Policy and Procedure for Restricted Treatments and Procedures concerning Clinical Commissioning Groups April 2021

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	Kyphoplasty and vertebroplasty removed from exclusions/

	Appraisal 279	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 appendix 2
December 2014	Hampshire CCGs	Draft revised criteria in appendix 2 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 – appendix 2 Inclusion of penile prosthesis – appendix 1
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	CCG clinical execs	Minor amendments to criteria re tonsillectomy and high BMI hip and knee replacements
April 2016	CCG clinical execs/Board	Implementation of Priorities Committee policy statements related to hip arthroscopy, continuous glucose monitoring, functional electrical stimulation, intensive decongestive therapy, adenoidectomy, surgery for 'snoring' and arthroscopy in knee pain. Amendment to clarify inguinal hernia policy changing 'all' to 'one' criteria to be met
Sept 2016	CCG clinical execs/ Board	Second eye cataracts from 'prior approval' to 'thresholds' (WH & NHCCG) Benign skin lesions from 'exclusion' to 'prior approval' (WH & NHCCG) Asymptomatic inguinal hernia from 'prior approval' to 'exclusions' (WHCCG & NHCCG) Addition of policies on patellar knee resurfacing and subacromial shoulder decompression Addition of bariatric thresholds
Jan 2017	WHCCG Clin Exec	Tonsillectomy to 'threshold and audit'
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
Jan 2018	SHIP Priorities Committee as endorsed by SHIP CCGs	Addition of policies related to - Autologous Blood injections - Chronic Anal Fissure and - Hydrocele surgery
Feb 2018	SHIP Priorities Committee as endorsed by SHIP CCGs	Addition of policies related to - Surgical management of pelvic organ prolapse.
May 2018	SHIP Priorities Committee policies 30-32	Addition of policies related to - Cryopreservation options for patients undergoing NHS treatment which might render infertility

		- Revisional bariatric surgery - Cataract surgery
Oct 2018	SHIP Priorities Committee policies 33, 36 and 37	Addition of policies related to Microsuction of earwax Amendment to policies on tonsillectomy and grommet insertion
April 2019	SHIP Priorities Committee policies 39-49	Addition of policies related to hysterectomy in heavy menstrual bleeding, haemorrhoid surgery, rotator cuff surgery, circumcision, knee revision, female sterilisation, Dupuytren's contracture, trigger finger, ganglions and dilation and curettage
Oct 2019	SHIP Priorities Committee policies 50-55	Addition of primary hip and knee replacement, hallux valgus surgery, eyelid surgery for ptosis and dermatochalasis, correction of ectropion and entropion, chalazia surgery and clarification related to arthroscopic surgery for meniscal tears
6th December 2019	SHIP Priorities Committee policies 002, 56-57	Policy revisions 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 policies 001, 008 & 013,	Policy revisions related to • Varicose veins • Adenoidectomy • Bariatric surgery
October 2020	SHIP Priorities Committee policies 61 – 65, 014 & 029	Policy revisions related to • 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 22, 23, 36, 60, 16, 55, 37 & 66	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

CONTENTS

1 INTRODUCTION

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

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

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

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

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

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

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

Such requests should not be confused with

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

2 REFERRALS TO BE DEALT WITH UNDER THE POLICY - EXCEPTIONALITY

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

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

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

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

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

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

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

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

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

3 POLICY SCOPE

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

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

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

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

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

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

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

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

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

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

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

4 PRIORITIES FRAMEWORK AND DECISION-MAKING

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

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

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

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

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

Assessing individual cases

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

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

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

5 PROCESS

All requests should be in writing using the IFR funding application forms (found at appendices 4 and 5 and available on NHS South CSU's website www.fundingrequests.cscsu.nhs.uk then click 'Hampshire')

A clear description of the exceptional circumstances, based on overriding clinical need,

- copies of any relevant correspondence; and
- other supporting documentation e.g. robust evidence of clinical and cost effectiveness, consultant and other specialist assessments, appropriate costings.

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

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

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

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

Before reaching the Panel, all requests will be addressed by the IFR team and, in cases where the referral clearly does not meet the exceptional circumstances explained above will be declined with an explanation. The IFR team will approve all referrals that clearly meet the criteria set out in this policy. In cases where

the referrer has not made the application on the IFR funding request form and/or has not sent all relevant information plus any supporting documentary evidence, the referrer will be invited to do so, to enable the request to proceed.

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

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

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.

6 IFR REFERRAL PANEL

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

Panel remit

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

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

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

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

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

Membership (IFR Panel)

The Panel should consist of primary care clinicians, the IFR lead or member of the team with a blend of medicines management, allied health professional and secondary care input as appropriate. The Panel should be chaired by a member with sufficient experience of the process and the concept of exceptionality. A guide to membership is as follows to ensure clinical participation.

