Policy and Procedure for Individual Funding Requests (IFRs) and the management of restricted treatments and procedures concerning Clinical Commissioning Groups April 2021

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
Portsmouth CCG
South Eastern Hampshire CCG
North Hampshire CCG (associate)
West Hampshire CCG (associate)

The function for addressing individual funding requests and the management of restricted treatments and procedures 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 to 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 treatments listed in this policy are restricted either by the relevant diagnosis and/or the relevant procedure. For example a patient with a diagnosis of Hallux Valgus who has a subsequent procedure will not be routinely funded irrespective of the type of procedure a patient ultimately receives.

SURGICAL RESTRICTED AND EXCLUDED PROCEDURES
This list sets out those procedures requiring either an IFR or Prior Approval and from where such an application should normally come from. Where applicable discretion will be applied by the CSU team regarding the origin of the request.

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.

Procedure – the specialties listed below are a guide only and patients may be treated under different treatment function codes	IFR Required	Prior Approval	Request normally expected from
ORTHOPAEDIC			
Patellar knee resurfacing as part of total knee replacement	✓		Secondary care
Arthroscopic lavage and debridement with or without partial meniscectomy for osteoarthritis of knee		✓	MSK or Secondary Care
Arthroscopic hip surgery in impingement		✓	MSK or Secondary Care
Autologous blood injections for musculo-skeletal conditions	✓		Secondary Care
Bunion (hallux valgus) surgery		✓	MSK or Secondary Care
Carpal tunnel release		✓	Primary Care, Secondary Care or MSK community service
Dupuytren's contracture surgery (palmar fasciectomy)		✓	Primary Care or MSK community service
Ganglion surgery		✓	Primary Care
Hip or knee replacement (primary) BMI 35+		✓	Secondary Care/ MSK
Hip resurfacing		✓	Secondary Care/ MSK
Trigger finger surgery		✓	Primary Care or MSK service
Rotator cuff tears		✓	MSK or Secondary Care
Subacromial shoulder decompression		✓	MSK or Secondary Care
Spinal Pain	✓	✓	MSK or Secondary Care
GENERAL, PLASTIC, VASCULAR AND GI SURGERY			
Abdominoplasty (cosmetic) (IFR **or prior approval if after massive weight loss**)	✓	✓	Primary Care
Skin reduction surgery (after massive weight loss)		✓	Primary Care
Breast procedures	✓		Primary Care
Chronic anal fissure in adults		✓	Secondary care
Gastric fundoplication for reflux disease		✓	Secondary Care
Varicose vein treatment		✓	Primary Care
Cosmetic devices/ appliances – e.g. silicon cosmeses/prostheses	✓		Primary Care
Laser treatment	✓		Primary Care or Secondary Care (Dermatology)
Benign skin lesions	✓		Primary Care
Foetal Alcohol Spectrum Disorders	✓		Secondary Care
Negative Pressure Wound Therapy	✓		Secondary Care

Low Intensity Pulsed Ultrasound (Exogen) in delayed and non-union fractres	✓		Secondary Care
Plastics procedures (facial, brow, facelift, thighs, upper arms)	✓		Primary Care
OPHTHALMOLOGY			
Eyelid Surgery for ectropion and entropion		✓	Secondary care
Eyelid Surgery (blepharoplasty) for ptosis and dermatochalasis		✓	Secondary care with visual fields test included
Eyelid surgery for chalazia		✓	Primary care
Short sight/ long sight corrective (laser) surgery (Refractive keratoplasty)	✓		Secondary care
ENT			
Adenoidectomy in children with upper respiratory tract infection	✓		Secondary care
Adenoidectomy in children with chronic rhinosinusitis (CRC)		✓	Secondary care
Balloon catheter sinus dilation in chronic rhino-sinusitis	✓		Secondary care
Functional endoscopic sinus surgery		✓	Secondary care
Nasal surgery for nasal blockage and or deformity		✓	Primary Care or Secondary Care (ENT)
Grommet insertion /myringotomy (adults and children 12 years and over and children under 12)		✓	Secondary Care
Pinnaplasty	✓		Primary Care
Surgery for 'snoring'	✓		Secondary care
Tonsillectomy adults and children		✓	Primary Care or Secondary Care (ENT)
GYNAECOLOGY/ UROLOGY			
Dilation and curettage in heavy menstrual bleeding	✓		Secondary care
Female cosmetic genital surgery (labiaplasty)	✓		Primary or secondary care
Female sterilisation		✓	Primary Care
Circumcision		✓	Primary Care or Secondary Care
Treatment of LUTS as a result of Benign Prostatic Hyperplasia		✓	Primary Care or Secondary Care
Hydrocele surgery		✓	Primary Care or Secondary Care
Hysterectomy for menorrhagia		✓	Secondary care
Inguinal hernia (**asymptomatic)**		✓	Secondary Care
Management of haemorrhoids (grade 3 and 4 only)		✓	Secondary Care
Pelvic organ prolapse		✓	Secondary Care
Reversal of sterilisation/ vasectomy	✓		Primary care
Faecal microbiota transplant (outside of use in C.difficile)	✓		Primary Care
INFERTILITY TREATMENTS			
Assisted conception IVF		✓	Secondary Care
Cryopreservation		✓	Secondary Care

Further procedures with criteria are managed on a thresholds basis i.e prior approval not required and these are listed in the section underneath the restricted procedures list

Secondary Care Flow Chart

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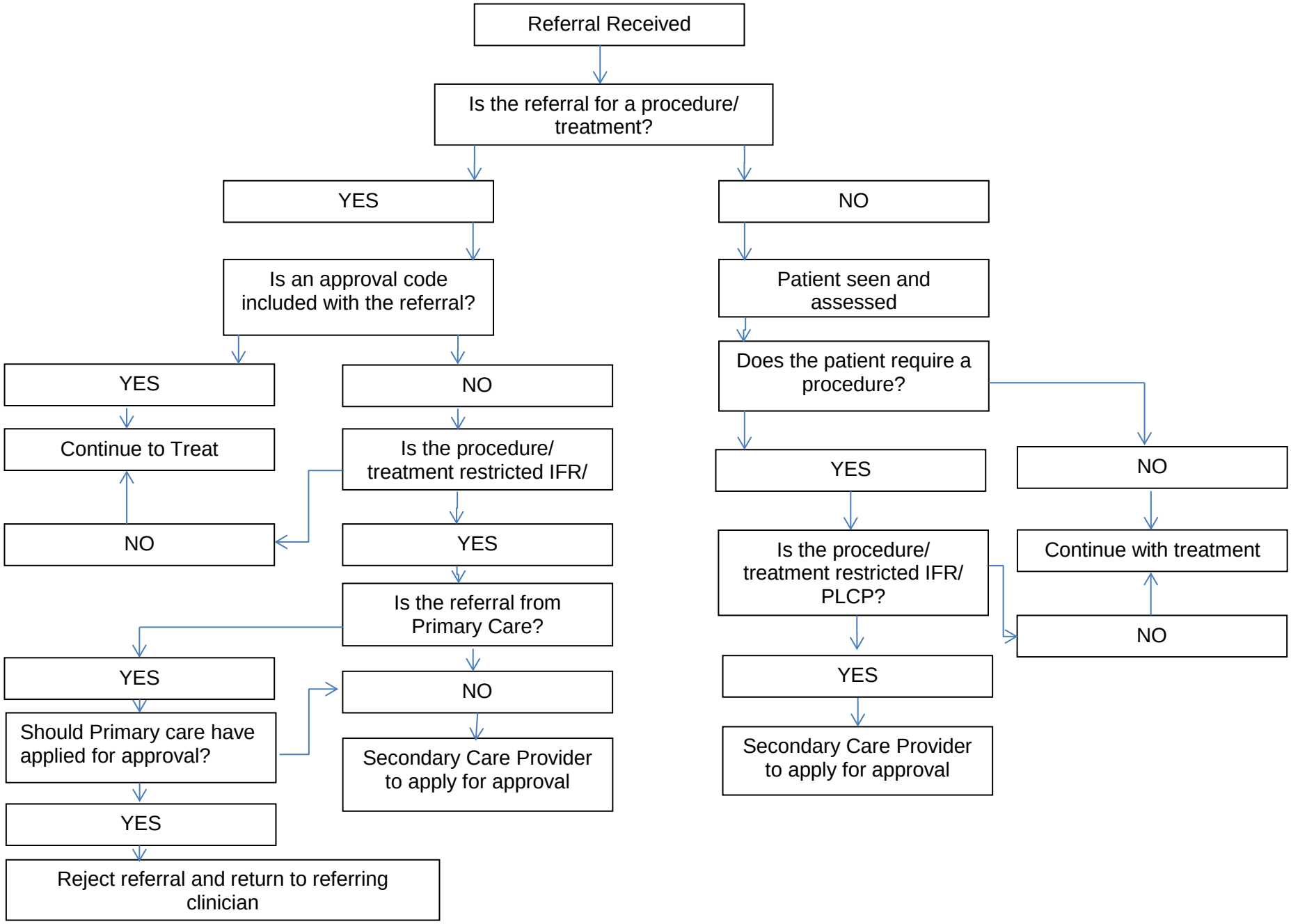

