advice e.g. children's or mental health commissioning advice who may in turn seek advice from members of the Panel or elsewhere. This advice should be recorded. Referrals may be returned to the referrer for greater clarification.

A summary of the referrals made, details of the request and outcome of decisions will be logged each month. Where a significant number of referrals are being made in a particular area or specialty these will be flagged to CCGs and the Priorities Committee.

Membership (IFR Panel)

The Panel should consist of primary care clinicians, the IFR lead or member of the team, an associate director / key contracting manager (Contracting) and a public health consultant. The Panel should be chaired by a senior clinician or public health consultant. Where appropriate, support should be secured from a medicines management lead and a nursing professional depending on the cases considered. A guide to membership is as follows to ensure clinical participation.

Chair
At least 2 local clinicians/ GPs
Nursing/pharmacy representation (as and when required)
Commissioning/ IFR lead
Minute taker to record decisions

The Panel will meet twice a month for which there should be a minimum of 3 clinicians/allied health professionals as a quorum. Additional members may be co-opted as the need arises. The key task of the Panel is to consider and discuss individual cases and to decide to approve funding, reject a request or defer to seek further information. It is intended that the Panel should be represented by each of the CCGs or that CCGs delegate representation so that it acts as a decision-making body on behalf of all the CCGs in the area it represents.

7 CCG APPEALS PANELS

The GP/clinician has a responsibility to refer appropriately. Good working relationships should ensure that proper procedures are followed. However, the referrer may wish to appeal against a decision and this should initially be made in writing to the IFR Lead with additional supporting information/evidence. If the information provided contains new evidence the referral should be reconsidered by the original Panel. If their decision remains unchanged the referral will be directed to the relevant CCG's Appeals Panel.

Terms of reference and membership

The Appeals Panel for each commissioner will remain to consider appeals from referring clinicians on behalf of patients from their area. The Appeals Panel's remit will be to consider whether the process and rationale behind the IFR Panel's decision-making has been adequately followed, that all relevant information has been considered and that the decision was fair, equitable and based on the evidence available at the time. It does **not** take funding decisions itself and, if any new evidence is brought before it, this must be referred back to the previous Panel.

The constitution of the Appeals Panel is to be determined by the CCG but it is recommendation that it should have at least two clinical members, preferably from its governing body, and a lay member. A member of the original decision-making Panel may also attend to present the audit trail of the case being considered but would not have a vote in any decision made. Clinical colleagues may be co-opted onto any Panel depending on the subject matter.

Should the Appeal Panel return a case for reconsideration by the IFR Panel, then funding would be expected to follow. The grounds for funding decisions need to be accepted as relevant to meeting the overall healthcare needs of the population within resource constraints.

The CSU will not accept appeals instigated by a patient, their family or other non-clinical representative (e.g. local MP).

At both the initial referral and appeal stages, cases will be considered with the GP/other referring clinician being the main point of contact. The decision of the Appeals Panel is final.

Complaints

Patients have the right to raise a formal complaint with the CCG via the NHS Complaints Procedure should they be unhappy with the CSU's handling of their case (i.e. staff attitude, communication or the way in which the policy or procedure has been followed, adherence to procedure). The NHS Complaints Procedure is set out to address concerns over service provision and not funding decisions. It cannot be used to investigate or influence funding decisions and the appropriate process for appeals should be followed i.e. from the referring clinician and not the patient.

8 SERVICE DEVELOPMENTS

Commissioners should not accept the introduction of new interventions through the IFR process. The NHS Contract makes it clear that the hospital provider is expected to seek support for new treatments through submission of a business case to the commissioner and thus a contract variation. There is, therefore, an expectation that new treatments will be properly assessed and prioritised. It is not rational for commissioners to manage new treatments by considering one patient at a time nor would this be fair, because it breaches a common principle that no treatment should be offered to an individual that would not be offered to patients with equal clinical need.

NHS England's draft policy on IFRs **http://www.england.nhs.uk/wp-content/uploads/2013/04/cp-03.pdf** states the following

A service development is any aspect of healthcare which the commissioner has not historically agreed to fund and which will require additional and predictable recurrent funding.

The term refers to all decisions which have the consequence of committing commissioners to new expenditure for a cohort of patients including:

- *New services*
- *New treatment including medicines, surgical procedures and medical devices*
- *Developments to existing treatments including medicines, surgical procedures and medical devices*
- *New diagnostic tests and investigations*
- *Quality improvements*
- *Requests to alter an existing policy (called a policy variation). This change could involve adding in an indication for treatment, expanding access to a different patient sub-group or lowering the threshold for treatment.*
- *Pump priming to establish new models of care*
- *Requests to fund a number of patients to enter a clinical trial.*
- *Commissioning a clinical trial.*

It is normal to consider funding new developments during the annual commissioning round.

An in-year service development is any aspect of healthcare, other than one which is the subject of a successful individual funding request, which the commissioner agrees to fund outside of the annual commissioning round.

When a commissioner considers funding a service development outside the normal commissioning process it is particularly important that those taking the decision pay particular attention to the need to take account of the opportunity cost …. to fund other areas of competing health needs.

Unplanned investment decisions should only be made where they have been approved in accordance with the terms of this policy, which will usually be in exceptional circumstances, because, unless they can be funded through disinvestment, they will have to be funded as a result of either delaying or aborting other planned developments.

It is common for clinicians to request an IFR for a patient where the request is, properly analysed, the first patient of a group of patients wanting a particular treatment. For example, a new drug has been licensed for a particular type of cancer and for patients with particular clinical characteristics. Any IFR which is representative of this group, represents a service development. As such it is difficult to envisage circumstances in which the patient can properly be classified to have exceptional clinical circumstances. Accordingly the IFR route is usually an inappropriate route to seek funding for such treatments as they constitute service developments. These funding requests are highly likely to be returned to the provider trust, with a request being made for the clinicians to follow the normal processes to submit a bid for a service development.

9 IMPLEMENTATION OF NICE GUIDANCE

NICE guidance is published as a series of Technology Appraisal Guidance documents, Multiple Technologies Guidance, Clinical Guidelines, and Interventional Procedures Guidance. These documents are distributed widely within the NHS. The guidance is also available on the NICE web site at www.nice.org.uk. **It should be noted that guidelines and Interventional Procedures guidance are not mandatory. Only Technology Appraisal Guidance published by NICE as mandatory carries a duty to make funding available to implement within 3 months of the publication date, unless otherwise stated.**

Provider contracts take account of a limited percentage – the NICE uplift - to meet the estimated costs of implementation in secondary care. The assumptions used to estimate the reserve involve a significant degree of financial risk. **Moreover, this reserve is top-sliced from any growth monies at the beginning of the year. Thus, the cost of funding NICE recommendations has a direct impact upon the ability to fund competing priorities for service development.**

In light of the above factors it is essential that interventions approved by NICE are used only in accordance with the published criteria. The secondary care clinician should provide evidence that the criteria are met.

If published NICE guidance is likely to have significant resource implications for the local NHS, implementation may be delayed for a period of 3 months from the date of publication. This is to enable the necessary administrative arrangements to be put in place. However, the PCTs accept that delayed implementation may not be appropriate for rapidly progressive conditions where delay is likely to compromise the clinical outcome significantly.

The NICE reserve does not cover the costs of implementation of NICE guidance in primary care. The funding for this is included within the annual uplift to primary care prescribing budgets.

As per Department of Health guidance, the above does not preclude commissioners from funding health interventions that are not subject to finalised NICE guidance or are currently in the NICE process awaiting guidance. Appropriate procedures for consideration should still be taken.

10 MANAGING THE ENTRY OF NEW DRUGS

Relevant District Prescribing Committees (DPCs) or Area Prescribing Committees (APCs) are responsible for considering whether new drugs and preparations are suitable for local use. The DPCs/APCs are joint bodies formed with members from provider and commissioners. The use of drugs not approved by DPCs/APCs is not generally supported.

If a referrer wishes to propose that a drug or preparation be considered for use by clinicians locally, a formal application should be made to the Chief Pharmacist. Additions to the formulary should represent a significant advance over current therapy. The application should be supported by any relevant published research evidence. The application forms can be found at the front of the Joint Formulary file.

There is no reserve to meet the costs of introducing new drugs (other than those approved by NICE) within the financial year. If a new drug is supported by the DPC/APC and agreed formally by the commissioners, the costs of its introduction will need to be met from existing resources. This applies equally whether the drug is prescribed within secondary care or in primary care. Where the costs cannot be absorbed, the addition of the drug to the Formulary may need to be deferred until resources allow. Cost pressures on the secondary care drugs budget are negotiated through the annual Operating Plan.

Appropriate drug therapy is commissioned as an integral part of patient care. Individual drugs should not be excluded from contracts as a separate cost item.

It is anticipated that a large number of new drugs either implemented following NICE guidance or the area Prescribing Committee arrangements will be commissioned by NHS England Specialised Services and not directly by CCGs.

Surgical restricted and excluded procedures
This lists sets out those requiring an IFR or prior approval and from where such an application should come but discretion can be applied where appropriate by the CSU team in terms of who may apply.