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

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

7 CCG APPEALS PANELS

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

Terms of reference and membership

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

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

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

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

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

Complaints

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

8 SERVICE DEVELOPMENTS

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

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

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

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

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

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

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

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

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

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

9 IMPLEMENTATION OF NICE GUIDANCE

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

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

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

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

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

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

10 MANAGING THE ENTRY OF NEW DRUGS

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

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

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

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

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

Surgical restricted and excluded procedures

This list sets out those requiring an IFR or prior approval if relevant, and from where such an application should normally come.

Procedure – the specialties listed below are a guide only and patients may be treated under different treatment function codes	IFR Required	Prior Approval OR Clinical Threshold (SCCCG)	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		✓	Secondary Care or MSK community service
Arthroscopic hip surgery in impingement		✓	Secondary Care or MSK community service
Autologous blood injections in musculo-skeletal conditions	✓		Secondary Care or MSK community service
Bunion (hallux valgus) surgery		✓	Secondary Care or MSK community service
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
Hallux valgus surgery		✓	Secondary Care or MSK community service
Hip or knee replacement (primary) BMI 35+		✓	Secondary Care or MSK community service
Hip resurfacing		✓	Secondary Care or MSK community service
Rotator cuff repair		✓	Secondary Care or MSK community service
Trigger finger surgery		✓	Primary Care or MSK service
Subacromial shoulder decompression		✓	Secondary care or MSK
Spinal Pain	✓	✓	Secondary Care or MSK
OTHER SURGICAL PROCEDURES			
Abdominoplasty (cosmetic) (IFR **or prior approval if after massive weight loss**)	✓	✓	Primary Care
Surgical treatment of chronic anal fissure		✓	Secondary care
Skin reduction surgery (after massive weight loss)		✓	Primary Care
Bariatric and revision bariatric surgery (see policy as to whether IFR or prior approval applies)	✓	✓	Secondary care
Breast procedures	✓		Primary Care

Gastric fundoplication for reflux disease		✓	Secondary Care
Inguinal hernia (asymptomatic)	✓		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)
Skin lesions	✓		Primary Care
Plastics procedures (facial, brow, facelift, thighs, upper arms)	✓		Primary Care
Negative Pressure Wound Therapy	✓		Secondary Care
Foetal Alcohol Spectrum Disorders	✓		Secondary Care
Low Intensity Pulsed Ultrasound (Exogen) in delayed and non-union fractures	✓		Secondary Care
OPHTHALMOLOGY			
Eyelid Surgery for ectropion and entropion		✓	Primary Care
Eyelid Surgery 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
First and second eye cataract surgery		✓	Community ophthalmology or secondary care
ENT SURGERY			
Adenoidectomy in children with upper respiratory tract disorders	✓		Secondary care
Adenoidectomy in children with chronic rhinosinusitis (CRC)		✓	Secondary care
Balloon catheter sinus dilation in chronic rhino-sinusitis	✓		Secondary care
Surgery for 'snoring'	✓		Secondary care
Functional endoscopic sinus surgery		✓	Secondary care
Nasal surgery for nasal blockage and or deformity		✓	Primary Care or Secondary Care (ENT)
Microsuction of earwax	✓		N/A To be offered in tier 2 services
Tonsillectomy adults and children		✓	Primary Care or Secondary Care (ENT)
Grommet insertion /myringotomy (adults and children)		✓	Secondary Care
Pinnaplasty	✓		Primary Care
GYNAECOLOGY/ UROLOGY			
Female cosmetic genital surgery (labiaplasty)	✓		Primary Care
Female sterilisation		✓	Primary Care or Secondary Care (Gynaecology)
Circumcision		✓	Primary Care or Secondary Care
Treatment of LUTS as a result of Benign Prostatic Hyperplasia		✓	Primary Care or Secondary Care
Hysterectomy for menorrhagia		✓	Secondary Care
Pelvic Organ Prolapse		✓	Secondary Care

Reversal of sterilisation/ vasectomy	✓		Primary Care
Faecal microbiota transplant (outside of use in C.difficile)	✓		Secondary care

Appendix 1: EXCLUDED PROCEDURES requiring Individual Funding Request

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

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

The recommendations and policy notes of the SHIP Priorities Committee, if endorsed by CCGs, will supersede or add to this list as will mandatory NICE Technology Appraisal Guidance. Where a Priorities Committee policy document is referenced, please consult www.fundingrequests.cscsu.nhs.uk then click 'Hampshire'