INDIVIDUAL FUNDING REQUESTS

The procedures listed below are not routinely funded. Funding may be considered in exceptional circumstances, using the criteria listed below.

All requests should be in writing using the IFR funding application forms available on NHS South, Central and West CSU's website www.fundingrequests.scwcsu.nhs.uk then click 'Hampshire'. They must include:

- a clear description of the patient's exceptional circumstances, including overriding clinical need and expected outcome
- copies of any relevant correspondence
- supporting documentation e.g. robust evidence of clinical and cost effectiveness, consultant and other specialist assessments

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	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** Clinical photography 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. Photographs are stored securely and anonymously to ensure patient confidentiality and will be returned on request.		
	Liposuction	CCGs do not routinely fund this procedure	N/A
	Facelift (Rhytidectomy/ Surgical removal of wrinkles)/ Brow lift and Submental lipectomy	CCGs do not routinely fund this procedure	N/A
	Buttock lift, thigh lift, upper arm lift (brachioplasty), abdominoplasty	CCGs do not routinely fund this procedure	N/A
	Breast and nipple procedures	CCGs do not routinely fund this procedure	• Reconstructive procedures following cancer treatment may go ahead as part of

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
			established pathways and must take place within one year of the last cancer treatment
	Pinnaplasty/meatoplasty/ plastic operations on external ear	CCGs do not routinely fund this procedure	N/A
	Rhinoplasty/ reconstruction of nose	CCGs do not routinely fund this procedure. **N.B. Nasal surgery for nasal blockage and or deformity is referenced as a separate procedure**	• Post-surgical reconstruction procedures may go ahead as part of the pathway following trauma and must take place within 12 months of the trauma occurrence.
Dermatology/ general surgery	Surgical removal of skin lesions.	CCGs do not routinely fund these procedures Treatments carried out are subject to 'trust and verify' verification process as detailed in section one of this document. 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**. Removal will only be considered if all reasonable self –care has been attempted and at least one of the following criteria is met:	• Where there is a valid suspicion of malignancy, e.g. the patient is referred using a two-week wait referral form for suspected cancer, or the patient's consultant upgrades the referral to reflect the suspected cancer

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
		- The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires 2 or more courses of antibiotics (oral or intravenous) per year. - The lesion bleeds in the course of normal everyday activity. - The lesion causes regular pain which affects daily functioning. - The lesion is obstructing an orifice or impairing field vision to the extent that the person does not meet DVLA standards for driving. - The lesion significantly impacts on function and causes a reduction in the Barthel ADL Score which is likely to improve after intervention. - The lesion causes pressure symptoms such as on a nerve. - If left untreated, more invasive intervention would be required for removal. - Lipomas on the body > 5cms, or in a sub-facial position, with rapid growth and/or pain. These should be referred to a Sarcoma clinic.	
Gynaecology	Female cosmetic genital surgery (labiaplasty)	CCGs do not routinely fund this procedure	N/A

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
	Dilation and curettage in heavy menstrual bleeding	CCGs do not routinely fund this procedure In line with Priorities Committee policy statement 49 (Mar 2019) and NHS England EBI position statement D&C should not be used for diagnosis or treatment for heavy menstrual bleeding because it is clinically ineffective. Ultrasound and hysteroscopy/biopsy to sample the womb lining can be used to investigate heavy periods.	
Plastic surgery	Laser removal of skin and excessive hirsutism	CCGs do not routinely fund this procedure.	N/A
	Laser therapy for recurrent pilonidal sinus	**CCGs do not routinely fund this procedure.** In line with Priorities Committee policy statement 016 (June 2021)	
	Appliances and devices for cosmetic purposes (high-grade silicon cosmesis and/or prosthesis)	CCGs do not routinely fund these appliances or devices.	N/A
Ophthalmology	Short sight/long sight corrective (laser) surgery (Refractive keratoplasty)	CCGs do not routinely fund this procedure	N/A
Dermatology	Surgical shaving/ laser treatment / chemical destruction of skin	CCGs do not routinely fund this procedure.	N/A

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
Urology	Reversal of sterilisation/ vasectomy	CCGs do not routinely fund this procedure.	N/A
	Erectile Dysfunction and Penile Rehabilitation following radical prostatectomy	CCGs do not routinely fund this procedure Reference SHIP Priorities Committee Policy 63 and replaces policy statement 137	Penile implants are managed under NHS England
Gastro-intestinal	Faecal microbiota transplants	CCGs do not routinely fund this procedure	Use in refractory C-difficile is routinely commissioned
ENT	Adenoidectomy in children with upper respiratory tract infections	In line with Priorities Committee policy statement Feb 2016 and revised in March 2020 policy no. 8 CCGs do not routinely fund this procedure in isolation.	When offered in **combination** with myringotomy (grommet insertion) and/or tonsillectomy **which are subject to separate prior approval arrangements**
	Surgery for 'snoring'	CCGs do not routinely fund this procedure In line with Priorities Committee policy statement Feb 2016	N/A
	Balloon catheter sinus dilation for chronic rhino-sinusitis	CCGs do not routinely fund this procedure In line with Priorities Committee policy statement 018 (Feb 2017)	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
Orthopaedics/ Spinal Pain	Spinal Pain	The following procedures are not routinely funded and should not be routinely offered, and a full **Individual Funding Request** would need to be raised demonstrating exceptionality. **Acupuncture** is not routinely commissioned **Spinal injections as a therapeutic intervention** including facet joint injections, medial branch blocks and epidural/ nerve root injections are not normally funded in non-specific neck pain **Imaging in a non-specialist setting** for patients with low back pain with or without sciatica, where there are no red flags or suspected serious underlying pathology following evaluation of medical history and examination **Epidural injections** for neurogenic claudication in patients who have central spinal canal stenosis are not normally funded **Therapeutic** medial branch blocks for facet joint pain are not routinely commissioned **Imaging** in patients with low back pain with specific facet joint pain as a prerequisite for radiofrequency denervation is not normally funded **Prolotherapy** for sacroiliac joint pain is not normally funded due to a lack of evidence on clinical and cost of effectiveness	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
	Autologous blood injections in MSK conditions	CCGs do not routinely fund this procedure In line with Priorities Committee policy statement 024 (Dec 2017)	
	Patellar knee resurfacing as part of total knee replacement	In line with SHIP Priorities Committee policy statement 015 stating that this is 'low priority' to support resurfacing as part of a routine total knee replacement	
	Negative Pressure Wound Therapy	In line with SHIP Priorities Committee Policy Statement 61 CCGs do not routinely fund this	
	Foetal Alcohol Spectrum Disorders	As there are locally commissioned services able to treat those with developmental difficulties associated with FASD funding is considered low priority and will not be routinely funded.	
	Low Intensity Pulsed Ultrasound (Exogen) in delayed and non-union fractures	Due to the lack of high quality evidence of clinical and cost effectiveness this intervention is NOT NORMALLY FUNDED.	
Alternative/ complementary/ homeopathic therapies	Complementary therapies/medicine	CCGs do not routinely fund this	N/A
Mental health	In patient treatment for severe chronic	CCGs do not routinely fund this.	N/A