Procedure – the specialties listed below are a guide only and patients may be treated under different treatment function codes	Page no. in policy	IFR Required	Prior Approval	Request normally expected from
ORTHOPAEDIC				
Bunion (hallux valgus) surgery	31		✓	Secondary Care or MSK community service
Carpal tunnel release	30		✓	Primary Care, Secondary Care or MSK service
Dupuytren's contracture surgery (palmar fasciectomy)	30		✓	Primary Care or MSK service
Ganglion surgery	36		✓	Primary Care
Hip or knee replacement (primary) BMI 35+	32		✓	Secondary Care or MSK community service
Hip resurfacing	30		✓	Secondary Care or MSK community service
Hip arthroscopy for impingement	30		✓	Secondary Care or MSK community service
Arthroscopic lavage and debridement with or without meniscectomy for persistent knee pain	30		✓	Secondary Care or MSK community service
Trigger finger surgery	30		✓	Primary Care or MSK service
PAIN				
Injections for back pain (see full policy guidance)	27		✓	Secondary Care
Radio-frequency denervation of facet joint	27		✓	Secondary Care
OTHER SURGERY				
Abdominoplasty/ apronectomy (IFR **or prior approval if after massive weight loss**)	34	✓	✓	Primary Care
Breast procedures	15	✓		Primary Care
Gastric fundoplication for reflux disease	35		✓	Secondary Care
Inguinal hernia (asymptomatic)	36		✓	Secondary Care
Varicose vein treatment	25		✓	Primary Care
Cosmetic devices/ appliances – e.g. silicon cosmeses/prostheses	18	✓		Primary Care
Laser treatment	18	✓		Primary Care/ Dermatology
Skin lesions (benign)	17	✓		Primary Care
Plastics procedures (facial, brow, facelift, thighs, upper arms)	15	✓		Primary Care
OPHTHALMOLOGY				
Blepharoplasty (eyelid surgery)	33		✓	Primary Care
Chalazia /Meibomian cyst excision	32		✓	Primary Care
Short sight/ long sight corrective (laser) surgery (Refractive keratoplasty)	18	✓		Secondary care
Second eye cataract surgery	33		✓	Community ophthalmology or secondary care
ENT				
Functional nasal airways surgery	24		✓	Primary Care or ENT
Tonsillectomy	23		✓	Primary Care or ENT
Grommet insertion /myringotomy (adults and children)	22/23		✓	Secondary Care

Adenoidectomy in children with upper respiratory tract disorders	18	✓		Secondary Care
Pinnaplasty	15	✓		Primary Care
Surgery for snoring	18	✓		Secondary care
GYNAECOLOGY/ UROLOGY				
Female cosmetic genital surgery (labiaplasty)	16	✓		Primary Care
Female sterilisation	26		✓	Primary Care or Gynaecology
Circumcision	27		✓	Secondary Care Primary Care or
Hysterectomy for menorrhagia	25		✓	Secondary Care
Reversal of sterilisation/ vasectomy	19	✓		Primary Care
Penile prosthesis	19	✓		Secondary care

Appendix 1: EXCLUDED PROCEDURES requiring Individual Funding Request

The procedures listed below are not routinely funded. Funding may be considered in exceptional circumstances, applying the definition detailed above of exceptionality provided by the NHS Confederation. The clinician will be required to complete the appropriate Individual Funding Request application form from appendices 4 and 5.

The following list is not exhaustive and will be subject to regular change as and when evidence is published and priority advice is taken around commissioning.

The recommendations and policy notes of the SHIP Priorities Committee, if endorsed by CCGs, will supersede or add to this list as will mandatory NICE Technology Appraisal Guidance. Where a Priorities Committee policy document is referenced, please consult http://www.southcsu.nhs.uk/documents/ifr

The specialties listed below are a guide only and patients may be treated under different treatment function codes	**Procedure**	**OPCS codes**	**Guidance notes**	**The exclusion does not apply in the following circumstances and patients may be treated without prior approval**
Plastic/ cosmetic procedures surgery	**CCGs do not fund the provision of plastic/ cosmetic procedures for cosmetic reasons as per the South Central Priorities Committee policy statement 15. See Appendix 6**			
	Liposuction	S621/2	CCGs do not routinely fund this procedure	
	Facelift	S01-	CCGs do not routinely fund this procedure	
	Buttock lift, thigh lift, upper arm lift (brachioplasty)	S03-	CCGs do not routinely fund this procedure	
	Breast and nipple procedures	B29, B30, B31, B35, B36	CCGs do not routinely fund this procedure	Reconstructive procedures may go ahead as part of established pathways and must take place within one year of the last cancer treatment
	Pinnaplasty/meatoplasty/ plastic operations on external ear	D03-	CCGs do not routinely fund this procedure	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
	Female cosmetic genital surgery (labiaplasty)	P01-, P055/6/7, P153/8/9	CCGs do not routinely fund this procedure	
	Rhinoplasty/ reconstruction of nose	E02- E072/3/8/9	CCGs do not routinely fund this procedure. Functional nasal airways surgery should not be confused for cosmetic rhinoplasty and is referenced as a separate policy under Appendix 2.	In cases of post-surgical reconstruction as part of the pathway following trauma and must be within 12 months of the trauma occurrence.

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
Dermatology/ general surgery	Surgical removal of skin lesions.	S04, S05, S06, S08, S09, S10, S11, S60, Y08, Y11, Y13	CCGs do not routinely fund this procedure. Referrals to secondary care for skin lesions should only be made directly to dermatology/general surgery where there is suspicion of malignancy. All other referrals for benign lesions including lipomas are not routinely funded and can only be supported via **prior approval** including reported symptoms. Removal should not be offered except via prior approval where there is - Obstruction of an orifice or vision - Functional limitation to movement or activity - Moderate to large facial lesions causing disfigurement - Significant symptoms such as recurrent bleeding, infection or inflammation; marked itching or severe pain failing to respond to medical or conservative management - Located in an area of recurrent trauma Applications in cases which are asymptomatic but considered severely disfiguring may be made with appropriate photography to demonstrate the level of disfigurement. The DLQI (Dermatology Life Quality Index) (appendix 7) offers a useful guide and should be included with the request. A summary of how the patient's daily function is affected must be provided.	Hidradenitis suppurutiva (coded as L73.2) **Where there is a suspicion of malignancy, the patient is referred using a two-week wait referral form for suspected cancer or via the local BCC fast track pathway.** **The patient is coded with a cancer diagnosis.**

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
Plastic surgery	Laser removal of skin and excessive hirsutism		CCGs do not routinely fund this procedure. Usually offered at Salisbury laser service – and only with supporting photography considered via IFR	
	Appliances and devices for cosmetic purposes (high-grade silicon cosmesis and/or prosthesis)		CCGs do not routinely fund these appliances or devices.	
Ophthalmology	Short sight/long sight corrective (laser) surgery (Refractive keratoplasty)	C461	CCGs do not routinely fund this procedure May be considered via IFR where laser or operative correction is the only treatment available to restore reasonable visual acuity/or where there are substantial other medical reasons that make correction by external visual aids inappropriate.	
ENT	Adenoidectomy in children with upper respiratory tract disorders	E201/4 as sole procedure	In line with Priorities Committee policy statement Feb 2016 CCGs do not routinely fund this procedure .	When offered in **combination** with myringotomy (grommet insertion) and/or tonsillectomy **which are subject to separate prior approval arrangements**
	Surgery for 'snoring'	Note **ICD10** code R06.5	In line with Priorities Committee policy statement Feb 2016 Any surgical procedure where. R06.5 (mouth breathing) is the primary diagnostic code will not be routinely funded routinely by CCGs.	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
Dermatology	Surgical shaving/ laser treatment / chemical destruction of skin	E094/6	CCGs do not routinely fund this procedure. May be considered via IFR on submission of clinical photography e.g. for port wine stains, excessive disfigurement	
Urology	Reversal of sterilisation/ vasectomy	♀- Q37, Q29, ♂ - N18	CCGs do not routinely fund this procedure May be considered via IFR on the death of a partner or only child or where sterilisation caused by proven surgical accident that was not a foreseen consequence of such a procedure.	
	Penile prosthesis for erectile dysfunction	N29	CCGs do not routinely fund this procedure Reference SHIP Priorities Committee Policy 96a	
Alternative/ complementary/ homeopathic therapies	Complementary therapies/medicine	X61	CCGs do not routinely fund this	When included as an adjunct to usual therapy e.g. acupuncture within physiotherapy or pain management services. **Not** funded as a separate procedure
Mental health	In patient treatment for severe chronic Fatigue/ME		CCGs do not routinely fund this. Severe cases require an IFR but mild-to-moderate cases are available in the commissioned outpatient service run by South Coast Fatigue.	
	Non-NHS residential		CCGs do not routinely fund this	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
	placements			
	Adult ADHD		CCGs do not routinely fund this. Agreed via IFR	

Appendix 2: PRIOR APPROVALS AND PROCEDURES SUBJECT TO CLINICAL THRESHOLDS

Where the clinical and cost effectiveness of a procedure is only proven when certain criteria are met, this has been known as a Procedure of Limited Clinical Value (PLCV) though may be more appropriately named a '**procedure of defined benefit'** as the procedure itself can offer significant clinical benefit so long as its offered to the **right patient for the right indications.**

Prior approval

The procedures listed below require prior approval before treatment can commence. The following CCGs will require approval for the procedures listed below before treatment can commence.