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

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
	Female cosmetic genital surgery (labiaplasty)	P01-, P055/6/7, P153/8/9	CCGs do not routinely fund this procedure	
	Rhinoplasty/ reconstruction of nose	E02-E072/3/8/9	CCGs do not routinely fund this procedure. Functional nasal airways surgery should not be confused with cosmetic rhinoplasty and is referenced as a separate policy under Appendix 2.	In cases of post-surgical reconstruction as part of the pathway following trauma and must be within 12 months of the trauma occurrence.
	Treatment of **asymptomatic** inguinal hernias		These procedures are not routinely funded Consideration will be given via **individual funding request** in the following cases documented on imaging • History of incarceration of or real difficulty in reducing the hernia • An inguinal-scrotal hernia • An increase in size raising concern over malignancy	Emergency procedures recorded under admission method 21-28 Surgery for **symptomatic** hernias do not require approval
Plastics/ laser surgery	Laser removal of skin and excessive hirsutism		CCGs do not routinely fund this procedure. Usually offered at Salisbury laser service – and only with supporting photography considered via IFR	
	Laser therapy for recurrent pilonidal sinus		**CCGs do not routinely fund this procedure.** In line with Priorities Committee policy statement 016 (June 2020)	

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

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
	Balloon catheter sinus dilation for chronic rhino-sinusitis	E081, E13*, E14* AND Y40.3 secondary with ICD10 code J31* and J32*	CCGs do not routinely fund this procedure In line with Priorities Committee policy statement 018 (Feb 2017)	
	Microsuctioning of earwax	D07*	**CCGs do not routinely fund this procedure in secondary care** In line with Priorities Committee policy statement 33 (June 2018) this procedure should be offered in tier 2 services only subject to agreed criteria as listed in the policy embedded in the above summary All treatment via secondary care including outpatients would require a full Individual Funding Request. Clinical judgement may require earwax clearance to conclude an OP **assessment** but this would not be charged separately as a **procedure**	ICD10 codes H60*, H61*, H62*, H70* and H74*

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
Gynaecology	Dilation and curettage in heavy menstrual bleeding	Q103	In line with the NHS England Evidence-based Interventions document D&C should not be used for diagnosis or treatment for heavy menstrual bleeding in women because it is clinically ineffective. UIltrasound scans and camera tests with sampling of the lining of the womb (hysteroscopy and biopsy) can be used to investigate heavy periods. Medication and intrauterine systems (IUS) can be used to treat heavy periods.	
Urology	Reversal of sterilisation/ vasectomy	♀- Q37, Q29, ♂ - N18	CCGs do not routinely fund this procedure May be considered via IFR on the death of a partner or only child or where sterilisation caused by proven surgical accident that was not a foreseen consequence of such a procedure.	
	Erectile Dysfunction and Penile Rehabilitation following radical prostatectomy	N29	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
Orthopaedics	Patellar knee resurfacing as part of total knee replacement	W401 **+ W581 at Z787**	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	Southampton City CCG (SCCCG) does not require IFR or Prior Approval for this.

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
	Autologous blood injections	T74.6	**CCGs do not routinely fund this** Priorities Committee policy statement 24 (Dec 2017)	
Gastro-intestinal	Faecal microbiota transplants	H218/ G578/ G488/ H628 **AND** Y378 secondary procedure	CCGs do not routinely fund this procedure	Use in refractory C-difficile is routinely commissioned (diagnostic code A04.7)
Alternative/ complementary/ homeopathic therapies	Complementary therapies/medicine	X61	CCGs do not routinely fund this	When included as an adjunct to usual therapy e.g. acupuncture within physiotherapy or pain management services. **Not** funded as a separate procedure
Mental health	In patient treatment for severe chronic Fatigue/ME		CCGs do not routinely fund this. Severe cases require an IFR but mild-to-moderate cases are available in the commissioned outpatient service run by South Coast Fatigue.	
	Non-NHS residential placements		CCGs do not routinely fund this	
	Adult ADHD		CCGs do not routinely fund this. Agreed via IFR	
Various services	Intensive decongestive therapy for lymphoedema	n/a	In line with SHIP Priorities Committee policy	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
			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, 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 **individual funding request**	
	Functional electrical stimulation in drop foot	n/a	In line with SHIP Priorities Committee policy statement 005 Functional Electrical Stimulation may be considered as a second line treatment option for carefully selected patients with drop foot (most commonly due to multiple sclerosis or stroke) who have clearly failed trials of orthosis (for example due to pressure sores, spasticity). It should be considered a **low priority** for all other patients	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval
			All cases must be sought via **individual funding request**	
	Negative Pressure Wound Therapy		In line with SHIP Priorities Committee Policy Statement 61 CCGs do not routinely fund this	
Children's Services	Assessment and admission to Bursledon House in Southampton for in-patient treatment	n/a	Admissions to Bursledon House are not routinely funded. Children considered for referral to Bursledon House must have referrals prior approved before assessment is carried out and, if agreed, further approval must be sought after assessment where admission is requested	
	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.	