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
	Fatigue/ME		
	Non-NHS residential placements	CCGs do not routinely fund this	N/A
	Adult ADHD	CCGs do not routinely fund this.	N/A

PRIOR APPROVALS AND PROCEDURES

The procedures and conditions 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
Isle of Wight CCG
North Hampshire CCG (all procedures with the exception of carpal tunnel, minor skin lesions, tonsillectomies and second eye cataract surgery)
West Hampshire CCG (all procedures with the exception of carpal tunnel, minor skin lesions, tonsillectomies and second eye cataract surgery)

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 the referring clinician from the Commissioning Support Unit at scwcsu.ship.ifrrequests@nhs.net . All proforma and resources can be found at the CSU's website at www.fundingrequests.cscsu.nhs.uk/ (then click 'Hampshire') 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/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
ENT/ Audiology	Myringotomy/ grommet insertion for children under 12 years old	This procedure is not routinely funded The possible option of a hearing aid and the use of nasal balloons such as Otovent must be discussed Prior approval will be considered under the following conditions: • 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 after referral; and o OME persists after the period of watchful waiting; and o The child has reported 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	• 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/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
		available)	
	Myringotomy/ grommet insertion for adults and children over 12 years of age	This procedure is not routinely funded Prior approval will be considered under the following conditions This procedure is not routinely funded for adults and children ≥ 12 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	N/A

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
		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 adults and children	Treatment funded subject to prior approval . Tonsillectomy should only be performed when the following conditions are met: • - in children and adults for cases of two or more quinsy requiring hospital intervention; **or** • • in children with diagnosed obstructive sleep apnoea where other treatments have failed or are inappropriate; **or** • • in children and adults for tonsillitis if all of the following criteria are met: • - Sore throats are due to tonsillitis **and** - There are 7 or more episodes per year of sore throat requiring treatment such as antibiotics or 5 or more episodes a year for two years or 3 or more episodes a year for three years **and** - There have been symptoms for at least a year **and**	• In children and adults for cancer where patient is coded with a cancer diagnosis directly related to the procedure • Where there is a valid suspicion of malignancy, e.g. 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/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
		- 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.	
	Tonsil stones (tonsilloliths)	Tonsil stones are caused by debris becoming calcified in the crevices of the tonsils. They may cause symptoms such as halitosis, sensation of a foreign body and irritation of the throat. Self-management can include gargling and prevention of the formation of tonsil stones by the use of good oral hygiene.	
	Nasal surgery for nasal blockage and or deformity	This procedure is not routinely funded In line with Priorities Committee policy no.23 Nasal septal deviation (NSD) can cause nasal obstruction (insufficient airflow through the nose) and lead to symptoms such as nosebleed, headaches and oral breathing. NSD occurs when the wall of cartilage between the two nasal cavities is displaced. Nasal surgery can be undertaken to straighten the nasal septum with the aim of alleviating symptoms.	• Trauma (for acute admissions identified as 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/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
		Septoplasty This procedure may be considered under the following conditions: • Obstruction of one or both nostrils causing significant symptoms **and** • Conservative measures without success for > 3 months; **and** • Overuse of nasal sprays excluded as a cause of nasal congestion or ceased prior to referral and congestion persists **Septorhinoplasty** (Septo)rhinoplasty may be considered if secondary care deem it to be the most effective intervention for the patient's nasal obstruction and they fully detail the expected outcome in functional improvement, all of the following conditions have been met and why septoplasty alone is not indicated. Patients are required to meet all the criteria. In addition, requests must explain the improvement in functional outcome that is expected, and why septoplasty alone is not indicated. Surgery to address the effects of facial trauma as part of the initial care pathway for that trauma and the care for relevant	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
		cancer treatments are excluded from this policy	
	Functional endoscopic sinus surgery in chronic rhino-sinusitis and/or nasal polyps	This procedure is not routinely funded. In line with Priorities Committee policy statement 019 (Feb 2017) Functional endoscopic sinus surgery is recommended ONLY for patients with chronic rhinosinusitis and/or nasal polyps in whom the following criteria are met: The patient has had severe and persistent symptoms despite treatment for at least twelve months AND Symptoms on optimal medical therapy have a significant impact on the patient's quality of life AND The following medical therapies have been tried with inadequate response or are contra-indicated • Regular use of saline douching and nasal steroid AND • For patients with nasal polys, attempts at medical polypectomy using prednisolone or a topical steroid AND/OR • For patients with chronic rhinosinusitis, an oral antibiotic + douche + topical steroids	• Where there is a valid suspicion of malignancy, e.g.has been referred via the two-week wait referral form.
	Adenoidectomy in children with chronic rhinosinusitis (CRC)	In line with Priorities Committee policy statement Feb 2016 and revised in March 2020	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
		policy no. 8 Treatment should be conservative in the first instance with intranasal corticosteroids, nasal saline douching, or ideally sinus rinses (but this may be poorly tolerated in younger children) for at least 3 months' management in primary care utilising secondary care Advice and Guidance where appropriate. If this fails AND symptoms interfere significantly with daily life, then referral for ENT review and consideration of surgical adenoidectomy is supported.	
Vascular Surgery	Varicose vein procedures	This procedure is not routinely funded. Prior approval may be considered under the following conditions: • People with a body mass index less than 32 kg/m^2 who satisfy **at least one** of the following criteria: o A first venous ulcer o A recurrent venous ulcer o Haemorrhage from a superficial varicosity Reference: SHIP Priorities Committee policy statement no. 001. http://www.fundingrequests.cscsu.nhs.uk/ then click 'Hamsphire'	• Acute admissions identified as 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/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
Gynaecology	Hysterectomy in heavy and/or painful menstrual bleeding	This procedure is not routinely funded. Requests for hysterectomy for heavy menstrual bleeding or dysmenorrhoea may be considered if **all** the following criteria are met: • Treatment with non-hormonal and hormonal methods have been trialled in primary care for at least 3 months • Patient has attended a 'One Stop' menstrual disorder (or similar) clinic and received extensive counselling on the risks and benefit sof the intervention	• 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.
	Female sterilisation	In line with Priorities Committee policy statement 45 (Jan 2019). This procedure is not routinely funded. Funding approval for surgical treatment of fertility in women will only be funded as a standalone procedure or during a caesarean section in women who meet all the following criteria; • The patient understands that the sterilisation procedure is irreversible and any attempt at the reversal of sterilisation operation would not be routinely funded • She is certain that her family is complete • She understands that vasectomy in the partner is the preferred option but the male partner is unwilling or unable to consent to	N/A