Fareham & Gosport CCG
South Eastern Hampshire CCG
Portsmouth CCG
West Hampshire CCG
North Hampshire CCG

For Southampton CCG only - If during the course of 2016/17, the CCG sees an unexpected spike in activity then evidence will be sought from the provider to justify activity above the agreed Plan. If the evidence from the provider cannot be provided then the cost of the procedure will be withheld. Alongside this, there will be monitoring of GP referral trends and if practices are seen as outliers this could trigger a practice level audit.

Providers will not be paid for activity that has been carried out without evidence of prior approval. Prior approval codes are valid for 12 months from date of issue.

Prior approval is requested via

1) Primary care or tier 2 intermediate care clinician via the Commissioning Support Unit using the proforma at www.southcsu.nhs.uk/documents/ifr (see 'Prior Approval forms')
2) The Prior Approval Tool https://priorapproval.hampshire.nhs.uk/.
3) Where the Tool is not used by, or is not available to, secondary care, the treating clinician should seek approval as per option 1

The decision to approve or reject a request is generally made within 5 working days. If a request is authorised a prior approval code will be issued.

For associate commissioners outside of this policy, approval should be sought from either the CCG 'in-house' service or from the CSU representing that commissioner.

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
ENT/ Audiology	Myringotomy/ grommet insertion for children	D151	This procedure is not routinely funded. Prior approval will be considered under the following conditions: • Children with disabilities such as Downs Syndrome and Cleft Palate where the insertion of grommets is part of an established pathway of care. • Children to treat a tympanic membrane retraction pocket. • Children aged over 3 years old with Otitis Media with Effusion (OME) and without a second disability (such as Downs Syndrome or Cleft Palate) when: o There has been a period of watchful waiting for three months in primary care from diagnosis of OME in primary care, followed by a further period of watchful waiting for up to three months in ; secondary care; and o OME persists after the three-six months of watchful waiting; and o The child has documented speech or language delay or behavioural problems; and o The child has a documented hearing level in the better ear of 25-30dBHL or worse averaged at 0.5, 1, 2 and 4kHz (or equivalent dBA where dBHL not available)	Children under 3 years of age

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
	Myringotomy/ grommet insertion for adults	D151, D222	This procedure is not routinely funded Prior approval will be considered under the following conditions This procedure is not routinely funded for adults (≥ 18 years old) except where prior approval is granted under the following conditions: - A middle ear effusion causing measured conductive hearing loss, persisting for 3 months and resistant to medical treatments. The patient must be experiencing disability due to deafness. The possible option of a hearing aid may be discussed, at the discretion of the clinician. - Persistent Eustachian tube dysfunction resulting in pain (e.g. flying) – 3-month wait not required - As one possible treatment for Meniere's disease. - Severe retraction of the tympanic membrane if the clinician feels this may be reversible and reversing it may help avoid erosion of the ossicular chain or the development of cholesteatoma – 3-month wait not relevant - Grommet insertion as part of a procedure for the diagnosis or management of head and neck cancer and/or its complications NB It is important that conductive unilateral hearing loss present for 4 weeks should be referred to an ENT surgeon without delay	
	Tonsillectomy	F34, F361	This procedure is not routinely funded Prior approval will be considered under the following conditions Tonsillectomy will be funded subject to prior approval - in children and adults for cancer or suspected cancer; or - in children and adults for cases of quinsy requiring hospital admission; or - in children and adults in a high risk category e.g. Down's	In children and adults for cancer where patient is coded with a cancer diagnosis. Patient is suspected with cancer and has been referred via the two-week wait referral form.

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			syndrome, cerebral palsy, cranio-facial disorders, chronic lung disease, sickle cell disease, neuro-muscular disorders, genetic or metabolic disease, central hyperventilation syndromes; or - severe halitosis due to tonsillar debris following conservative management - in children and adults with diagnosed obstructive sleep apnoea where other treatments have failed or are inappropriate; or - in children and adults for tonsillitis if <u>all</u> of the following criteria are met: • Sore throats are due to tonsillitis **and** • There are <u>5 or more</u> episodes of sore throat per year **and** • There have been symptoms for at least a year **and** • Episodes of sore throat are disabling and preventing normal functioning **GP referrals must include the practice record detailing frequency of reported episodes and prescribing in line with the criteria above. Providers should alert commissioners/CSU where this is not being included.**	
	Functional nasal airways surgery (which may include (septo) rhinoplasty)	E02.3/4 E03- E04- E07.3 E07.8/9 E64.8/9	This procedure is not routinely funded Prior approval will be considered under the following conditions • There is continuous nasal airway obstruction causing significant symptoms such as diagnosed obstructive sleep apnoea; and • Obstructive symptoms persisting despite conservative management for > 3 months including nasal steroids or immunotherapy Correction of complex congenital conditions that are not otherwise covered under specialised commissioning	Emergency procedures recorded under admission method 21-28

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			arrangements will also be considered	
Vascular Surgery	Varicose vein procedures	L84, L85, L86, L87, L88	This procedure is not routinely funded Prior approval will be considered under the following conditions Reference: SHIP Priorities Committee policy statement no. 001. http://www.southcsu.nhs.uk/documents/ifr People with a body mass index less than 32 kg/m^2 who satisfy **at least one** of the following criteria may be considered for interventions to treat varicose veins: • a first venous ulcer persists despite a six-month trial of conservative management of the ulcer • a recurrent venous ulcer • haemorrhage from a superficial varicosity	Emergency procedures recorded under admission method 21-28
Gynaecology	Hysterectomy in heavy menstrual bleeding/ dysmennorhea	Q07- (except Q076), Q08	This procedure is not routinely funded Requests for hysterectomy for heavy menstrual bleeding or dysmenorrhoea will be considered if **all** the following criteria are met: Other treatments for heavy menstrual bleeding (in accordance with NICE Clinical Guideline 44 “Heavy Menstrual Bleeding”) or dysmenorrhoea • Such as a trial of a Mirena coil have failed or are medically contraindicated; • An alternative first line treatment has failed including tranexamic acid, NSAIDs, combined oral contraceptives, oral progesterone or injected progesterone;	Hysterectomy for uterine problems amenable to surgery and not related to heavy menstrual bleeding or dysmenorrhoea will be funded and do not require prior approval.

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			• Endometrial resection/ablation has failed to relieve symptoms, or is contraindicated e.g. fibroids >3cm, abnormal uterus; and • There is a wish for amenorrhoea; and • The woman no longer wishes to retain her uterus and fertility	
	Female sterilisation	Q27, Q28, Q35, Q36	This procedure is not routinely funded Prior approval will be considered under the following conditions • Sterilisation will not be available on non-medical grounds unless the woman has had at least 12 months' trial using Mirena or Implanon and found it unsuitable. • Where sterilisation is to take place at the time of another procedure such as caesarean section. • Where there is a clinical contraindication to the use of a Mirena/Implanon. • Where there is an absolute clinical contraindication to pregnancy. These are:- ▪ young women (under 45 years of age) undergoing endometrial ablation for heavy periods ▪ women with severe diabetes ▪ women with severe heart disease Women should be informed that vasectomy carries a lower failure rate in terms of post-procedure pregnancies and that there is less risk related to the procedure.	
Urology	Male circumcision	N303	This procedure is not routinely funded Prior approval will be considered under the following	Patients coded with a cancer diagnosis

