

Policy and Procedure for Individual Funding Requests (IFRs) for treatments concerning Clinical Commissioning Groups

Date	Approved By	Activity	Amended by
November 2010	NHS Southampton Clinical Leadership Board	Changes to Policy title to 'Individual Funding Requests' and first joint policy covering NHS Hampshire and NHS Southampton City with joint Panel structure.	Chris Ashdown
12 January 2011	For NHS Hampshire PAC (not convened)	Housekeeping of document to take account of changes to application form which will include reference to potential service development Re-arrangement of exclusions list to separate between: <ul style="list-style-type: none"> i. Core list of interventions that are "not normally funded". ii. Criteria-based commissioning for procedures of limited clinical value (PLCV) using the Prior Approval Tool iii. Volume thresholds/ quota-based commissioning 	Chris Ashdown
15/02/11	NHS Hampshire PAC / Management Committee	Finalising of 'new' procedures of limited clinical value, addition of procedure codes and ordering into 'don't dos' and 'may dos'. Inclusion of revised application form and guidance notes for use in primary care only. (Current application still to be used in secondary care)	Chris Ashdown/ Cathy Price/ Marie-Claire Lobo
May – June 2011	NHSH/ PAC	Amendment to criteria in Dupuytren's contracture, trigger finger and carpal tunnel surgery to align with Map of Medicine pathways. Amendment to bone-anchored hearing aid criteria to cover single-sided hearing loss	CA/ GPC West leads
Mar 2012	BoCC (for information)	Amendments for 2012-13 contract re prior approval procedures including removing the need for prior approval for skin lesions,	CA

		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	Stuart Ward/ CA
Feb 2013	CCG clinical execs	Amendments to a headline policy for NHS South CSU for adoption/variation by individual CCGs Removal of cholecystectomy from 'thresholds list' Shift ganglions from 'thresholds' to 'restrictions' with clear criteria Hallux valgus criteria amended Skin lesions criteria amended Changes to management of prior approval for tonsillectomy All NHSCB-designated specialised services as well as dentistry removed from exclusions and restrictions lists	CA
March 2013	CCG clinical execs	Amendments to policies on adult and children grommet insertions	CA
May 2013	NICE Technology Appraisal 279	Kyphoplasty and vertebroplasty removed from exclusions/ restrictions lists provided NICE criteria met	CA
	CCG clinical execs	Amendment to hallux valgus pathway (podiatry not essential as long as MSK triage in place)	
January 2014	CSU	Amendments to update CCG Priorities Committee details and ethical framework	CA
Feb 2014	CSU	Note re varicose veins policy review Soton CCG only Amendment re skin lesions to recognise established So'ton CCG pathways	CA
Mar 2014	W Hants CCG	Reference of 'pre-auricular skin tags / accessory auricles' as removed from exclusions list	CA

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1 INTRODUCTION

This document sets out the Policy and Procedure for Clinical Commissioning Groups (CCGs) in Hampshire with respect to treatments which are not routinely commissioned or are restricted to clinical criteria. The function for addressing individual funding requests lies with the NHS South 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 at the time but 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"*

NB This policy currently does not directly apply to the Isle of Wight CCG though their restricted and excluded procedures lists will be largely aligned.

2 REFERRALS TO BE DEALT WITH UNDER THE POLICY - EXCEPTIONALITY

Since the NHS Confederation published its guidance in 2009, further guidance was issued by the then NHS Commissioning Board 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 exceptionality¹:

"It is important to distinguish between an exceptional case and an individual funding request. In an exceptional case, a patient seeks to show that he or she is an 'exception to the rule' or policy and so may have access to an intervention that is not routinely commissioned for that condition. In contrast, 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*

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.

- *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. IFRs also need to be understood in the context of routinely funded services. Most established treatments and services are subject to routine commissioning arrangements: a portfolio of contracts and service level agreements, clinical commissioning policies, mandatory National Institute of Health and Clinical Excellence (NICE) technology appraisal guidance.

This guidance note is intended to distinguish the broad types of request that may be received. These are where the request:

1. *represents a service development for a cohort of patients*
2. *is on grounds of clinical exceptionality where there are commissioning arrangements in place*
3. *is on grounds of rarity and no commissioning arrangements exist*
4. *is for a new intervention or for use of an intervention for a new indication, where no commissioning arrangements exist*

In the event that an IFR is approved, this does not necessarily set any precedent and relates to the individual patient only.

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, commissioning colleagues, members of the public health directorate and a clinically-led Referral Panel.