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
		vasectomy or where vasectomy for relevant male partner(s) is not feasible • She has received counselling about all other forms of contraceptives and has either undergone an unsuccessful trial of Long Acting Reversible Contraception (LARC) or where LARC is contraindicated or inappropriate • She understands that she will be required to avoid sex or use effective contraception until the menstrual period following the operation and that sterilisation does not prevent against the risk of sexually transmitted infections • Women should be counselled well before caesarean section in order to reduce the incidence of regret.	
	Pelvic organ prolapse surgery	In line with Priorities Committee policy statement 29 (Jan 2018 reviewed July 2020) For women who wish to be referred for specialist surgical opinion, a full range of conservative and pharmacotherapy should been tried and failed before referral, including lifestyle interventions, supervised pelvic floor muscle training for at least 3 months (only in women with stage 1-2 prolapse); trial of topical vaginal oestrogen and pessary in appropriate patients. Mesh should not be used trans-vaginally for pelvic organ prolapse unless the operation is part of a research trial. Other	Stage 3 and 4 prolapses may automatically proceed to surgery

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
		abdominal pelvic organ prolapse mesh procedures can only be carried out under high-vigilance reporting regimes. For women considering surgery, the use of appropriate patient decision aids is highly recommended.	
Urology	Male circumcision	In line with Priorities Committee policy statement 43 (Nov 2018). Male circumcision is not routinely funded but prior approval can be considered under one of the following conditions; • Pathological phimosis due to lichen sclerosus (formerly known as BXO) • Pathological phimosis due to balanitis/ balanoposthitis resistant to conservative treatment • Congenital urological abnormality where skin grafting is required • Recurrent splitting and scarring of the prepuce which affects sexual function and does not respond to at least two months of conservative management Further guidance on conservative management can be found in the statement	• Patients coded with a cancer diagnosis directly related to the procedure • Where there is a valid suspicion of malignancy, e.g. has been referred via the two-week wait referral form
	Treatment of LUTS as a result of Benign	In line with Priorities Committee policy	Any surgical modality offered

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
	Prostatic Hyperplasia	statement 66 (APR 2021). Benign prostatic hyperplasia (BPH) is a condition in which the flow of urine is blocked due to the enlargement of the prostate gland. This enlargement can cause lower urinary tract symptoms (LUTS) including hesitancy on urination, interrupted or decreased urine stream, nocturia, incomplete voiding and urinary retention. Red flag symptoms are excluded from this policy and patients should be referred via the 2 week wait criteria. Men with BPH may be referred for a specialist surgical opinion if the following criteria are met: Severe voiding symptoms Conservative and lifestyle interventions have been undertaken for a period of 3 months (for example advice on fluid intake and urethral milking) and symptoms persist Appropriate pharmacological therapy for LUTS has been trialled and symptoms persist, for example: • Trial of an alpha blocker for 6 weeks for moderate to severe LUTS (for example an IPSS	should take into account the latest published NICE guidance and the NHS England Evidence Based Interventions Programme: **The following interventions are NOT NORMALLY FUNDED:** • Transurethral needle ablation • Transurethral microwave thermotherapy • High-intensity focused ultrasound • Transurethral ethanol ablation of the prostate

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
		score between 8-19 for moderate symptoms and 20-35 for severe symptoms). • Trial of an anticholinergic for 6 weeks, for symptoms of over active bladder. • Trial of an alpha reductase inhibitor for 3 months for LUTS, when there is evidence of prostatic hypertrophy and the patient is considered to be at high risk of progression. • Combination of an alpha blocker and a 5-alpha reductase inhibitor for bothersome moderate to severe LUTS when there is evidence of prostatic hypertrophy Men are involved in shared decision making including which surgical modality is appropriate and when or whether surgery should be undertaken. Any surgical modality offered should take into account the latest published NICE guidance and the NHS England Evidence Based Interventions Programme: • The UroLift system relieves lower	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
		urinary tract symptoms while avoiding the risk to sexual function. This should be considered as an alternative to current surgical procedures for use in a day-case setting in men who are aged 50 years and older and who have a prostate of less than 100ml without an obstructing middle lobe. • TURP, TUVP (including laser prostatic vaporisation) or HoLEP should be offered to men with voiding LUTS presumed secondary to BPH. HoLEP should be performed within centres specialising in the technique or where mentorship arrangements are in place. • TUIP should be offered to men with a prostate estimated to be smaller than 30ml. • Open prostatectomy should only be offered as an alternative to endoscopic surgery, to men with prostates estimated to be larger than 80-100ml.	
	Hydrocele surgery	Prior approval will be considered under the	Cases of testicular torsion are

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
		following conditions • Interventions in children should be delayed until at least 2 years of age • Surgical treatment should only be offered where there is significant discomfort preventing voiding, sexual function, mobility or dressing Ultrasound may be of value in initial assessment where there is diagnostic uncertainty but should not be repeated	a surgical emergency and should proceed directly
Orthopaedics/ Spinal Pain	Spinal Pain Non-specific low back/neck pain.	The following procedures are not routinely funded and should not be routinely offered, and a full **Individual Funding Request** would need to be raised demonstrating exceptionality. **Acupuncture** is not routinely commissioned **Spinal injections as a therapeutic intervention** including facet joint injections, medial branch blocks and epidural/ nerve root injections are not normally funded in non-specific neck pain **Imaging in a non-specialist setting** for patients with low back pain with or without sciatica, where there are no red flags or suspected serious underlying pathology following evaluation of medical history and	

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		examination **Epidural injections** for neurogenic claudication in patients who have central spinal canal stenosis are not normally funded **Therapeutic** medial branch blocks for facet joint pain are not routinely commissioned **Imaging** in patients with low back pain with specific facet joint pain as a prerequisite for radiofrequency denervation is not normally funded **Prolotherapy** for sacroiliac joint pain is not normally funded due to a lack of evidence on clinical and cost of effectiveness **The following procedures are not normally funded in non-specific low back pain;** • Disc replacement • Spinal fusion and/ or discectomy **All local anaesthetic and steroid spinal injections including;** • Facet Joint Injections • Therapeutic medial branch blocks • Intradiscal therapy • Prolotherapy • Trigger point injections with any agent,	

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		including botulinum toxin • Epidural steroid injections for chronic low back pain or got neurogenic claudication in patients with central spinal canal stenosis Any other spinal injections not specifically covered above.	
Spinal Pain	Spinal pain Cervical neck Pain (neck)	Referenced Priorities Committee policy statement 060 (Apr 2021) Interventions are undertaken using a multi-disciplinary team approach and that conservative therapies, including a course of structured physiotherapy and exercise with or without psychological therapy have been offered as first line treatment Assessment should include the biopsychosocial impact on the individual such as with EQ-5D or STarT back tool for low back pain. Patients receiving any surgical intervention should be registered on the British Registry and the providers are expected to participate in the Regional Spinal Network. Prior Approval may be considered for the following interventions providing criteria is met:	Emergency admissions for severe pain Interventions related to pain arising from cancer (C&D codes), fractures (S12*, S220/1, S32*), infection or inflammatory disease processes (M468/9)

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
	Lumbar (low back pain) Facet joint pain	**Repeat epidural/nerve root injection for sciatica or for cervical radiculopathy** • Please provide documented evidence that the patient's co-morbidities exclude surgery or that less invasive treatment is not possible and that the previous injection offered at least 70% improvement in pain sustained for at least 6 months. **Spinal decompression (sciatica) with or without fusion** • Please provide documented evidence that all non-operative options have been tried or are contraindicated **Lumbar discectomy (for sciatica) in the presence of concordant MRI changes** • Please provide documented evidence the patient has compressive nerve root signs and symptoms lasting 3 months (except in severe cases) despite best efforts with non-operative management **Radio-frequency denervation (for facet joint pain)** • The main source of pain is thought to come from structures supplied by the medial branch • All non-surgical and alternative	