Appendix 2: PRIOR APPROVALS AND PROCEDURES SUBJECT TO CLINICAL THRESHOLDS (PLCV)

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

Prior approval

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

Fareham & Gosport CCG
South Eastern Hampshire CCG
Portsmouth CCG
Isle of Wight CCG
West Hampshire CCG
North Hampshire CCG

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

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

Prior approval is requested via the Commissioning Support Unit at scwcsu.ship.ifrrequests@nhs.net using the proforma at www.fundingrequests.cscsu.nhs.uk then click 'Hampshire'

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

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

Please note that Southampton City CCG does not currently operate a Prior Approval Process, however the Clinical Thresholds as set out below are still clinically applicable.

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
ENT/ Audiology	Myringotomy/ grommet insertion for children under 12 years of age	D151	This procedure is not routinely funded. 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 The child has a documented hearing level in the better ear of 25-30dBHL or worse averaged at 0.5, 1, 2 and 4kHz (or equivalent dBA where dBHL not available)	Children under 3 years of age
	Myringotomy/ grommet insertion for adults and children over 12 years of age	D151, D222	This procedure is not routinely funded Prior approval will be considered under the following conditions This procedure is not routinely funded for adults and	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			children ≥ 12 years old except under the following conditions: - A middle ear effusion causing measured conductive hearing loss, persisting for 3 months and resistant to medical treatments. The patient must be experiencing disability due to deafness. The possible option of a hearing aid may be discussed, at the discretion of the clinician. - Persistent Eustachian tube dysfunction resulting in pain (e.g. flying) – 3-month wait not required - As one possible treatment for Meniere's disease. - Severe retraction of the tympanic membrane if the clinician feels this may be reversible and reversing it may help avoid erosion of the ossicular chain or the development of cholesteatoma – 3-month wait not relevant - Grommet insertion as part of a procedure for the diagnosis or management of head and neck cancer and/or its complications NB It is important that conductive unilateral hearing loss present for 4 weeks should be referred to an ENT surgeon without delay	
	Functional endoscopic sinus surgery in chronic rhino-sinusitis and/or nasal polyps	Y76.1 combined with ICD10 code starting J31, J32 or J33	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	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	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			• 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	
	Nasal surgery for nasal blockage and or deformity	E02*, E03.6/7, E04*, E64.8/9, E073	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. 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	Emergency procedures recorded under admission method 21-28 S02 - fracture

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			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 cancer treatments are excluded from this policy.	
	Adenoidectomy in children with chronic rhinosinusitis		In line with Priorities Committee policy statement Feb 2016 and revised in March 2020 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	L84, L85, L86, L87, L88	This procedure is not routinely funded Prior approval will be considered under the following conditions Reference: SHIP Priorities Committee policy statement no. 001. www.fundingrequests.cscsu.nhs.uk then click	Emergency procedures recorded under admission method 21-28

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			'Hampshire' People with a body mass index less than 32 kg/m^2 who satisfy **at least one** of the following criteria may be considered for interventions to treat varicose veins: • a first venous ulcer • a recurrent venous ulcer • haemorrhage from a superficial varicosity	
Gynaecology	Hysterectomy in heavy menstrual bleeding/ dysmennorhea	Q07- (except Q076), Q08	In line with Priorities Committee statement 39 Sept 2018 Hysterectomy for heavy menstrual bleeding (HMB) is not normally funded. Treatment should begin in primary care with non-hormonal and hormonal methods being trialled. Each method should be used for a minimum period of 3 months and preferably 6 months Patients who do not respond to pharmacological treatment should ideally be referred to a "One Stop" menstrual disorder or similar clinic. Referral should include a recent full blood count. Ferritin levels are no longer recommended. Patients should be counselled extensively by an appropriately trained healthcare professional, on the risks and benefits of intervention, including; • affect on libido • impact on fertility • bladder function • need for further treatment • treatment complications	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. This is not related to management of suspected malignancy or trauma

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			• her expectations • alternative surgery • psychological impact. Information aids such as the Shared Decision Making tool (https://www.england.nhs.uk/rightcare/shared-decision-making/) should be considered. Patients who have failed all other interventions and are proceeding to surgery should be offered laparoscopic interventions where clinically viable.	
	Female sterilisation	Q27, Q28, Q35, Q36	In line with Priorities Committee statement 45 – Jan 2019 This procedure is not routinely funded but approval for surgical treatment of fertility in women may be sought 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 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	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			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.	
Urology	Male circumcision	N303	In line with Priorities Committee policy statement 43 (Nov 2018) The procedure is not routinely funded but prior approval can be considered under the following conditions: • Pathological phimosis due to lichen sclerosus (formerly known as balanitis xerotica obliterans) • 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. Circumcision for cultural or religious indications will not be commissioned. Circumcision for paraphimosis and physiological phimosis are not normally funded and requests need approval through the Individual Funding Request Process. Further guidance on conservative treatments below **Balanitis/balanoposthitis** Treatment includes hygiene measures, using an emollient (such as emulsifying	Patients coded with a cancer diagnosis Patient is suspected with cancer and has been referred via the two-week wait referral form