Treatments that require Prior Approval for Funding due to their high cost or uncertain cost effectiveness may be dealt with by the same team. However, it is expected that the CCGs will hold specific conditions whereby permission is granted. 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 IFR application can be found at Appendix 2.

NB. 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. R&D 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 NSH England applies

<http://www.england.nhs.uk/wp-content/uploads/2013/08/who-pays-aug13.pdf>

- The provider can meet the quality standards as per Healthcare Assurance Standards / Care Quality Commission guidelines

- **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 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 SHIP (Southampton, Hampshire, Isle of Wight, Portsmouth) Priorities Committee worked on behalf of its constituent commissioners to develop and agree clinical policies using an ethical decision making framework and standard procedures, supported by Solutions for Public Health. Their recommendations were advisory but became active policy following consultation with the constituent CCGs and endorsement by the former Cluster PCT's Board of Clinical Commissioners. An index of policy statements can be found on the Commissioning Support Unit's website <http://www.southcsu.nhs.uk/documents/ifr>. This includes all relevant inherited, 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 relaunched in September 2013 to offer advice and support to CCGs in both Hampshire and Surrey 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 4 – 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 to support robust and transparent ethical decision-making and was agreed and adopted by the nine former PCTs within the NHS South Central region and still has relevance today.

Assessing individual cases

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

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

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

5 PROCESS

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

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

There are specific forms for primary care and secondary care.

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 a letter of explanation. The IFR team will approve all referrals that clearly meet the criteria set out in this policy. In cases where the referrer has not made the application on the IFR funding request form and/or has not sent

all relevant information plus any supporting documentary evidence, the referrer will be invited to do so, to enable the request to proceed.

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

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

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

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

Urgent cases

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

6 IFR REFERRAL PANEL

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

Panel remit

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

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

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

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

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

Membership (IFR Panel)

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

Chair (either a GP or public health consultant)
Public Health Consultant
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 recommended that it should have at least two clinical members of the 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, commissioners 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.

Appendix 1: EXCLUDED PROCEDURES

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. It is for the referring clinician to provide detail of exceptional circumstances as per the appended form in light of the earlier definition of exceptionality provided by the NHS Confederation. Guidance notes are included where appropriate and only as a pointer towards consideration.

The recommendations and policy notes of the South Central Priorities Committees will supersede or add to this list as will mandatory NICE Technology Appraisal Guidance. The list below is under constant review and development.

Where a Priorities Committee policy document is referenced, please consult <http://www.southcsu.nhs.uk/documents/ifr> where all policy statements are listed in one document

Specialty	Procedure	OPCS codes	Notes
Plastic/ cosmetic procedures surgery (see Appendix 6 for further detail)	Any procedure carried out for primarily cosmetic reasons is excluded i.e. not funded. See Appendix 7		
	Liposuction	S621/2	
	Facelift (Rhytidectomy/ Surgical removal of wrinkles)/ Brow lift and Submental lipectomy	S01	
	Buttock lift, thigh lift, upper arm lift (brachioplasty)	S03	
	Breast and nipple procedures	B30, B31, B351/4/6, B36	As per the South Central Priorities Committee policy statement 15. Post cancer treatment is an exception to this policy and will go ahead as part of established cancer pathways without the need for prior approval
	Pinnaplasty/meatoplasty/ plastic operations on external ear	D03	Excision of post-natal 'accessory auricles/ pre-auricular skin tags' should be allowed to proceed at the appropriate point
	Female cosmetic genital surgery	P01, P055/6/7, P153/8/9	
	Rhinoplasty/ reconstruction of nose	E02 E036/7 E072/3/8/9	In cases of post-surgical reconstruction following trauma, congenital malformation or respiratory difficulty these should automatically go ahead. Functional endoscopic sinus/nasal surgery should not be confused for cosmetic rhinoplasty and coding will be monitored to ensure this activity is unchallenged subject to audit.