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Spinal Pain	Sacroiliac (SIJ) pain	treatments have been tried and failed • The patient does not have radicular symptoms • There is moderate to severe chronic pain that has improved in response to diagnostic medial branch block **Repeat radiofrequency denervation (for facet joint pain)** • The patient has received a previous successful response with benefits lasting >12 months. **Radiofrequency denervation (for sacroiliac joint pain)** • The patients has received a diagnostic injection with a successful response **iFuse device (sacroiliac joint pain)** • Please provide documented evidence that all other treatments has failed **The following procedures do not require Prior Approval**	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
		A single epidural/ nerve root injection for sciatica or for cervical radiculopathy not responding to conservative therapy can be considered as part of a rehabilitation pathway or as one-off diagnostic intervention to inform surgical management **does not require prior approval.** **A single medial branch nerve block for diagnostic purposes** is supported as part of potential radio frequency denervation for facetogenic low back pain **does not require prior approval.** **Steroid and local anaesthetic injections of the sacroiliac joint (to treat SIJ pain)** may assist in the diagnosis as well as allowing physiotherapy and therefore **does not require prior approval.** **Imaging** in low back pain should be offered if serious underlying pathology is suspected. Serious underlying pathology includes but is not limited to; cancer, infection, trauma, spinal cord trauma (full or partial loss of sensation and/ or movement of part(s) of the body) or inflammatory disease **does not require prior approval.**	
Orthopaedics/ MSK	Trigger finger surgery	In line with Priorities Committee policy statement 47 (Feb 2019). These procedures	N/A

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Orthopaedics/ MSK		are not routinely funded. Cases interfering with activities or causing pain should first be treated with one or two steroid injections and there is strong evidence that this is typically successful but the problem may recur, especially in patients with diabetes. There is weak evidence that splinting of the affected finger for 3-12 weeks may also be effective and can be considered Prior approval for surgery should only be considered where: • The triggering persists or recurs after one of the above measures (particularly steroid injections); or • The finger is permanently locked in the palm; or • The patient has previously had 2 other trigger digits unsuccessfully treated with appropriate non-operative methods; or • The patient has diabetes.	
	Carpal tunnel release/ nerve entrapment at wrist	These procedures are not routinely funded. In line with Priorities Committee policy statement 22 Prior approval may be considered under the following conditions: In moderate symptoms i.e pins and needles in the day with occasional night symptoms (2-3	N/A

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Orthopaedics/ MSK		nights/ week) • All conservative measures (e.g. wrist splint **and** a corticosteroid injection into the carpal tunnel) have failed; **and** • There have been symptoms for longer than 6 months In severe symptoms • With severe symptoms where there is evidence of severe disease causing permanent reduction in sensation in the median nerve distribution or muscle wasting or weakness of thenar abduction.	
	Palmar fasciectomy /Dupuytren's contracture	In line with Priorities Committee policy statement 46 (Feb 2019). These procedures are not routinely funded. Conservative management is advised if there is: no contracture OR only mild (less than 20 degrees) contracture OR contracture that is not progressing and does not impair function. Surgery should only be offered if there are • Finger contractures causing loss of finger extension of 30 degrees or more at the metacarpophalangeal joint (MCPJ) or 20	N/A

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure/Condition	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
Orthopaedics/ MSK		degrees at the proximal interphalangeal joint (PIPJ) resulting in functional loss OR • Severe thumb contractures which interfere with function Collagenase (Xiapex) injections DO NOT require prior approval should only be offered to participants in ongoing clinical trials or in adults with palpable cords where the following criteria are met • Moderate disease (functional problems and MCPJ contracture of 30-60 degrees and PIPJ contracture of less than 30 degrees or first web contracture) plus up to two affected joints; AND • Needle fasciotomy is not considered appropriate but where limited fasciectomy is considered appropriate	
	Treatment of bunions (hallux valgus)	In line with Priorities Committee policy statement 51 (April 2019) The trial evidence for benefit from interventions was lacking. The committee recommends that this intervention should be low priority. However, patients with **significant** functional impairment that do not respond to conservative measures must be assessed through the MSK triage service to ascertain if they are likely to	Management of patients with bunions and peripheral neuropathy or diabetes is outside of the scope of this review and needs to continue to be managed carefully through a multi-disciplinary approach.

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		benefit from intervention. In this instance 'significant' is taken to mean: • Symptoms of significant functional impairment that prevent them from properly fulfilling work, domestic or carer duties or educational responsibilities; AND • Significant functional impairment is present more than half the time; AND • This impairment happens frequently over the preceding 30 days	
	Arthroscopic lavage and debridement with or without meniscectomy of the knee in patients over 40 with non-traumatic and persistent knee pain	These procedures are not routinely funded. Prior approval may be considered under the following condition: • Where the patient has a clear history of mechanical locking. Reference SHIP Priorities Committee policy statement 010 (April 2016) and clarified by policy statement 55 (July 2019) related to meniscal tears http://www.fundingrequests.cscsu.nhs.uk/ then click 'Hampshire'	Cases of acute traumatic knee pain should not require prior approval

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	Arthroscopic surgery for meniscal tears	In line with SHIP Priorities Committee policy statement 055 Patients with **persistent mechanical knee symptoms** should be referred to secondary care and should have an MRI scan of the knee to investigate for a meniscal tear and/or other pathology. Arthroscopic meniscal repair is supported for patients with treatable (BASK guidance) lesions who are suitable candidates, after 3 months of conservative treatments and which have failed to resolve.	
	Hip resurfacing	These procedures are not routinely funded. Prior approval may be considered under the following conditions: • 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 Reference SHIP Policy Recommendation 105 on Metal on Metal (MOM) hip resurfacing http://www.fundingrequests.cscsu.nhs.uk/ then click 'Hampshire'	N/A
	Primary hip and knee replacement in patients with a BMI above 35	These procedures are not routinely funded for patients with a BMI above 35.	• Trauma (for acute admissions identified as emergency

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		Prior approval may be considered under the following conditions: • 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 • 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 to the commissioned 'tier 3' obesity management programme prior to offering surgery**.	procedures recorded under admission method 21-28)
	Arthroscopic hip surgery in impingement	In line with SHIP Priorities Committee policy statement 006 – Nov 2015 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	

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		procedure data should be submitted to the registry set up by the British Hip Society Registry (in line with NICE guidance).	
	Treatment of ganglions	In line with Priorities Committee policy statement 48 (Feb 2019) These procedures are not routinely funded. Interventions for ganglia are considered to be of limited clinical value and are not commissioned except in the following circumstances; **Wrist Ganglion i**nterventions should only be considered if there are significant neurological symptoms. Initially this will be by aspiration with surgical excision considered only if aspiration fails to resolve the pain and there is restricted hand function. **Seed Ganglion - g**anglia in the palm of the hand occur at the base of fingers. Interventions should only be considered if there is significant pain and a loss in function. This should be by aspiration using a hypodermic needle initially with surgical excision only considered if ganglion persists or recurs and there is significant pain and a loss in function **Mucoid Cysts** Ganglions which form just below the nail come from the last joint in the finger and are related to degeneration in the	N/A

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		joint. Interventions should only be considered if there are recurrent spontaneous discharges of fluid or the cyst disrupts the nail growth causing significant functional impairment or pain.	
	Management of rotator cuff tears	In line with Priorities Committee statement 41 (Sept 2018) The place of surgery for rotator cuff syndrome is limited and rarely a first line treatment. The majority of tears are degenerative and often relatively asymptomatic. **First line options should begin with:** Physiotherapy and analgesia for 6 weeks with a further 6 weeks of physiotherapy if there has been incomplete resolution, at which point the patient, if not already managed under MSK services, should be referred Imaging with MRI is no better than ultrasound. Ultrasound should not be used as a diagnostic investigation in primary care but should be reserved for confirmation of diagnosis and assist management plans and only by referral from MSK	Traumatic tears should be considered for surgery without delay
	Subacromial decompression of shoulder	In line with SHIP Priorities Committee policy statement 014 Open subacromial decompression is not routinely funded	**Emergency procedures recorded under admission method 21-28**