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			ointment) as a soap substitute and topical treatments as per the underlying diagnosis, such as topical steroids, anti-fungals and oral antibiotics. **Treatment of lichen sclerosus (LS)** as guided by the British Association of Dermatologists - BAD (2018) Guidelines for the management of LS. Children: Offer a trial of an ultrapotent topical steroid applied once daily for 1–3 months combined with emollients and barrier preparations to all male children and young people with phimosis caused by LS. Adults initial treatment: Offer all male patients with genital LS clobetasol propionate (CP) 0.05% ointment once daily for 1–3 months with an emollient as a soap substitute and as a barrier preparation.	
	Treatment of LUTS as a result of Benign Prostatic Hyperplasia		In line with Priorities Committee policy 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:	Any surgical modality offered 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

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			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 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 urinary tract	• 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	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			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.	
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	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
	Non-specific low back/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 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, including botulinum toxin	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			• 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	Cervical neck Pain (neck)	Please see Policy 60	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: **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.	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	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
	Lumbar (low back pain) Facet joint pain		**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 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 specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
	Sacroiliac (SIJ) 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 **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	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS code(s)	Comments/ guidance for prior approval	Exclusion (may be treated without prior approval)
			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	T723	In line with Priorities Committee policy 47 (Feb 2019) 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 Surgery should only be considered if: • 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.	
	Palmar fasciectomy / Dupuytren's contracture	T521/2 T541	In line with Priorities Committee policy 46 (Feb 2019) These procedures are not routinely funded and intervention should only be offered via prior approval if there are; • Finger contractures causing loss of finger	

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			extension of 30 degrees or more at the metacarpophalangeal joint (MCPJ) or 20 degrees at the proximal interphalangeal joint (PIPJ) resulting in functional loss OR • Severe thumb contractures which interfere with function Collagenase may be offered without approval to participants in ongoing clinical trials or in adults with palpable cords if the following criteria are met 1. 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 2. Needle fasciotomy is not considered appropriate but limited fasciectomy is considered appropriate by the treating hand surgeon	
	Treatment of bunions (hallux valgus)	W791/2 W151-4	In line with Priorities Committee policy 51 (April 2019) Patients with bunions and peripheral neuropathy or diabetes are outside of the scope of this policy and need to continue to be managed carefully through a multi-disciplinary approach. 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 does not respond to conservative measures must be assessed through the MSK triage service to ascertain if they are likely to benefit from intervention.	

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			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 partial meniscectomy of the knee in patients over 40 with non-traumatic and persistent knee pain	W82-, W83-, W85-, W86.1, W87-, W89.1 (combined with diagnostic codes M179 or M232….)	These procedures are not routinely funded Reference SHIP Priorities Committee policy statement no 010 - April 2016 as reviewed in July 2018 and by policy statement 55 referencing meniscal tears (July 2019) The Priorities Committee has reviewed the evidence for knee arthroscopy as part of treatment for generalised knee pain in the over 40's and recommend that arthroscopic lavage and debridement with or without partial-meniscectomy in non-traumatic and persistent knee pain with no clear history of recurrent mechanical locking resulting in appreciable loss of function is low priority. This includes any approach for diagnostic purposes. Further detail can be found here http://www.fundingrequests.cscsu.nhs.uk In addition, the committee recommends that: Arthroscopic surgery should be offered to patients with meniscal tears after 3 months of conservative treatment which have failed to resolve and which have occurred as a result of trauma or injury. Arthroscopic surgery for patients with degenerative meniscal tears and no clear history of recurrent mechanical locking, resulting in appreciable loss of	Cases of traumatic knee pain (diagnostic codes M233…) will not require prior approval as will those beginning S* to exclude trauma

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			function, is low priority. This is due to lack of evidence of positive long term outcomes over conservative treatments such as physiotherapy.	
	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	W580/1/2 + Z843	These procedures are not routinely funded Prior approval will be considered under the following conditions Reference SHIP Policy Recommendation 105 on Metal on Metal (MOM) hip resurfacing www.fundingrequests.cscsu.nhs.uk then click 'Hampshire' As an alternative to hip replacement in men younger than 55 years of age provided the risks and benefits have been	