Specialty	Procedure	OPCS codes	Notes
Dermatology/ general surgery	Surgical removal of benign non-infected skin lesions. These might include: cysts, 'lumps and bumps', warts, rosacea, scars, thread veins, venous flares, spider naevia, telangiectasia, seborrhoeic keratoses, tattoo removal, resurfacing blemishes and skin tags anywhere on the body	S04, S05, S06, S08, S09, S10, S11, S60 (except S605), Y08, Y11, Y13	<p>Referrals to secondary care for skin lesions should only be made directly to dermatology/general surgery where there is diagnostic doubt around malignancy.</p> <p>Any referrals for benign lesions including lipomas are not routinely funded and require prior approval <u>to be made by primary care</u> which details symptoms.</p> <p>The Trust will be expected to return referrals that do not have prior approval and, from Q2 (1 July 2014), any procedures undertaken without prior approval will be subject to challenge and non-payment where prior approval has not been received.</p> <p>Exceptions that may be <u>considered</u> for secondary care treatment would be repeated infection or persistent discharge of a sebaceous cyst or clearly demonstrated symptoms affecting a patient's activities of daily living/function.</p> <p>These can be better measured objectively using the Dermatology Life Quality Index (DLQI) (See appendix 7). A separate form for children is available on request. A score of ≥ 10 would be considered for treatment but should not be considered as an absolute criterion but as a guide. <u>The form should be completed by the GP with their patient.</u></p> <p>Applications in cases which are asymptomatic but considered severely disfiguring may be made with appropriate photography to demonstrate the level of disfigurement.</p> <p>Southampton CCG patients excepted from the above in recognition of existing GPwSI services and referral pathways</p>
Plastic surgery	Laser removal of skin lesions (haemangioma, portwine stain, HHT) and excessive hirsutism		Usually offered at Salisbury laser service – prior approval basis only with supporting photography considered on a named patient level
	Appliances and devices for cosmetic purposes (high-grade silicon cosmesis and/or prosthesis)		

Specialty	Procedure	OPCS codes	Notes
Ophthalmology	Short sight/long sight corrective (laser) surgery (Refractive keratoplasty)	C461	May be considered 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.
Dermatology	Surgical shaving/ laser treatment / chemical destruction of skin	E094/6	Routinely excluded but considered on submission of clinical photography e.g. for portwine stains, excessive disfigurement
Urology	Reversal of sterilisation/ vasectomy	♀ - Q37, Q29, ♂ - N18	In circumstances of 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.
Alternative/ complementary/ homeopathic therapies	Complementary therapies/medicine	X61	When included as an adjunct to usual therapy – not funded as a separate procedure
Mental health	Inpatient psychotherapy		
	In patient treatment for Chronic Fatigue/ME		
	Non-NHS residential placements		
	Adult ADHD		On an individual patient basis.

Appendix 2: Prior approvals

Where procedures are either high cost, fall outside specialised commissioning arrangements or where the clinical and cost effectiveness of a procedure is only proven when certain criteria are met then the CCGs request prior approval of those procedures. These are known as the Restricted Procedures. **Arrangements for the management of these procedures may vary between lead commissioner and provider and should be set out in the NHS contract prior approval scheme.**

The prior approval tool (where used by acute providers)

For secondary care consultants, prior approval for a number of common but restricted surgical procedures can be applied for via a secure web-based tool at <https://priorapproval.hampshire.nhs.uk> This will need to be applied for in advance of the treatment being provided. The Map of Medicine also provides information on these procedures and thresholds for referral. This list has been prepared by public health. **This list is not exhaustive and will be updated regularly with one month's formal written notice to providers.**

Where policy criteria are met – as described within the tool – instant approval is obtained and a printout made. This will mean that, for certain procedures, the full paper application need not be completed unless the patient does not meet the policy criteria. If patient does not meet the policy criteria and a clinician is of the opinion that a patient is clinically exceptional, an Individual Funding Request will need to be submitted to the IFR team in line with the IFR Policy

If there any problems in connecting to the tool, please contact Mark Barnes (mark.barnes@hampshire.nhs.uk) or Daniel Forrester (Daniel.forrester@hampshire.nhs.uk) at the CSU at Omega House. The Trust and the CSU should also be advised and an alternative manual system reverted to in the meantime.

The introduction of specialist dental triage services covering orthodontic and minor oral surgery explicitly removes the requirement for prior approval in such instances, subject to audit.

For those interventions not listed on the tool but remaining on the exclusions list within the Policy, the normal funding application procedure applies.