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			conditions - Suspected cancer - Balanitis xerotica obliterans (BXO) - Congenital urological abnormality where skin grafting is required - Interference with normal sexual activity - Phimosis interfering with urine flow and/or recurrent urinary tract infections - Symptomatic paraphimosis - Symptomatic or minor hypospadias - Recurrent balanophosphitis resistant to antibiotics Where appropriate conservative measures e.g topical steroids should have been exhausted first. Paraphimosis is not a routine indication for circumcision	Patient is suspected with cancer and has been referred via the two-week wait referral form
Pain management	Interventional treatments for back pain (spinal/epidural injections; facet joint and medial branch blocks; radio-frequency lesioning/denervation)	A52-A54.2 A57.3 A60.4 V48-V544	These procedures are not routinely funded Prior approval will be considered under the following conditions **NON-SPECIFIC BACK PAIN** As per NICE Guidance, injections of therapeutic substances into the back for non-specific low back pain should not be offered. Therapeutic facet joint injections should only be offered in the context of either special arrangements for clinical governance and clinical audit or research and are not routinely funded. Epidural injections (either sacral or interlaminar) or nerve root injections are not of value for patients with non-specific low back pain. **SPECIFIC BACK PAIN** Interventional treatments should only be offered in the context of a comprehensive multi-disciplinary programme of care with arrangements for ongoing assessment and following a trial of treatment that shows no evidence of	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			response. Diagnostic facet joint injections and medial branch block or spinal/ epidural injections should be part of a comprehensive MDT led programme. They are only funded for patients with chronic back pain if performed by a clinician trained in the assessment, diagnosis and management of back pain as part of an MDT. These should only be funded • As a diagnostic tool to improve the specificity of radio-frequency lesioning where this is being considered **OR** • One injection where all the following criteria are met - Pain lasting > 12 months **AND** - Failed conservative treatment including maximal oral and topical analgesia **AND** - The patient has been assessed by a clinician trained in the management, diagnosis and management of back pain who considers it would enable mobilisation and participation in rehabilitation **AND** - There is documented use of a standardised Pain and Quality of Life tool before and after the procedure **Repeat** injections will only be funded as part of that pain management pathway where there is significant improvement in the Pain and Quality of Life score. No more than **TWO** injections will be funded within any one year	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			Where appropriate it is expected that some procedures will be offered on an outpatient basis and priced accordingly. See British Pain Society and Royal College of Anaesthetists (Faculty of Pain Medicine) guidelines 'Standards of good practice for spinal interventional procedures in pain medicine (2015)' **CHRONIC BACK PAIN** Radiofrequency denervation/ endothermal ablation should be part of a comprehensive MDT-led plan with ongoing assessment and only following a trial of treatment (medial branch/facet joint block) demonstrating evidence of response. **ONE** diagnostic medial branch/ facet joint block may be funded prior to denervation techniques and this should demonstrate >50% improvement in pain using a validated scoring tool before proceeding with denervation. **Repeat** denervation procedures may only be offered following a previous successful response (as above) with benefits lasting > 6 months. This should only be permitted with a minimum interval of 12 months. Therefore those patients experiencing <12 months relief following two procedures will not be offered further denervation treatment	
Orthopaedics/ MSK	Trigger finger surgery	T723	These procedures are not routinely funded Prior approval will be considered under the following conditions for patients diagnosed with trigger finger: • who fail to respond to conservative treatment, including no response from up to two corticosteroid injections; and • moderate to severe pain/locking sufficient to cause interference with hand function; and • persistent symptoms > 3 months	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
	Carpal tunnel release/ nerve entrapment at wrist	A65-	These procedures are not routinely funded Prior approval will be considered under the following conditions • All conservative measures (e.g. wrist splint, anti-inflammatories or injection into the carpal tunnel) have failed; and • There have been symptoms for longer than 6 months or • Evidence of neurological deficit such as sensory blunting or weakness of thenar (thumb base) abduction.	
	Palmar fasciectomy /Dupuytren's contracture	T521/2 T541	These procedures are not routinely funded Prior approval will be considered under the following conditions ○ patient has a fixed flexion in one or more joints exceeding 25° or • Patients under 45 years of age with 2 or more affected digits and fixed flexion exceeding 10° and • there is functional impairment which may include safety concerns	
	Treatment of bunions (hallux valgus)	W791/2 W151-4	These procedures are not routinely funded Prior approval will be considered under the following conditions • Have been managed via MSK or podiatry services first before consideration of orthopaedic surgery AND • Has documented functional impairment AND • Inability to wear suitable footwear AND • Patient is fully aware of pros and cons of surgery	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			having used patient decision aids	
	Arthroscopic lavage and debridement with or without partial meniscectomy of the knee in patients with non-traumatic and persistent knee pain	W82- (combined with diagnostic codes M179 or M232….)	These procedures are not routinely funded Reference SHIP Priorities Committee policy statement no 010 - April 2016. http://www.southcsu.nhs.uk/documents/ifr a. Where the patient has persistent pain and clear mechanical symptoms of locking	Cases of traumatic knee pain will not require prior approval
	Hip resurfacing	W580/1/2 + Z843	These procedures are not routinely funded Prior approval will be considered under the following conditions Reference SHIP Policy Recommendation 105 on Metal on Metal (MOM) hip resurfacing http://www.southcsu.nhs.uk/documents/ifr As an alternative to hip replacement in men younger than 55 years of age provided the risks and benefits have been explained and the patient is keen to proceed. In older men and in women of all ages, funding for hip resurfacing is not funded.	
	Primary hip and knee replacement in patients with a	W371/381 (hip) W40/W41/ W42	These procedures are not routinely funded for patients with a BMI above 35 Prior approval will be considered under the following	**Emergency procedures recorded under admission method 21-28**

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
	BMI above 35	(knee)	conditions a) In patients whose pain is so severe and/or mobility compromised that they are at risk of losing their independence and that joint replacement would relieve this risk b) In patients whose destruction of the joint is of a severity that delaying surgery would increase the technical difficulty of the procedure Referral should also have been made for referral to the commissioned tier 2 or tier 3 obesity management programme prior to offering surgery.	
	Arthroscopic hip surgery in impingement	X22.8, W084/5, W091, W581, W83-, W84-, W861/8, W891 **(+ Y76.7 + Z84.3)**	In line with SHIP Priorities Committee policy statement 006 Arthroscopic femero-acetabular surgery for hip impingement should be considered as a second line treatment option for patients who are symptomatic, have significant impaired activities of daily living and have undergone activity modification as part of conservative treatment. Patients with evidence of osteoarthritis in the hip joint are not suitable for arthroscopic hip impingement surgery. All arthroscopic surgery for hip impingement procedure data should be submitted to the registry set up by the British Hip Society Registry (in line with NICE guidance).	
Ophthalmology	Chalazia (meibomian cysts)	C121	Chalazia (meibomian cysts) are benign, granulomatous lesions that will normally resolve within 6 months. Treatment consists of regular (four times daily) application of heat packs. These procedures are not routinely funded	Patients coded with a cancer diagnosis Patient is suspected with cancer and has been referred via the two-week wait referral form

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			Prior approval will be considered under the following conditions - The chalazia has been present for more than 6 months - Where it is situated subcutaneously in the upper or lower eyelid - Where it is causing impairment of vision	
	Eyelid surgery/ blepharoplasty	C13-, C16-, C18-	These procedures are not routinely funded Prior approval will be considered under the following conditions - There is significant effect on visual fields as documented by formal clinical photography or a visual field test which should be provided with the prior approval application; or - for relief of ectropion or entropion; or - other demonstrated complications causing visual dysfunction as detailed by the referring clinician	
	Second eye cataract surgery	C71/2/3/4/5	Requests should come from either primary care or community optometry services. Requests from secondary care ophthalmology should only involve patients on long-term follow-up or listed for bilateral two-stage procedures. These procedures are not routinely funded Prior approval will be considered under one of the following conditions; • Best corrected visual acuity worse than 6/9 in the second eye for drivers (6/12 or worse for non drivers) • Best corrected binocular visual acuity of 6/18 or worse irrespective of the visual acuity of the first	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			eye • Anisometropia +/- 2D or where symptomatic • Surgery indicated for control of glaucoma or to facilitate further surgery (as determined by consultant ophthalmologist) • Surgery indicated for view of diabetic retinopathy or retinal disease (where cataract impairs retinal view) • Severe glare • Patient wishes to/is required to drive and does not meet DVLA sight test requirements • The cataract is preventing the management of other co-morbid eye conditions Where visual acuity is a criterion, the referring clinician should demonstrate the level via Snellen test score.	
Cosmetic/Plastic/ Aesthetic surgery	Excision of skin following massive weight loss	S02-	These procedures are not routinely funded Removal of excess skin including abdominoplasty, mammoplasty and removal of skin folds from the inner thighs following significant weight loss may be considered under **all** the following conditions : 1. The patient's starting BMI before weight loss must have been no less than 45kg/m^2 (the threshold for access to bariatric surgery in HIOW). 2. The patient's BMI must be less than 30kg/m^2. (In some patients a BMI of less than 30kg/m^2 may not be achievable, due the weight of excess skin. In these circumstances an exception to the policy may be considered, provided that the patient has lost at least 50% of their excess weight, and their clinician confirms that no further reduction in BMI will be possible without removal of excess skin.) 3. The patient's weight must have been stable for a minimum of 2 years,	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			4. There must be documented evidence of clinical pathology or disability due to the skin fold in question (e.g. recurrent infection, intertrigo, cellulites, restricted mobility, inability to undertake physical exercise to maintain cardiovascular fitness). Purely cosmetic procedures, such as removal of surplus skin from the arms, will not be funded.	
Gastroenterology	Gastric fundoplication for chronic reflux oesophagitis	G241 G243 G461	These procedures are not routinely funded Prior approval will be considered under the following conditions - regular, significant symptoms of gastro-oesophageal reflux despite receiving at least one year of continuous pharmacological treatment up to the maximum dose licensed for reflux oesophagitis - significant volume reflux placing them at risk of aspiration - anaemia because of oesophagitis Reference: South Central Priorities Committees policy statement no 51.	For all other indications, treatment is funded
General surgery/ hand surgery/	Treatment of **asymptomatic** inguinal hernias		These procedures are not routinely funded Prior approval will be considered where one of the following conditions are met • History of incarceration of or real difficulty in reducing the hernia • An inguinal-scrotal hernia • An increase in size • Pain or discomfort significantly interfering with activities of daily living directly related to the hernia	Emergency procedures recorded under admission method 21-28
	Treatment of	T59-,	There is a reasonable chance that ganglia will disappear	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
	ganglions	T60	spontaneously and even if they persist they do not cause adverse long term effects. These procedures are not routinely funded Prior approval will be considered where one ofll the following conditions are met: • the ganglion is the likely cause of persistent pain, either through local effects or likely pressure on a nerve • the ganglion is the cause of reduced function, perhaps through loss of range of movement or pain • there is a sudden increase in size raising suspicion of an alternative diagnosis	
Various services	Intensive decongestive therapy for lymphoedema	n/a	In line with SHIP Priorities Committee policy statement 004 Assessment and treatment (particularly skincare, compression, remedial exercise, and self-management education) should be available for patients with lymphoedema within existing NHS services, for all patients who have lymphoedema irrespective of the cause. Patients, who receive treatment which may cause lymphoedema in the short or medium term, should be properly informed about the risk of lymphoedema (through consent arrangements) and educated in its management. Intensive courses of decongestive therapy for refractory lymphoedema must be sought via **prior approval**	
	Functional electrical stimulation in drop foot	n/a	In line with SHIP Priorities Committee policy statement 005 Functional Electrical Stimulation may be considered as a second line treatment option for carefully selected patients	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			with drop foot (most commonly due to multiple sclerosis or stroke) who have clearly failed trials of orthosis (for example due to pressure sores, spasticity). It should be considered a **low priority** for all other patients All cases must be sought via **prior approval**	
Infertility treatments	In vitro fertilisation (including the prescriptions of infertility drugs) and ICSI (intracytoplasmic sperm injection)	n/a	This treatment is not routinely funded Prior approval will be considered in line with the SHIP Priorities Committee policy statement 002 - September 2014 where endorsed by individual CCGs http://www.southcsu.nhs.uk/documents/ifr	
Children's Services	Assessment and admission to Bursledon House in Southampton for in-patient treatment	n/a	Admissions to Bursledon House are not routinely funded. Children considered for referral to Bursledon House must have referrals prior approved before assessment is carried out and, if agreed, further approval must be sought after assessment where admission is requested	