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			explained and the patient is keen to proceed. In older men and in women of all ages, funding for hip resurfacing is not funded.	
	Primary hip and knee replacement in patients with a BMI above 35	W371/381 (hip) W40/W41/ W42 (knee)	These procedures are not routinely funded for patients with a BMI above 35 Prior approval will be considered under the following conditions a) In patients whose pain is so severe and/or mobility compromised that they are at risk of losing their independence and that joint replacement would relieve this risk b) In patients whose destruction of the joint is of a severity that delaying surgery would increase the technical difficulty of the procedure Referral should also have been made for referral to the commissioned tier 2 or tier 3 obesity management programme prior to offering surgery.	**Emergency procedures recorded under admission method 21-28**
	Arthroscopic hip surgery in impingement	X22.8, W084/5, W091, W581, W83-, W84-, W861/8, W891 **(+ Y76.7 + Z84.3)**	In line with SHIP Priorities Committee policy statement 006 Arthroscopic femero-acetabular surgery for hip impingement should be considered as a second line treatment option for patients who are symptomatic, have significant impaired activities of daily living and have undergone activity modification as part of conservative treatment. Patients with evidence of osteoarthritis in the hip joint are not suitable for arthroscopic hip impingement surgery. All arthroscopic surgery for hip impingement procedure data should be submitted to the registry set up by the	

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			British Hip Society Registry (in line with NICE guidance).	
	Rotator cuff repair	T79* (with Y76.7) with ICD code M75*	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. However traumatic tears are less common and occur in a predominantly younger population. Consideration for surgery without delay is recommended in such patients. The majority of tears are degenerative and often relatively asymptomatic. The committee heard that 25% of the population would have a demonstrable tear by the age of 60 and more than 50% of those in their eighties. **First line options should begin with** - Physiotherapy and analgesia for 6 weeks is recommended as the first line of treatment, 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 services. - Whilst the Committee considered longer term issues related to injection of corticosteroids it was	Traumatic rotator cuff tears

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			considered reasonable to inject once, repeating once more only if there had been considerable but temporary relief in symptoms. It was noted that poorer outcomes were associated with older patients and those with diabetes, multiple tendon involvement, larger tears, or tears with fatty infiltration. Conservative options should always be considered and discussed with patients.	
	Subacromial decompression of shoulder	O291 (primary code)	In line with SHIP Priorities Committee policy statement 014 Open subacromial decompression is not routinely funded 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 compliant with physiotherapy intervention for at least 6 weeks • There has been a positive response to a steroid injection	**Emergency procedures recorded under admission method 21-28**
Ophthalmology	Chalazia (meibomian cysts)	C121	In line with Priorities Committee statement 54 (June 2019) This policy does not cover cases where malignancy is suspected or there is peri-orbital cellulitis which needs to be treated in the usual manner. Most chalazia are self-limiting and do not cause problems. Conservative treatment is by daily application of warm (not excessively hot) compresses and massage to help drain the cyst. This should be done in the direction of the	Patients coded with a cancer diagnosis Patient is suspected with cancer and has been referred via the two-week wait referral form

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			eyelashes using clean fingers or a cotton bud. Surgical intervention with incision and curettage causes discomfort, swelling and bruising in the majority of individuals. It also carries the very small risk of infection, bleeding and scarring and a proportion of chalazia return. The size of the lesion has little impact on the symptomatology. Equally a “feeling of pressure” is not an indication for intervention. The committee recommends; 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. been present for more than 6 months - Where it is situated subcutaneously in the upper or lower eyelid - Where it is causing impairment of vision	
	Surgery for ectropion and entropion		In line with Priorities Committee statement 53 (June 2019) Surgery for ectropion and entropion for cosmetic reasons alone is not normally funded. Surgery should be considered if there is:	

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			• Abnormal lid position causing • Chronic epiphora (at least 2 months) and • Ocular irritation unresponsive to topical treatments Surgery that is necessary prior to intraocular surgery such as cataract extraction is without restriction.	
	Surgery for ptosis and dermatochalasis		In line with Priorities Committee statement 52 (June 2019) 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. The committee heard that a variety of tools could be used to assess the condition including Marginal Reflex Height. However, these are measuring the appearance of the patient which is cosmetic and the committee recommends that 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. For those with a Class 2 occupational licence 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. The committee realises that this assessment of visual fields is outside the scope of primary care and it is suggested that referral should be to the optician in the first instance who will need to be appraised of the pathways. Abnormal head posture and headache are not considered criteria for intervention	

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Cosmetic/Plastic/ Aesthetic surgery	Excision of skin following massive weight loss	S02-	These procedures are not routinely funded Removal of excess skin including abdominoplasty, mammoplasty and removal of skin folds from the inner thighs following significant weight loss may be considered under all the following conditions : 1. The patient's starting BMI before weight loss must have been no less than the access criteria for bariatric surgery. 2. The patient's BMI must be less than 30kg/m2 or the patient has lost at least 75% of the excess weight. 3. The patient's target weight has both been documented as being achieved and maintained for a period of at least six months, 4. The patient is proven to be a non-smoker. 5. The patient is experiencing significant functional disturbance with a measurable reduction in the "Barthel ADL Score" due to the excess skin which is likely to improve with its removal.	
Gastroenterology	Gastric fundoplication for chronic reflux oesophagitis	G241 G243 G461	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 at risk of aspiration - Significant difficulty sleeping due to gastro-oesophageal reflux symptoms	For all other indications, treatment is funded