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		Prior approval is required for arthroscopic subacromial decompression if **all** the following criteria are fulfilled • Symptoms for at least 6 months • Symptoms are intrusive and debilitating (e.g. waking at night, pain when putting on a coat) • Patient complaint with physiotherapy intervention for at least 6 weeks • There has been a positive response to a steroid injection	
Ophthalmology	All eyelid surgery including blepharoplasty and chalazia excision	These procedures are not routinely funded. <u>Eyelid surgery for ptosis and dermatochalasis</u> Ptosis is a sign rather than a diagnosis and the cause must be adequately investigated and managed. Dermatochalasis is a diagnosis whereby there is excess skin which may eventually drop and impair vision. intervention should only be considered when there is a functional restriction due to visual field loss and it further recommends the guidance from the DVLA should be referenced. The requirements for visual fields are set out in the DVLA guidance currently available <u>here</u>. For those with a Class 2 occupational licence	

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		the thresholds for interventions would be to enable them to maintain their eligibility with reference to visual fields. For all other individuals the Class 1 position should be used, whether they drive or not. Assessment of visual fields is outside the scope of primary care and referral should be to the optician in the first instance who will need to be appraised of the pathways. <u>Eyelid ectropion and entropion</u> Ectropion is the outward rotation of the eyelid margin and entropion is the inward rotation. Treatment for ectropion and entropion depends on its severity and the underlying cause. Mild cases may not need any treatment and minor symptoms may be relieved by conservative treatment, such as eye drops, to protect the eye. Surgery for ectropion and entropion for cosmetic reasons alone is not normally funded. Surgery should be considered if there is:	Surgery that is necessary prior to intraocular surgery such as cataract extraction is without restriction.

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		• Abnormal lid position causing • Chronic epiphora (at least 2 months) and • Ocular irritation unresponsive to topical treatments <u>Chalazia (Meibomian cysts)</u> These procedures are not routinely funded Incision and curettage of chalazia should only be undertaken if: • It has been present for 6 months or more; **and** • Conservative therapy has been undertaken for at least 4 weeks; **and** • There is significant interference with vision **OR** • It is a source of infection that has - required medical attention with systemic antibiotics twice or more within the previous 6 months; or - is causing an abscess which requires drainage.	Suspected malignancy or peri-orbital cellulitis

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Surgery	Revision bariatric surgery G283/5/9 G308/ G321/ G331	**In line with Priorities Committee policy statement 31 (April 2018)** Revision surgery should only be undertaken in specialised centres with a multi-disciplinary team (MDT) approach which are directly commissioned to provide this service. Providers not commissioned to provide this service should ensure patients are redirected to locally commissioned services (Spire Southampton and Portsmouth Hospitals NHS Trust). Procedures carried out by other providers will not be reimbursed for any such procedure. Patients whose primary surgery fails due to mechanical failure such as obstruction, band slippage etc. (**Group 1** patients) should be offered revision following granting of prior approval (Amber). Patients who have had primary surgery but fail to achieve expected weight loss or regain their pre-operative weight (**Group 2** patients) should **not** be routinely offered revision surgery unless they fall into **Group 3** below when the case will be considered via the IFR process Patients who have been fitted with a gastric band and whose weight does not fall consistently but whose clinical condition deteriorates developing multiple, severe and life threatening co-morbidities (**Group 3** patient) will not be routinely offered revision surgery but, because of the small numbers involved, will be considered using the IFR route Patients who have funded their own primary	

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		bariatric surgery (**Group 4** patients) should be eligible for treatments, following the same pathway and with the same thresholds as NHS patients. This includes meeting the criteria for primary surgery including input from tier 3 obesity management services **NB** Such revision surgery should be attempted as a single stage- procedure. A planned two stage procedure requires a full IFR application	
	Treatment of chronic anal fissure in adults	In line with Priorities Committee statement 25 (Dec 2017) The majority of cases will be treated in primary care and advice regarding diet and avoidance of constipation is imperative. Surgery (lateral sphincterotomy) will be considered via prior approval when the following pathway has been followed • First line pharmacological therapy with GTN (glyceryl trinitrate) rectal ointment • Diltiazem where GTN is not tolerated but after education on proper application of extremely small amounts • Medical therapies have been tried for at least a month • Injection of botulinum toxin restricted to one injection offered to women and anally receptive men • All the above options have failed	

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	Haemorrhoidectomy	Surgical treatment in **grade 1 or 2** haemorrhoids should only be offered under the following conditions: Haemorrhoids have persisted despite dietary changes and advice on bowel habits and cannot be managed via banding ligation or injections; **OR** Patient has a coagulation defict (eg. Use of Warfarin or NOACs) and repeated bleeding is causing anaemia Skin tags are considered cosmetic and will **not** normally be funded. Such skin tags should be considered in the context of a benign skin lesion and clinicians should refer to this policy for criteria for prior approval.	Band ligation in grade 1 or 2 haemorrhoids. Haemorrhoidectomy in **grade 3 or 4** haemorrhoids provided diagnostic coding is clear (K64.2/3)
Gastroenterology	Gastric fundoplication for chronic reflux oesophagitis	These procedures are not routinely funded Prior approval will be considered for adults who have at least one of the following characteristics; - 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 or in those where long term pharmacological intervention is contraindicated. - Significant volume reflux placing them	• For all other indications, treatment is funded

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		at risk of aspiration - Significant difficulty sleeping due to gastro-oesophageal reflux symptoms - Anaemia because of oesophagitis Reference: South Central Priorities Committees policy statement no 51.	
Infertility treatments	In vitro fertilisation (including the prescriptions of infertility drugs) and ICSI (intracytoplasmic sperm injection)	This treatment is not routinely funded. Prior approval may be considered in line with the SHIP Priorities Committee policy statement 002 - September 2014 where endorsed by the CCG http://www.fundingrequests.cscsu.nhs.uk/ then click 'Hampshire'	N/A
	Cryopreservation of fertility ahead of NHS treatment likely to render infertility	See SHIP Priorities Committee policy 30 This now extends previous provision to transgender people	
General surgery/ hand surgery/	Treatment of **asymptomatic** inguinal hernias	These procedures are not routinely funded. Prior approval may be considered where all 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	N/A

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		with activities of daily living directly related to the hernia	
Various services	Intensive decongestive therapy for lymphoedema	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	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 with drop foot (most commonly due to multiple sclerosis or	

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		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	Assisted Conception IVF	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.fundingrequests.cscsu.nhs.uk/	
	Cryopreservation	Prior approval may be considered ahead of NHS treatment that is likely to render the patient infertile.	