THRESHOLDS COMMISSIONING

Clinical threshold management has been introduced to reduce variation and ensure that elective procedures accessed by patients are at the most appropriate time and consider the entire clinical pathway. The Map of Medicine tool supports this process and is available through NHS Athens accounts. Reduced variation will improve fairness to patients and allow optimum use of funding. Thresholds on activity currently exist for a number of procedures as in the core exclusions list but there will be a number of procedures subject to negotiated volume thresholds. **Treatment will not be subject to prior approval but will be subject to audit of an agreed sample of activity. This sample will be extrapolated against all activity so that the proportion of procedures considered inappropriate will not be reimbursed. It is therefore essential that, where treatment is offered that falls outside the agreed clinical thresholds, that the rationale is clearly recorded in the patient notes.** Such audits will be independently carried out with consultant input invited to validate the results.

Ophthalmology	First eye cataract surgery (threshold criteria)	C71, C72, C73, C74, C75	GPs should refer patients with cataracts in the first eye in line with the following criteria. Optometrists will have carried out the appropriate assessments and referred back to GP for onward referral to secondary care. A copy of the optometrist report (GOS18 or suitable referral form) must be included with the referral. Patients should be referred where best corrected visual acuity as assessed by high contrast testing (Snellen) is: Binocular visual acuity of 6/10 or worse for drivers, OR Binocular visual acuity of 6/12 or worse for non-drivers, OR Reduced to 6/18 or worse irrespective of the acuity of the other eye OR: The patient wishes to/is required to drive and does not meet Driving and Licensing Authority (DVLA) eyesight requirements Any suspicion of cataracts in children (e.g. altered or absence of red reflex at neonatal or 6 week check) should be referred urgently Exceptionally, patients who have significant glare, asymmetrical refraction or monocular diplopia affecting work or quality of life, but do not meet the thresholds above, should be referred for assessment
Orthopaedics	Primary hip replacement	W371/381	In line with MOBBB Priorities Committee policy and agreed by West Hampshire and Southampton CCGs RECOMMENDED in patients in whom the following criteria are met: 1. Moderate or severe arthropathy confirmed on X-ray.

			2. A minimum of 6 months' conservative, primary care-based, management appropriate to their condition and needs (e.g. supported self-management, exercise, weight loss and analgesia) without improvement in symptoms. 3. Persistent severe joint pain, particularly night pain sufficient to disturb sleep, despite optimum analgesia. 4. Persistent and significant impact on activities of daily life which has been clearly documented by the referring clinician. 5. The risks and benefits of surgery applicable been explained to the patient, and they are willing to be referred for surgery. 6. The patient is fit for surgery at the time of referral. In all other circumstances, funding should be LOW PRIORITY.
	Primary knee replacement	W40/W41/ W42	RECOMMENDED in patients in whom the following criteria are met: 1. Moderate or severe arthropathy confirmed on X-ray. 2. A minimum of 6 months' conservative, primary care-based, management appropriate to their condition and needs (e.g. supported self-management, exercise, weight loss and analgesia) without improvement in symptoms. 3. Persistent severe joint pain, particularly night pain sufficient to disturb sleep, despite optimum analgesia. 4. Persistent and significant impact on activities of daily life which has been clearly documented by the referring clinician. 5. The risks and benefits of surgery applicable to them have been explained to the patient, and they are willing to be referred for surgery. 6. The patient is fit for surgery at the time of referral

Appendix 3: SOUTH CENTRAL ETHICAL FRAMEWORK

Background

The Priorities Committee is a committee of representatives of all Clinical Commissioning Groups (CCG) in Hampshire and the Isle of Wight. It includes the breadth of CCG representation, but as individuals providing their specialist knowledge on behalf of all their organisations, rather than being present as an organisational representative per se.

CCGs are required to adhere to a range of legal obligations which include commissioning value healthcare for their population, considering inequalities and managing within their annual allocation. Thus, difficult choices may need to be made. This Committee is established to support the due process behind decision making across the CCG population. Decisions regarding individual patients are without the remit of this process.

Purpose of the Ethical Framework

The purpose is to support and underpin decision making processes of constituent NHS commissioning organisations through their priorities committee by development of consistent policy by:

- Providing a coherent structure for discussion, ensuring all important aspects of each issue is covered
- Promoting fairness and transparency in decision making during meetings, between meetings and with regard to different topics to reduce any potential for inequity
- Providing a means of expressing the reasons behind the decisions made
- Ensuring implementation of robust decision making processes that are based on evidence of clinical and cost effectiveness adhering to an ethical framework
- Informing and supporting the development of CCG commissioning plans.

Formulating policy recommendations regarding health care priorities involves the exercise of judgment and discretion and there will be room for disagreement both within and outwith the Committee. Although there is no objective or infallible measure by which such decisions can be based, the Ethical Framework enables decisions to be made within a consistent setting which respects the needs of individuals and the community. The committee recognises that such recommendations may be influenced by national policy drivers.

The Ethical Framework is especially concerned with the following:

A: Evidence of Clinical and Cost Effectiveness

1.1. The Committee will seek to obtain the best available evidence of clinical and cost effectiveness using robust and reproducible methods. Methods to assess clinical and cost effectiveness are well established. The key success factors are the need to search effectively and systematically for relevant evidence, and then to extract, analyse, and present this in a consistent way to support the work of the Committees. Choice of appropriate clinically and patient-defined outcomes needs to be given careful consideration, and where possible quality of life measures and cost utility analysis should be considered.

1.2. The Committee will promote treatments for which there is good evidence of clinical effectiveness in improving the health status of patients and will not normally recommend treatment that is shown to be ineffective. Issues such as safety and drug licensing will also be carefully considered. When assessing evidence of clinical effectiveness the outcome measures that will be given greatest importance are those considered important to patients' health status. Patient satisfaction will not necessarily be taken as evidence of clinical effectiveness. Trials of longer duration and clinically relevant outcomes data may be considered more reliable than those of shorter duration with surrogate outcomes. Reliable evidence will often be available from good quality, rigorously

appraised studies. Evidence may be available from other sources and this will also be considered. Patients' evidence of significant clinical benefit is relevant.

1.3. The Committee will compare the cost of a new treatment to the existing care provided and will also compare the cost of the treatment to its overall benefit, both to the individual and the community. They will consider technical cost-benefit calculations where these can be accessed (e.g. quality adjusted life years), but these will not by themselves be decisive. The Priorities Committee may use the ethical framework to guide context-specific judgements about the relative priority that should be given to each intervention.

B: Equity

1.4. The Committee believes that people should have access to health care on the basis of need. There may also be times when some categories of care are given priority in order to address health inequalities in the community. However, the Committees will not discriminate on grounds of personal characteristics, such as age, gender, sexual orientation, gender identity, race, religion, lifestyle, social position, family or financial status, intelligence, disability, physical or cognitive functioning. However, in some circumstances, these factors may be relevant to the clinical effectiveness of an intervention and the capacity of an individual to benefit from the treatment.