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			- Anaemia because of oesophagitis Reference: South Central Priorities Committees policy statement no 51.	
	Treatment of **asymptomatic** inguinal hernias	T20-, T21-	These procedures are not routinely funded Prior approval will be considered where one of the following conditions are met • History of incarceration of or real difficulty in reducing the hernia • An inguinal-scrotal hernia • An increase in size • Pain or discomfort significantly interfering with activities of daily living directly related to the hernia **Treatment of symptomatic hernias do not require prior approval**	Emergency procedures recorded under admission method 21-28 Surgery for **symptomatic** hernias will not require approval
Bariatric surgery	Bariatric surgery	G28-, G30-, G31- (except G314), G321-, G331, G38-	**In line with Priorities Committee policy statement #13** 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:	

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			• They have a BMI of 40 kg/m^2 or more, or between 35 kg/m^2 and 40 kg/m^2 and 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.	
	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	

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			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 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	
Other surgery	Treatment of ganglions	T59-, T60	In line with Priorities Committee policy 48 (Feb 2019) Most ganglia get better on their own. Interventions for ganglia are considered to be of limited clinical value and are not commissioned except in the following circumstances; **Wrist Ganglion** Interventions for wrist ganglion 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	

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			restricted hand function. **Seed Ganglion** Ganglia in the palm of the hand (seed ganglia) 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 (mucous cysts) come from the last joint in the finger and are related to degeneration in the 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**.	
	Surgical management of pelvic organ prolapse	P22*, P23*, P24*, Q544/5/6 with diagnostic codes of N81* or N993	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	

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			organ prolapse unless the operation is part of a research trial. Other 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.	
	Management of haemorrhoids	H51*	In line with Priorities Committee policy 40 (Sept 2018) and the guidance in NHS England's Evidence Based Interventions document • Surgical interventions for Grade 1 and 2 haemorrhoids should not be commissioned except where there is a coagulation deficit e.g. use of Warfarin or NOACs and the repeated bleeding is causing anaemia. • Persistent grade 1 or 2 haemorrhoids which have not responded to dietary changes and conservative measures may be managed with banding or injections in an outpatient setting. • Skin tags are considered cosmetic and removal is not routinely commissioned 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. • Surgical removal of recurrent grade 3 or 4 haemorrhoids with persistent pain should be available with the most suitable procedure being decided by the surgeon.	H52.4 (ligation), L70.3 (artery ligation) Diagnostic codes K64.2 and K64.3 (third and fourth degree haemorrhoids) are excluded from challenge

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	Treatment of chronic anal fissure	Codes H562/4/8 against a **primary diagnostic code** of K600/1/2	In line with Priorities Committee Policy statement 25 (Dec 2017) The majority of cases will be treated in primary care. Advice about diet and avoidance of constipation is imperative. · First line pharmacological therapy is GTN (glyceryl trinitrate) rectal ointment. · Diltiazem should only be used if there is continued intolerance to GTN after education on proper application of extremely small amounts. · Medical therapies should be tried for at least a month. · Injection of botulinum toxin should be restricted to one injection and offered to women and anally receptive men due to the increased risk of incontinence from surgery. · Lateral sphincterotomy is supported for cases where all the aforementioned options have failed. Other interventions are considered **low priority and therefore require a full IFR**.	
Infertility treatments	In vitro fertilisation (including the prescriptions of infertility drugs) and ICSI (intracytoplasmic sperm injection)	n/a	This treatment is not routinely funded Prior approval will be considered in line with the SHIP Priorities Committee policy statement 002 - September 2014 where endorsed by individual CCGs www.fundingrequests.cscsu.nhs.uk then click 'Hampshire'	
	Cryopreservation of fertility ahead of NHS treatment likely to render	n/a	In line with Priorities Committee policy statement 30 – April 2018. This extends previous CPAF policy 135 to transgender people.	

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	infertility			
Children's Services	Assessment and admission to Bursledon House in Southampton for in-patient treatment	n/a	Admissions to Bursledon House are not routinely funded. Children considered for referral to Bursledon House must have referrals prior approved before assessment is carried out and, if agreed, further approval must be sought after assessment where admission is requested	

CLINICAL THRESHOLDS COMMISSIONING

Clinical threshold management has been introduced to reduce variation in clinical practice and ensure that elective procedures accessed by patients are appropriate. Clinical Decision Support systems support this process. Reduced variation will improve fairness to patients and allow optimum use of funding.