PRIORITIES COMMITTEE CLINICAL POLICY STATEMENTS NOT REQUIRING PRIOR APPROVAL

	Procedure/Condition	Comments/ guidance on thresholds
Ear, Nose & Throat	Micro-suction for Earwax Policy Statement No.32	The Committee recommend that microsuction should be available for the following indications; □ Patients who have had an episode of acute otitis externa - up to a maximum of 3 microsuctioning procedures per year □ The tympanic membrane is obscured by wax but needs to be viewed to establish a diagnosis in high risk individuals such as people with learning disabilities and/or Down's syndrome. □ The patient has a history of unilateral hearing and there is a need for wax removal from that or the contralateral ear Also microsuction should be offered to patients with symptoms caused by ear wax build up e.g. pain or hearing loss, if ear drops have been unsuccessful at softening the ear wax and irrigation is contraindicated i.e. If one or more of the following criteria is met; □ Previously undergone ear surgery other than grommet insertion that have been extruded for at least 18 months or □ Had a recent history of otalgia and / or middle ear infection in the previous 6 weeks or □ Has a retraction pocket or a cholesteatoma or □ Has a current perforation or a history of ear discharge in the past 12 months or □ Had previous complications following ear irrigation including perforation of the ear drum, severe pain, deafness or vertigo or □ Two attempts at irrigation of the ear canal in primary/community care are unsuccessful In such cases patients should be a maximum of 2 microsuction appointments per year at no less than 6 monthly intervals

	Primary joint replacement in hip and knee osteo-arthritis	In line with Priorities Committee policy statement 50 (Mar 2019) which makes the following recommendations: • **Obesity** is an important factor in the aetiology of joint disease as well as being detrimental to the outcomes. Consequently, weight management has an important role throughout the patient's life, and should be reflected in prevention strategies • There is clear evidence of poorer outcomes for patients with increased body mass index. The committee therefore recommends that primary replacement should be reserved for patients with a BMI below 35. • Patients with a BMI of 35 or above: Separate prior approval criteria are in place to manage access to surgery for patients with a BMI of 35 and above, namely under the following conditions prior approval may be granted: ➢ 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; ➢ 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. • **Smoking** is the most important factor for the development of postoperative cardiopulmonary and wound-related complications in elective surgery and the most important risk factor for the development of serious post-operative complications in patients undergoing elective hip and knee replacement. • Stopping smoking should be encouraged for at least 8 weeks prior to operation and patients should be referred to a structured smoking cessation programme prior to or at time of referral for surgical assessment or there should be documented informed dissent. • With reference to Policy Statement 21: Smoking and Non-Urgent Surgery (July 2017); ➢ Prescribing smoking cessation medication outside of supported programmes is low priority; ➢ All clinicians have a responsibility to undertake patient education and offer brief intervention with every contact; ➢ Use of e-cigarettes is less harmful and is preferable to cigarette smoking. • Shared decision making was seen to be helpful and effective at improving outcomes and should be started in Primary Care or in the Community based MSK service using resources such as the Joint replacement Decision Aid (https://www.cimauk.org/science-update/national-joint-registry-patient-decision-supp) There should be a period of **3 months** for patients to consider the risk and benefits to them of knee replacement surgery and to address issues such as weight loss or smoking cessation if required.

	Knee Joint Replacement Revision Surgery **Policy Statement No.44 Nov 2018** **(superseding interim statement 42)**	NHS funding for referral and assessment for revision of knee joint replacement surgery should be recommended in patients in whom the following criteria are met: Knee revision surgery can be considered where; The patient has persistent pain which is suggestive of the presence of joint infection OR Where infection is not suspected, the patient has **all** of the following; o Persistent joint pain with or without significant loss of range of movement and function o X-ray confirms the presence of aseptic loosening and wear of the prosthesis OR has had significant malalignment or malrotation diagnosed by a multi-disciplinary team that is likely to be improved o Has had the evidence for outcome from revision surgery explained to them and understands that the outcomes from revision surgery are not likely to be as good as those from primary replacement surgery. o Has a BMI below 35 o Is fit for surgery at the time of referral
Ophthalmology	**Cataract surgery** **(first and second eye)**	Following Priorities Committee policy statement 32 (April 2018) • The pathway for patients must include a form of community-based validation and assessment. This would need to include a holistic assessment of their vision and the effect the cataract is having on them as well as explaining the risks and benefits of intervention and understanding the patient's wishes. • A functional impact scoring scale could be considered in the assessment process. Several scoring systems were discussed such as cat-PROM5 and VF-14 but there was no consensus other than that this should not be on visual acuity (VA) alone but VA would be an important factor, as would driving status and glare. • Patients should be fit for surgery at the time of referral • The thresholds for first and second eye cataract extraction should be the same. • Bilateral cataract extraction is preferable where clinically appropriate.

Bariatric Surgery	Bariatric surgery for obesity including gastric bypass and gastric banding (see policy for techniques allowed)	In line with Priorities Committee policy statement 13 (June 2016) and reviewed January 2020. Bariatric surgery (limited to adjustable gastric banding, sleeve gastrectomy and Roux-en-Y gastric bypass performed at a recognised specialist centre with a multi-disciplinary team) will be prioritised as a treatment option for people with obesity if all the following criteria are fulfilled: • They have a BMI of 40 kg/m^2 or more (or between 35 and 40 with either type 2 diabetes mellitus or uncontrolled hypertension (after all medical therapies have been tried)) that may be improved if they lost weight. • All appropriate non-surgical measures (including Tier 2 and Tier 3 interventions) have been tried for at least 12 months continuously but the person has not achieved or maintained adequate, clinically beneficial weight loss. • The person is generally fit for anaesthesia and surgery. • The person commits to the need for long-term lifestyle modification and follow-up. **Other types of procedures e.g. gastric plication (G251), intragastric balloon G485/6, and biliopancreatic diversion with duodenal switch (G284) are not routinely funded and will need prior approval through the CSU.**
	Sativex for symptom improvement in adult patients with moderate to severe spasticity due to multiple sclerosis	In line with Priorities Committee Policy Statement 64 The CCG supports the restricted use of Sativex in line with NICE Clinical Guideline number 144 (November 2019), and in accordance with its recommendations. Prescribing should be initiated by the specialist and continued for 3 months, after which time the patient should be reviewed. If the individual's response remains in line with the criteria above, consideration of transfer to GP prescribing may be appropriate with specialist symptom review after the first 6 months, and then periodically as normally required.

VERSION CONTROL

Date	Approved By	Activity
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.
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
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)
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
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).
May 2012	Board of Clinical Commissioners	Formal endorsement of finalised policy in line 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
March 2013	CCG clinical execs	Amendments to policies on adult and children grommet insertions
May 2013	NICE Technology Appraisal 279	Kyphoplasty and vertebroplasty removed from exclusions/ restrictions lists provided NICE criteria met
	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
February 2014	SE Hants, Ports and F&G CCGs	Removal of dilatation & curettage and sympathectomy from criteria
December 2014	Hampshire CCGs	Draft revised criteria and revised description of prior approval arrangements
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 Inclusion of penile prosthesis
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
Feb 2016	PSEH CCGs and CSU	Moved opening information of policy to appendix 12 'further useful/ supporting information' Removal of the word 'benign' with regards to skin lesions. Addition of process flow diagram
Feb 2016	SHIP8	Amendment to tonsillectomy guidance to ensure clarification
Feb 2016	PSEH CCGs and CSU	Change in terminology from Procedures of low clinical value (PLCV) to Procedures of Lower Clinical Priority (PLCP)
May 2016	PSEH CCGs and CSU	Functional endoscopic or sinus surgery changed to functional nasal airway surgery Change of arthroscopic lavage and debridement to include 'with or without partial meniscectomy' Addition of surgery for snoring and adenoidectomy policies
May 2016	PSEH CCGs and CSU	Chalazia removed from own section and noted under all eyelid surgery section Arthroscopic lavage and debridement prior approval consideration wording updated in line with finalised SHIP priorities committee statement
June 2016	PSEH CCGs and CSU	Secondary Care Flowchart moved from appendices to after contents table at the beginning of the document. DQLI form removed from document and references to it removed from surgical removal of skin lesions section of the document.
September 2016	PSEH CCGs and CSU	Addition of subacromial shoulder decompression Addition of Arthroscopic lavage and debridement with or without partial-meniscectomy in non-traumatic and persistent knee pain in patients over 40's with no clear history of mechanical locking
October 2016	PSEH CCGs and CSU	Additional wording around exception clause for possible malignancy or urgent clinical reasons.