C: Health Care Need and Capacity to Benefit

1.5. Health care should be allocated justly and fairly according to need and capacity to benefit, such that the health of the population is maximised within the resources available. The Committee will consider the health needs of people and populations according to their capacity to benefit from health care interventions. So far as possible, it will respect the wishes of patients to choose between different clinically and cost effective treatment options, subject to the support of the clinical evidence.

1.6. This approach leads to three important principles:

- In the absence of evidence of health need, treatment will not generally be given solely because a patient requests it;
- A treatment of little benefit will not be provided simply because it is the only treatment available;
- Treatment which effectively treats "life time" or long term chronic conditions will be considered equally to urgent and life prolonging treatments.

D: Cost Of Treatment and Opportunity Costs.

1.7. Because each CCG is duty-bound not to exceed its budget, the cost of treatment must be considered. The cost of treatment is significant because investing in one area of health care inevitably diverts resources from other uses. This is known as opportunity costs and is defined as benefit foregone, or value of opportunities lost, that would accrue by investing the same resources in the best alternative way. The concept derives from the notion of scarcity of resources. A single episode of treatment may be very expensive, or the cost of treating a whole community may be high.

E. Needs of the Community

1.8. Public health is an important concern of the Committee and it will seek to make decisions which promote the health of the entire community. Some of these decisions are promoted by the Department of Health (such as the guidance from NICE). Others are produced locally. The Committee also supports effective policies to promote preventive medicine which help stop people becoming ill in the first place.

1.9. Sometimes the needs of the community may conflict with the needs of individuals. Decisions are difficult when expensive treatment produces very little clinical benefit. For example, it may do little to improve the patient's condition, or to stop, or slow the progression of disease. Where it has been decided that a treatment has a relatively low priority and cannot generally be supported, a patient's doctor may still seek to persuade the CCG that there are exceptional circumstances which mean that the patient should receive the treatment.

2. POLICY DRIVERS

2.1. The Department of Health issues guidance and directions to NHS organisations, including the NHS Constitution and NHS Mandate, which may give priority to some categories of patient, or require treatment to be made available within a given period. These may affect the way in which health service resources are allocated by individual CCGs. The Committee will operate with these factors in mind and recognise that its discretion may be affected by national policy, NICE publications, Secretary of State Directions to the NHS and performance and planning guidance.

2.2. Locally, choices about the funding of health care treatments will be informed by the needs of each individual CCG.

3. EXCEPTIONAL NEED

3.1. There will be no blanket bans on treatment since there may be cases in which a patient has special circumstances which present an exceptional need for treatment. Each case of this sort will be considered on its own merits in light of the clinical evidence. CCGs have procedures in place to consider such exceptional cases on their merits.

Authors:	CCG Priorities Committee
Date of Issue:	July 2014

Appendix 4

INDIVIDUAL FUNDING REQUEST (IFR) - SECONDARY CARE USE

Please note it is the clinician's responsibility to obtain patient consent to share this and all supporting materials with the CSU. All information will be used and stored in accordance with the data protection act. Photographic evidence, where appropriate, may be submitted separately using only the minimum data set (GP details, initials, DOB and NHS number) to ensure patient confidentiality

On completion the request form and all supporting materials as defined within this request form should be posted, faxed or emailed to the IFR team – contact details included at the end of this form.

All sections are to be completed in requests from secondary care and specialist provider services. In recognition of the nature of requests from primary care those sections denoted by an asterisk ***(*)*** *are to be completed at the discretion of the requesting general practitioner.* ***The fields are expandable so please include as much as you need***

CONTACT INFORMATION

Trust / GP Surgery		
1. *Address*		
2. *Applicant Details*	***Name:***	
	Position/job title:	
	Tel:	
	Email:	
3. *Patient Details*	***Name:***	
	Hospital ID number:	
	NHS Number:	
	DoB:	
	Registered Consultant:	
	Registered GP name:	
	Referred by (other than GP):	
	Date of referral:	

4. *Application reviewed by Chief Pharmacist or nominated deputy (in the case of a drug intervention)*	***Name:***	
	Signature or email confirmation:	

STATEMENT CONFIRMING APPROPRIATENESS FOR CONSIDERATION AS AN IFR
If it is foreseeable that there are one or more other patients within the PCTs' population who are or are likely to be in the same or similar clinical circumstances as the requesting patient in the same financial year, and who could reasonably be expected to benefit to the same or a similar degree from the requested treatment then the request should properly be considered as a request for a service development and inappropriate for consideration as an IFR except in the circumstances where all the similar patients are expected to be from the same family group, a situation which may arise in the context of a rare genetic disease.

5. ***I confirm that it is not expected that there will be more than one patient from within the PCTs' population who is or is likely to be in the same or similar clinical circumstances as the requesting patient in the same financial year and who could reasonably be expected to benefit to the same or a similar degree from the requested treatment unless similar patients are expected to be from the same family group.***	***Tick box as appropriate*** ***☐Yes*** ***☐ No***

DIAGNOSIS AND PATIENT'S CURRENT CONDITION		
6. ***Patient Diagnosis*** *(for which intervention is requested)*		
(a)	*What is the patient's clinical severity? (Where possible use standard scoring systems e.g. WHO, DAS scores, walk test, cardiac index etc.)*	
(b)	*Please summarise the current status of the patient in terms of quality of life, symptoms etc.*	

INTERVENTION REQUESTED ***(NB: Intervention refers to requested treatment, investigation, etc.)***		
7. Details of intervention (for which funding is requested). ***If the intervention forms part of a regimen, please document the full regimen*** *(e.g. Drug X as part of regimen Y (consisting of drug V, drug W, drug X and drug Z).* *Regarding anticipated cost Acute Trusts to provide this from finance departments*	***Name*** *of intervention:*	
	Dose and frequency (*)*:*	
	Planned duration (*) *Of intervention:*	
	Route of administration (*)*:*	***(IV/SC/IM/oral)***
	Anticipated cost (inc VAT) or HRG tariff	
	Are there any offset costs? (*)	*Delete as appropriate:* ***Yes/No*** *(refer to pharmacy if required)*
	Describe the type and value of the offset costs (*)	
	Funding difference being applied for (*)	

8. Is requested intervention part of a clinical trial?	*Delete as appropriate:* ***Yes / No*** *If* ***Yes****, give details (e.g. name of trial, is it an MRC/National trial?)*
	Is the drug funded through a clinical trial? *Delete as appropriate:* ***Yes / No***
a) What would be the standard intervention at this stage?	
b) What would be the expected outcome from the standard intervention?	
c) What are the exceptional circumstances that make the standard intervention inappropriate for this patient?	

d) Please explain how this individual has an exceptional ability to benefit from the requested intervention over and above another individual with the same condition.			
e) If the requested intervention was not available what would your next planned intervention be?			
10. Summary of previous intervention(s) this patient has received for the condition. *Reasons for stopping may include (not exclusively):* ▪ *Course completed* ▪ *No or poor response* ▪ *Disease progression* ▪ *Adverse effects/poorly tolerated*	***Dates***	***Intervention (e.g. drug / surgery)***	***Reason for stopping / Response achieved***
11. Anticipated start date	*Processing a request **usually takes up to 2 weeks** from the date received by the CSU. If the case is more urgent than this, please state why:*		

EVIDENCE OF CLINICAL EFFECTIVENESS

12. Where the intervention is a drug / medicine is the requested drug / medicine licensed for the requested indication in the UK?	*Delete as appropriate: **Yes / No** (refer to pharmacy if required)*
*13. Has the Trust Drugs and Therapeutics Committee or equivalent Committee approved the requested intervention for use? (if drug or medical device) **(*)***	*Delete as appropriate: **Yes / No*** *If **No,** Committee Chair or Chief Pharmacist approved: **Yes / No***
14. Give details of National or Local Guidelines / recommendations or other published data / evidence base supporting the use of	***PUBLISHED[2] trials / data** (Please forward papers / web links for peer-reviewed papers where available. **This needs to be supplied for all secondary care and specialist provider requests – the request will not be considered if these have not been included.**)*

[2] *Full published papers, rather than abstracts, should be submitted*

the requested intervention for this condition? ***(*)***	
(a) How will you monitor the clinical effectiveness of this intervention?	
(b) Detail the current status of the patient according to these measures.	
(c) What would you consider to be a successful outcome for this intervention in this patient?	
(d) What is the minimum time frame/course of treatment at which a clinical response can be assessed? (e.g. after a single course of treatment)	
15. What is the anticipated toxicity of the intervention for this patient?	
16. Are there any additional clinical factors of the patient that need to be considered not already included in 8c or 8d?	*Delete as appropriate:* ***Yes / No*** *If* ***Yes****, please give details:*
17. Form completed by	***Name:***
	Signature or email confirmation:

Contact details for IFR Submissions

All applications should be made using the Individual Funding Request Application Form **and provide all the required information as outlined in the Funding Request Form**. The form should be completed electronically / typed – handwritten submissions may not be accepted.