Treatment will not be subject to prior approval but will be subject to audit of an agreed sample of activity. This sample will be extrapolated against all activity so that the proportion of procedures considered inappropriate will not be reimbursed. It is therefore essential that, where treatment is offered that falls outside the agreed clinical thresholds, that the rationale is clearly recorded in the patient notes.

Ophthalmology	First and second eye cataract surgery (threshold criteria)	C71, C72, C73, C74, C75	In line with Priorities Committee policy statement 32 • 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.
Orthopaedics	Primary hip and knee replacement	W371/381 or W40*/41*/42*	In line with Priorities Committee statement 50 (March 2019) The committee has considered the current thresholds for operative interventions for primary joint replacement of hips and knees. It heard from a variety of orthopaedic consultants, both directly and by message as well as an in-depth evidence review. The committee makes the following recommendations: • **Obesity** is an important factor in the aetiology of joint disease as well as being detrimental to the outcomes.

			Consequently, the committee recommends that weight management has an important role throughout the patient's life, and this should be reflected in prevention strategies • There is clear evidence that there are 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 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.
	Revision of knee replacement	W403/4 W413/4 W423/4/5	In line with Priorities Committee statement 44 (Nov 2018) Hip and knee revision surgery can be carried out by local Specialist Orthopaedic Units, with the required expertise, with the exception of patients requiring specialist procedures for massive bone defects, pelvic fractures, infection or complex segmental femoral reconstruction who should be referred to a National Specialist Orthopaedic Centre. 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 but 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
	Carpal tunnel release/ nerve entrapment at wrist	A65-	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 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.
ENT	Tonsillectomy adults and children	F34, F361	**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 episodes a year for three years **and** - There have been symptoms for at least a year **and**

			- Episodes of sore throat are disabling and preventing normal functioning GP referrals must include the practice record detailing frequency of reported episodes and prescribing in line with the criteria above. Providers should alert commissioners/CSU where this is not being included.
	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.
Dermatology/ general surgery	Surgical removal of skin lesions.	E094, S04, S05, S06, S08, S09, S10, S11, S60	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: - 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.
Other surgery	**Treatment of hydrocele**	N11* and T193 with diagnostic code of N43* or P835	In line with Priorities Committee policy statement 26 Surgery for hydrocele should only be offered under the 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
	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.

SOUTH CENTRAL ETHICAL FRAMEWORK

Background

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

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

Purpose of the Ethical Framework

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

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

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

The Ethical Framework is especially concerned with the following:

A: Evidence of Clinical and Cost Effectiveness

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

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

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

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

B: Equity

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

C: Health Care Need and Capacity to Benefit

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

1.6. This approach leads to three important principles:

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

D: Cost Of Treatment and Opportunity Costs.

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

E. Needs of the Community

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

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

2. POLICY DRIVERS

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

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

3. EXCEPTIONAL NEED

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

Authors:	CCG Priorities Committee
Date of Issue:	July 2014

Appendix 4

INDIVIDUAL FUNDING REQUEST (IFR) - SECONDARY CARE USE

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

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

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

CONTACT INFORMATION

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

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

STATEMENT CONFIRMING APPROPRIATENESS FOR CONSIDERATION AS AN IFR

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

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

DIAGNOSIS AND PATIENT'S CURRENT CONDITION

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

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

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

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

EVIDENCE OF CLINICAL EFFECTIVENESS

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

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

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

Contact details for IFR Submissions

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

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

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

Tel: 02380 622700 E-mail: southcsu.ifrs@nhs.net

Appendix 5

IFR APPLICATION FORM
PRIMARY CARE USE ONLY

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

CONTACT INFORMATION

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

DIAGNOSIS AND PATIENT'S CURRENT CONDITION

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

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

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

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

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

Contact details for IFR Submissions

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

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

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

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

Tel: **02380 622700**
E-mail: southcsu.ifrs@nhs.net

General guidance on completion

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

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

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

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

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

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

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

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

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

Asperger's/autism diagnosis in adults

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

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

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

PATIENT INPUT

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

SECONDARY CARE APPLICATIONS

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

APPENDIX 6

COSMETIC/ PLASTIC SURGERY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Please check you have answered EVERY question. Thank you.

APPENDIX 8

REFERRAL FOR ASSISTED CONCEPTION
CHECK LIST FOR ELIGIBILITY

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

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

NHS South, Central & West Commissioning Support Unit, Omega House, 112 Southampton Road, Eastleigh, Hampshire, SO50 5PB. southcsu.ifrs@nhs.net. Phone number: 023 8062 2700.

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

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

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

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

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

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

STATEMENT TO BE SIGNED BY THE REFERRING CONSULTANT / GP

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

Referrer's name (Please print) _____

Referrer's signature: _____

Date of referral: _____

Designated Centres. Please circle as appropriate.

- **The Chiltern Hospital**, London Road, Great Missenden, Bucks HP16 9DT - 01494 892276
- **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