June 2017	SHIP Priorities Committee as endorsed by SHIP CCGs	Addition of policies related to laser therapy in pilonidal sinus, faecal microbiota transplants, balloon catheter sinus dilation (ENT) and functional endoscopic sinus surgery. Introduction of revised pain pathway.
Sept 2017	SHIP Priorities Committee as endorsed by SHIP CCGs	Revisions to carpal tunnel pathway and functional endoscopic nasal airways surgery
Feb 2018	SHIP Priorities Committee as endorsed by SHIP CCGs	Addition of policies related to • Autologous blood injections in MSK conditions • Treatment of chronic anal fissure • Treatment of hydrocele • Surgical management of pelvic organ prolapse
May 2018	SHIP Priorities Committee as endorsed by SHIP CCGs	Addition of policies related to • Cryopreservation of fertility • Revision bariatric surgery • Cataract surgery
Aug 2018	SHIP Priorities Committee as endorsed by SHIP CCGs	Addition of policies related to • Amendment to pelvic organ prolapse surgery
Nov 2018	SHIP Priorities Committee as endorsed by SHIP CCGs	Revised criteria and policies related to • Tonsillectomy • Grommet insertion (children and adults)
Jan 2019	SHIP Priorities Committee as endorsed by Hampshire Alliance Executve	Revised criteria related to • Hysterectomy in heavy and/or painful menstrual bleeding And addition of policies related to • Management of haemorrhoids • Rotator cuff tears Removal from prior approval of Cataract surgery Addition of Policy category for Priorities Committee Policy Statements to be enacted in the Contract, but for which Prior Approval is not required.
March 2019	SHIP Priorities Committee as endorsed by SHIP CCGs	Revised criteria related to • Male Circumcision

May 2019	SHIP Priorities Committee as endorsed by SHIP CCGs	Policies 44 – 51 related to • Revision knee replacement • Female sterilisation • Dupuytren's contracture • Trigger finger release • Ganglion excision • Dilation and curettage in heavy menstrual bleeding • Primary hip and knee replacement • Hallux valgus (bunions) surgery
Sept 2019	SHIP Priorities Committee as endorsed by SHIP CCGs	Policies 52-55 related to • Eyelid surgery for ptosis and dermatochalasis • Entropion and ectropion surgery • Chalazia surgery • Arthroscopic surgery for meniscal tears
6th December 2019	SHIP Priorities Committee	Policy revisions to; 002, 56-57 related to • Assisted Conception Services • Excision of skin following massive weight loss • Removal of benign skin lesions • Gastric Fundoplication in reflux Oesophagitis
March 2020	SHIP Priorities Committee	Policy revisions to; 001, 008 & 013 related to • Varicose veins • Adenoidectomy • Bariatric surgery
October 2020	SHIP Priorities Committee policies	Policy revisions related to 61 – 65, 014 & 029 • • Negative Pressure Wound Therapy • Foetal Alcohol Spectrum Disorders • Erectile Dysfunction and Penile Rehabilitation following radical prostatectomy • Sativex • Low Intensity Pulsed Ultrasound (Exogen) in delayed and non-union fractures • Subacromial shoulder decompression

		• Pelvic Organ Prolapse
April 2021	SHIP Priorities Committee	Policy revisions related to 22, 23, 36, 60, 16, 55, 37 & 66. • Carpal Tunnel Syndrome • Nasal Surgery for nasal blockage and or deformity • Tonsillectomy adults and children • Spinal Pain • Laser therapy for Recurrent Pilonidal Sinus • Arthroscopic Surgery for Meniscal Tears • Grommets insertion – adults and children • Treatment of LUTS as a result of Benign Prostatic Hyperplasia

APPENDICES

Appendix 1: 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.

Prior Approval requests will be addressed by the CSU IFR team. Where the conditions are not met but the clinician wishes to make an exception they may be dealt by the IFR process.
Commissioners comply with mandatory Technology Appraisal Guidance published by the National Institute for Health and Clinical Excellence (NICE)

Research
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 meets the quality standards as per Healthcare Assurance Standards / Care Quality Commission guidelines
- **Only an NHS GP, NHS Consultant,** Allied health professionals, specialist nurse **or consultant in a Treatment Centre holding an NHS contract** can make a funding application. The procedure/treatment is not already purchased under existing service agreements.
- Patient Choice guidelines will apply where relevant.

Where there are specific limitations on an individual 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 will only consider a specialist referral 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.

Appendix 2: PROCESS

All requests should be in writing using the IFR funding application available on NHS South, Central and West CSU's website http://www.fundingrequests.cscsu.nhs.uk/ then click 'Hampshire' and should include:

- a clear description of the patient's exceptional circumstances, including overriding clinical need and expected outcome
- copies of any relevant correspondence
- supporting documentation e.g. robust evidence of clinical and cost effectiveness, consultant and other specialist assessments

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 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 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 which require consideration 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 will be referred 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.

After a decision has been made, a full written explanation will be provided to the referrer who in turn would share this with the patient. The IFR team also shares an anonymised summary of 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.

Appendix 3: 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) these advisors 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 amongst the roles above to achieve quoracy. 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.

Appendix 4: CCG APPEALS PANEL

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 recommended 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 will 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.

Appendix 5: 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.

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 out of 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 lower 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.

3.2. Where a procedure normally requiring prior approval is required urgently for clinical reasons, including, but not exclusively limited to, vascular compromise, retention, infection, potential malignancy, uncontrolled pain or severe mechanical impairment, it may be carried out on the authority of the consultant responsible for the patients care at that time. The exceptional need will need to clearly documented to avoid payment for the procedure being challenged

Authors:	CCG Priorities Committee
Date of Issue:	July 2014

Appendix 6

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 must be completed in full. ***The fields are expandable so please include as much detail as possible.***

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*	***Name:***	

Chief Pharmacist or nominated deputy (in the case of a drug intervention)	***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 CCG's 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 CCG's 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 the requested intervention for this condition? **(*)***	***PUBLISHED[1] 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.**)*

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

(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.

All submissions should be sent by **email** to: scwcsu.SHIP.IFRrequests@nhs.net (Emails must be sent from a secure nhs.net address)

Only submissions containing medical photography which cannot be emailed may be posted to:

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

Tel: 02380 622700

Appendix 7

INDIVIDUAL FUNDING REQUEST (IFR) APPLICATION – PRIMARY CARE

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 – handwritten submissions may not be accepted. Please ask your Practice Manager to load this form onto your practice server for ease of use.

All submissions should be sent by **email** to: scwcsu.SHIP.IFRrequests@nhs.net (Emails must be sent from a secure nhs.net address)

Only submissions containing medical photography which cannot be emailed may be posted to:

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

Tel: 02380 622700

General guidance on completion

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 above 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.

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 – CCGs commission this surgery in linew with Priorities Committee policy 13 but prior approval is no longer required provided the criteria are met which would include access through a tier 3 obesity management service.

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 at http://www.fundingrequests.cscsu.nhs.uk/ then click 'Hampshire and Isle of Wight'

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 .
- Portsmouth CCG – please contact the Integrated Commissioning Unit via ECRdutymailbox@portsmouthcc.gcsx.gov.uk or contact Dawn Jordan

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 8

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.

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.

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 9

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*
SOUTH EAST 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 the Individual Funding Request team at the NHS South, Central & West Commissioning Support Unit to scwcsu.SHIP.IFRrequests@nhs.net

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 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
- **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.

APPENDIX 10

FURTHER USEFUL/ SUPPORTING INFORMATION

The NHS Confederation document "Priority setting: managing individual funding requests." was drafted for Clinical Commissioning Guidelines 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 CCG 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"*

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[2]:

> *".. 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."*

[2] 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.

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.

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 www.fundingrequests.cscsu.nhs.uk then click 'Hampshire'. This includes all relevant 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 6 – 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.

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.

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 CCGs 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.

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.