Submissions should be sent (by post or fax or email) to:

Individual Funding Request team
NHS South, Central & West Commissioning Support Unit
Omega House
112 Southampton Road
Eastleigh
Hants SO50 5PB

Tel: 02380 623254/5/6 Fax: 02380 620343 E-mail: southcsu.ifrs@nhs.net

Appendix 5

IFR APPLICATION FORM
PRIMARY CARE USE ONLY

When receiving an application, patient consent is implied so please note it is the clinician's responsibility to obtain patient consent to share this and all supporting materials with the CSU. All information will be used and stored securely in accordance with the Data Protection Act.

CONTACT INFORMATION

GP and Surgery Name		
1. *Address inc. postcode*		
2.	***Position:***	
	Tel:	
	Email:	
3. *Patient Details*	***Name:***	
	NHS Number:	
	DoB:	
	Date of referral:	

DIAGNOSIS AND PATIENT'S CURRENT CONDITION

4. ***Patient Diagnosis*** *(for which intervention is requested)*	***Diagnosis*** ***Please summarise the current status of the patient in terms of quality of life, symptoms etc.***

INTERVENTION REQUESTED ***(NB: Intervention refers to requested treatment, investigation, etc.)***	
5. *Details of intervention (for which funding is requested)* *If costs are known, please state (optional)*	***Name** of intervention:*

6 Is the requested treatment available locally? (state where if possible)	
7 Are there any clinical factors that need to be considered that would set this patient out as exceptional? The following is an excerpt from the NHS Confederation guide 'Priority setting: managing individual funding requests' 2008 which clarifies this: *In making a case for special consideration, it needs to be demonstrated that:* - *the patient is significantly different to the general population of patients with the condition in question, and* - *the patient is likely to gain significantly more benefit than might be normally expected for patients with the same condition* *The fact that the treatment is likely to be efficacious for a patient is not, in itself, a basis for exceptionality. Social and psychological circumstances, whilst recognised, are not considered decisive factors in funding.*	**Exceptionality - this is best expressed by the question 'On what grounds can the commissioner justify funding a particular patient over and above others from the same patient group who are not being funded?'** **THIS IS THE MOST IMPORTANT PART OF THE APPLICATION AND WOULD EXPECT THE MOST DETAIL TO BE INCLUDED HERE**

8 Summary of previous intervention(s) this patient has received for the condition. ▪	***Dates***	***Intervention***	***Reason for stopping / Response achieved***

9 Please summarise any additional supporting information and ***attach all relevant clinical correspondence in support of the application***	
10 Form completed by	***Name:***
	Signature or email confirmation:

Contact details for IFR Submissions

All applications should be made using the Individual Funding Request Application Form **and provide all the required information as outlined in the Funding Request Form**. The form should be completed electronically / typed – hand written submissions may not be accepted. Please ask your Practice Manager to load this form onto your practice server for ease of use.

General guidance can be found directly below but, if you have any questions as to whether to submit an application or regarding the form itself, please contact the IFR team on the number or email address below as this may well save you a lot of time! General enquiries without patient identifiable data can also be made to the team by phone or email which may avoid the need for an application.

Submissions should be sent (by post or fax or email) to:

Individual Funding Request team
NHS South, Central & West Commissioning Support Unit
Omega House
112 Southampton Road
Eastleigh
Hants SO50 5PB

Tel: **02380 623253/5/6**
Fax: 02380 620343
E-mail: southcsu.ifrs@nhs.net

General guidance on completion

This form has been devised in a shorter format than the one now reserved for secondary care. However if you are seeking approval for a Procedure of Limited Clinical Value (see those listed in appendix 2) then there is a single sided Excel or Word proforma found on our website at www.southcsu.nhs.uk/documents/ifr then click 'Prior Approval Forms'.

The guide below should avoid requests for additional information and delays in decision-making. Please contact the team on the details above if you have any queries.

The list below details the most common referrals received and the information required by the CSU to make an informed decision

Breast reduction – this will require details of the patient's BMI, cup size, confirmation that patient has had a professionally fitted bra, evidence of any intervention to address symptoms e.g. physiotherapy for posture, details of how quality of life is affected. In addition, **clinical photography** is almost always required by the Panel to aid their decision. Please note that psycho-social issues and distress alone will not be a justification for funding.

Breast augmentation for asymmetry, lack of breast development or tubular breast development – this is routinely considered as a 'cosmetic' procedure and has no direct physiological clinical benefit. In this case, **clinical photography** – as with any 'plastics'/'cosmetic' procedure is a useful adjunct to an application compared to a written description. Although this cannot be insisted upon due to the sensitivity of such requests and patient consent, for equity of decision-making Panels would normally be unable to take an informed decision without it. Photographs are stored securely and anonymously to ensure patient confidentiality and will be returned on request. Again psycho-social issues will not be a decisive factor.

Abdominoplasty - guidance regarding this procedure for removal of excess skin following massive weight loss is included in the Policy and Procedure for IFRs. We receive many cases for this procedure particularly following multiple Caesarean sections and there is little evidence to support direct physiological benefit. Once again **clinical photography** may assist in decision-making but psycho-social factors will not.

Pinnaplasty – the CSU receives many requests for this procedure in children suffering from teasing and bullying at school. This is no longer commissioned routinely and the Panel, whilst sympathetic with such cases, does not approve requests on the basis of a child's distress.

Bariatric surgery – Until 1 April 2015, NHS England commissioned this surgery via a national policy. http://www.england.nhs.uk/wp-content/uploads/2013/04/a05-p-a.pdf .
Prior approval is no longer required provided the national criteria are met which would include access through a tier 3 obesity management service. CCGs are reviewing arrangements for access over the coming year but all patients will require review under the tier 3 service first

IVF – access to IVF is managed by the Commissioning Support Unit to regional policy criteria. In short, this is restricted to childless couples where the woman is aged under 35 and following either diagnosis of absolute infertility or at least a year of both attempting to start a family and going through the NICE recognized fertility pathway. Referrals meeting the criteria should be made by a secondary care fertility specialist. Cases outside the criteria that you deem exceptional can be made to the CSU using the form on their website www.southcsu.nhs.uk/documents/ifr

Asperger's/autism diagnosis in adults

There are now contractual arrangements in place for diagnostic assessments as follows

- West Hampshire, SE Hampshire, North Hampshire and Fareham & Gosport CCGs Assessments are arranged via direct referral to the Surrey & Borders Service using secure email rxx.HampshireautismSABP@nhs.net .
- NE Hants & Farnham CCG - contact Joanna Keegan, AAA Services, Ramsay House, West Park, Horton Lane, Epsom, KT19 8PB. Telephone: 01372 202100 Fax: 01372 202138.
- Southampton CCG - contact Deborah Brown, Specialist Practitioner – Autism, Southern Health NHS Foundation Trust, Thomas Lewis House, 236 Empress Road, Southampton, SO14 0JY Tel: 023 8029 4420 deborah.brown5@nhs.net or deborah.brown@southernhealth.nhs.uk
- Portsmouth CCG – please contact the Integrated Commissioning Unit via dawn.jordan@portsmouthcc.gcsx.gov.uk

Functional electrical stimulation (FES) – this is a particularly common request to treat 'dropped foot' for neurological problems (e.g. stroke, MS) and may well be due to the local presence of the national FES Centre in Salisbury. This has been extensively reviewed on at least two occasions by the South Central Priorities Committees and, whilst agreed as a more 'elegant' approach to dropped foot in terms of greater walking speed/distance and lower fatigue, it is not yet considered a cost-effective option for the local NHS. Our Panel reviews on a named patient basis particularly where the standard use of ankle-foot orthosis has been proven to be intolerant or where there is a falls history/risk.

PATIENT INPUT

Direct patient applications and appeals cannot be accepted by the CSU but patient accounts may be included in an application should they wish to contribute towards their case. We would expect the referring clinician to act on their patient's behalf and to make necessary enquiries. All applications and appeals should be clinically-led.

SECONDARY CARE APPLICATIONS

We would encourage primary care clinicians to request specialists/ secondary care consultants to complete funding applications themselves for treatments that require specialist intervention, expertise or opinion. We would support all Practices should there be any problems in obtaining secondary care support in completion of funding applications which we would expect to come directly from the Trusts themselves.

APPENDIX 6

COSMETIC/ PLASTIC SURGERY

Overall the policy for funding of cosmetic/plastic surgery is that this is not normally funded and only considered following surgery, trauma or for congenital malformation. (Post-surgical reconstruction would be part of service level agreements for surgical services in any case.)

The effect of the problem on essential **activities of day-to-day living** is a key factor in decision-making. In such cases, psychological treatment such as counselling or cognitive behavioural therapy may be considered as an appropriate alternative to surgery.

It is not necessary to obtain a psychiatric opinion to support an application. We would expect mental health professionals to treat related problems through established procedures commissioned from the mental health trust and this would not include surgery. Our Panel consistently takes the view that psycho-social considerations should not be a justification for surgery.

Exceptions criteria in previous policies for procedures such as breast augmentation, breast reduction, mastopexy, implant removal and replacement, gynaecomastia, pinnaplasty and abdominoplasty have been removed with referrers asked to provide individual detail of exceptional circumstances and conditions in line with the points above.

We would request that all applications for such procedures should be accompanied by suitable clinical photography that demonstrates the extent of the problem. This, of course, would be subject to patient consent.

Social and psychological circumstances (quoted from Dorset CCG policy 2015)

If social and psychological factors are included in decision making, it becomes more difficult to prevent inequity. Agreeing to fund a case based on social or psychological factors almost inevitably sets a precedent for funding a sub group and so, would prompt a review of access protocols. Therefore the CCG has defined exceptionality in relation to unique clinical factors. Case examples in Appendix C outline the rationale for decisions not to have social and psychological circumstances as the basis is for consideration of exceptionality.

The CCG has not identified a group of patients whose social worth overrides the usual considerations of cost and clinical effectiveness, not only for the intervention in question but arguably for all their health care needs. If it did do this it would mean that others with a different social contribution or whose non-clinical circumstances are unknown would be subjected to inequity.

The CCG has not identified a group of patients with psychological factors that would override the usual considerations of cost and clinical effectiveness. The CCG takes the view that because of the difficulties associated with obtaining normative values for the majority of patients for whom an intervention is not available and in the interests of equity, psychological distress alone will not be considered as reason for exceptionality.

Exceptionality has been defined solely in clinical terms; to consider social and other non clinical factors automatically introduces subjectivity and inequality, implying that some patients have a higher intrinsic social worth than others with the same condition. It runs contrary to a basic tenet of the NHS namely, that people with equal need should be treated equally and introduces discrimination into the provision of medical treatment. Therefore social and psychological circumstances are not factors that would make an individual exceptional.

Appendix 7 – Dermatology Life Quality Index (DLQI) form (ADULTS)

NHS No: Date:
Name: Score (CSU to complete):
Date of Birth: Diagnosis:

The aim of this questionnaire is to measure how much your patient's skin problem has affected their life OVER THE LAST WEEK. Please tick ☑ one box for each question.

1.	Over the last week, how **itchy**, **sore**, **painful or stinging** **painful** or **stinging** has the patient's skin been?	Very much A lot A little Not at all	☐ ☐ ☐ ☐	
2.	Over the last week, how **embarrassed** or **self conscious** has the patient been because of their skin?	Very much A lot A little Not at all	☐ ☐ ☐ ☐	
3.	Over the last week, how much has the patient's skin interfered with their going **shopping** or looking after their **home** or **garden**?	Very much A lot A little Not at all	☐ ☐ ☐ ☐	 Not relevant ☐
4.	Over the last week, how much has their skin influenced the **clothes** they wear?	Very much A lot A little Not at all	☐ ☐ ☐ ☐	 Not relevant ☐
5.	Over the last week, how much has their skin affected any **social** or **leisure** activities?	Very much A lot A little Not at all	☐ ☐ ☐ ☐	 Not relevant ☐
6.	Over the last week, how much has their skin made it difficult for them to do any **sport**?	Very much A lot A little Not at all	☐ ☐ ☐ ☐	 Not relevant ☐
7.	Over the last week, has their skin prevented them from **working** or **studying**?	Yes No	☐ ☐	 Not relevant ☐
	If "No", over the last week how much has their skin been a problem at **work** or **studying**?	A lot A little Not at all	☐ ☐ ☐	
8.	Over the last week, how much has their skin created problems with their **partner, close friends** or **relatives**?	Very much A lot A little Not at all	☐ ☐ ☐ ☐	 Not relevant ☐
9.	Over the last week, how much has their skin caused any **sexual difficulties**?	Very much A lot A little Not at all	☐ ☐ ☐ ☐	 Not relevant ☐
10.	Over the last week, how much of a problem has the **treatment** for their skin been e.g. making the home messy or by taking up time?	Very much A lot A little Not at all	☐ ☐ ☐ ☐	 Not relevant ☐

Please check you have answered EVERY question. Thank you.

APPENDIX 8

REFERRAL FOR ASSISTED CONCEPTION
CHECK LIST FOR ELIGIBILITY

SOUTHAMPTON CCG *WEST HAMPSHIRE CCG* *NORTH HAMPSHIRE CCG*
NE HAMPSHIRE & FARNHAM CCG *PORTSMOUTH CCG* *FAREHAM & GOSPORT CCG*
SOUTHEASTERN HAMPSHIRE CCG

To access NHS treatment for IVF cycle complete this checklist and send one copy with the referral letter and relevant test results to the provider unit and a further copy to:

NHS South, Central & West Commissioning Support Unit, Omega House, 112 Southampton Road, Eastleigh, Hampshire, SO50 5PB. Fax number: 023 8062 0343. Phone number: 023 8062 3256.

Patients must not be offered an appointment until eligibility and funding has been confirmed by the Commissioning Support Unit on behalf of CCGs.

Name of NHS Gynaecologist* (please print):	**Patient's GP:**
Referring Hospital:	**Address:**
Address/Tel:	
	Tel No: **Fax No:**
Post Code:	**Post Code:**

*** All patients must have had a consultation with an NHS gynaecologist.**

Female Patient. **Dob:** **Name:** **CCG:** **Age:** **NHS No:** **Patient Reference:**	**Partner Details.** **Dob:** **Name:** **F/M:** **CCG:** **Age:** **NHS No:** **Patient Reference:**
Home Address: **Post Code:**	**Home Address:** **Post Code:**
Tel/Mobile No:	**Tel/Mobile No:**

Criterion	Yes / No	Eligibility
NICE Clinical Practice Has the couple gone through the primary and secondary care sub-fertility pathways appropriate to them before IVF is considered? http://www.nice.org.uk/guidance/CG11/niceguidance/pdf/English (summary) http://www.nice.org.uk/guidance/CG11/guidance/pdf/English (full guideline) NB The following investigations must all have been completed prior to referral for assisted conception: rubella, FSH/AMH, Chlamydia, hepatitis B, hepatitis C, HIV **and results sent with referral to the Provider.**		No = excluded
Duration of infertility a) Having the followed the above treatment pathway, does the couple have infertility of at least one year's duration and have they followed all investigations as part of the NICE pathway? (The couple should have had no natural pregnancies or been using contraception within this timeframe – referring clinician should verify this with GP.) **If a) = no then please consider b)** b) Does the couple have a diagnosed cause of **absolute** permanent infertility (which precludes any possibility of natural conception)? If so, specific details **must** be provided. c) Same sex couple or single person: 10 failed insemination cycles or a diagnosed fertility problem will be accepted as evidence of infertility		No to both = excluded
Age of woman at time of cycle starting* At the time of commencing treatment will the female be **below the age of 35** years? *A fresh assisted conception treatment cycle commences either: ❖ at commencement of down regulation or ❖ the start of ovarian stimulation or ❖ if no drugs are used, when an attempt is made to collect eggs.		No = excluded
Previous infertility treatment Has the patient ever received previous IVF or ICSI treatment funded by the NHS?		Yes = excluded
Has the patient received more than 2 previous cycles of IVF or ICSI (irrespective of whether NHS or privately funded)?		Yes = excluded
Women in same sex couples or a woman not in a partnership Is the woman demonstrably sub-fertile? *(10 unsuccessful cycles of IUI will be accepted as evidence of unexplained infertility*)		No = excluded
Childlessness Does either partner have a living child (including adopted) from their relationship, or from any previous relationship?		Yes = excluded

Sterilisation Has either partner been sterilised?		Yes= excluded
BMI Does the female have a BMI range between of 19 - 29.9 for at least the last six months?		No = excluded
Smoking Have both partners been non-smokers for at least the last six months?		No = excluded

STATEMENT TO BE SIGNED BY THE REFERRING CONSULTANT / GP

I confirm that all the above access criteria have been met and this person/couple is therefore eligible for NHS funded IVF treatment. They have been advised that, from the below list, they have a choice of Centre for their treatment.

Referrer's name (Please print) _____

Referrer's signature: _____

Date of referral: _____

Designated Centres. Please circle as appropriate.

- **The Chiltern Hospital**, London Road, Great Missenden, Bucks HP16 9DT - 01494 892276
- **Care Fertility**, 67 The Avenue, Northampton, NN1 5BT - 01604 601606
- **Nuffield Health Woking Hospital**, Shores Road, Woking, Surrey, GU21 4BY - 01483 227 800
- **Oxford Fertility Unit**, Institute of Reproductive Sciences, Oxford Business Park, Oxford OX4 2HW - 018 6578 2800
- **Complete Fertility Centre**, Level G, Mailpoint 105, Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA - 023 8077 7222
- **Salisbury Fertility Centre**, Salisbury District Hospital, Salisbury, Wiltshire SP2 8BJ - 01722 417224
- **Wessex Fertility**, The Freya Centre, 72-74 Anglesea Road, Southampton S015 5QS - 023 8070 6000

STATEMENT TO BE SIGNED BY THE COUPLE

I confirm that I have read and understood the questions above and that the information I have given is correct. **I understand that if I knowingly give false information I may be liable to prosecution.** I have been advised that I may choose from the above list, which Clinic I/we may receive treatment.

First partner's signature: _____

Date: _____

Second partner's signature: _____

Date: _____

NB This form will be returned to the referrer if any of the information requested is incomplete