Specialty	Low priority procedure	OPCS code(s)	Guidance on exceptions / exceptions criteria
ENT/Audiology	Myringotomy/ grommet insertion for children	D151	<p>1. Treatment with grommets will be funded for children with disabilities such as Downs Syndrome and Cleft Palate where the insertion of grommets is part of an established pathway of care.</p> <p>2. Treatment with grommets will be funded for children to treat a tympanic membrane retraction pocket.</p> <p>3. Treatment with grommets will be funded for 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:</p> <ul style="list-style-type: none"> • There has been a period of watchful waiting for three months in primary care from diagnosis of OME in primary care, followed by a further period of watchful waiting for up to three months in ; secondary care; and • OME persists after the three-six months of watchful waiting; and • The child has documented 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) <p>NB Children under 3 years of age may be referred in without restriction and surgery would be at the ENT clinic's discretion</p>
	Myringotomy/ grommet insertion for adults	D151	<p>This procedure is not routinely funded for adults (≥ 18 years old) except under the following conditions:</p> <ul style="list-style-type: none"> - 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

Specialty	Low priority procedure	OPCS code(s)	Guidance on exceptions / exceptions criteria
			<ul style="list-style-type: none"> - 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 <p>NB It is important that conductive unilateral hearing loss present for 4 weeks should be referred to an ENT surgeon without delay</p>
	Tonsillectomy	F34, F361	<p>Tonsillectomy will be funded</p> <ul style="list-style-type: none"> - in children and adults for cancer or suspected cancer; or - in children and adults for cases of quinsy; or - in children and adults for obstructive sleep apnoea where other treatments have failed or are inappropriate; or - in children and adults for tonsillitis if <u>all</u> of the following criteria are met: <ul style="list-style-type: none"> • Sore throats are due to tonsillitis • There are <u>5 or more</u> episodes of sore throat per year (confirmed in Primary Care) • There have been symptoms for at least a year • Episodes of sore throat are disabling and prevent normal functioning <p>GP referrals should include the practice record detailing frequency of attendances and prescribing in line with the criteria above. Providers should alert commissioners/CSU where this is not being included.</p>
Vascular Surgery	Varicose vein procedures	L84, L85, L86, L87, L88	<p>This will be commissioned in accordance with the South Central Priorities Committees policy statement no. 39. http://www.southcsu.nhs.uk/documents/ifr</p> <p>Varicose vein surgery will be funded in people with a body mass index less than 32 who satisfy at least one of the following criteria:</p> <ul style="list-style-type: none"> • a recurrent venous ulcer <p>(OR)</p> <ul style="list-style-type: none"> • a first venous ulcer which persists despite a six-month trial of conservative management (compression stockings, exercise and

Specialty	Low priority procedure	OPCS code(s)	Guidance on exceptions / exceptions criteria
			<p>daily elevation two to three times a day) (OR)</p> <ul style="list-style-type: none"> • haemorrhage from a superficial varicosity <p>Treatment in all other circumstances is LOW PRIORITY and not routinely commissioned.</p> <p>Surgical treatment may be with ligation and stripping, phlebectomy and/or foam sclerotherapy. All techniques which involve heating the vein (whether by laser, radio-frequency, microwave or any other means) are LOW PRIORITY and not routinely commissioned.</p> <p>This policy is currently under review but remains in place until formal notice ads as an ‘in-year’ variation via Service Development and Improvement Plan (SDIP) requirements</p>
Gynaecology	Dilatation and Curettage	Q103/8/9	<p><i>Dilatation and Curettage alone should not be used as a diagnostic tool and should not be used as a therapeutic procedure.</i></p> <p>Dilatation and curettage will be funded if either of the following criteria are met:</p> <p>The patient has had outpatient negative pressure endometrial sampling (e.g. Pipelle™ sampling) with an unsatisfactory histological result Or The patient has had a hysteroscopy and endometrial biopsy with an unsatisfactory histological result</p>
	Hysterectomy in heavy menstrual bleeding/ dysmenorrhoea	Q07- (except Q076), Q08	<p>Hysterectomy for heavy menstrual bleeding or dysmenorrhoea will be funded if all the following criteria are met:</p> <p>Other treatments for heavy menstrual bleeding (in accordance with NICE Clinical Guideline 44 “Heavy Menstrual Bleeding”) or dysmenorrhoea such as a Mirena coil have failed or are contraindicated; and</p> <p>There is a wish for amenorrhoea; and</p>

Specialty	Low priority procedure	OPCS code(s)	Guidance on exceptions / exceptions criteria
			<p>The woman no longer wishes to retain her uterus and fertility</p> <p>2. Hysterectomy for the treatment of uterine problems amenable to surgery but are <u>not</u> related to heavy menstrual bleeding or dysmenorrhoea will be funded</p>
Urology	Male circumcision	N303	<p>Male circumcision is LOW PRIORITY as per SHIP Priorities Committee policy statement no 5. http://www.southcsu.nhs.uk/documents/ifr</p> <p>This procedure should only be considered in cases of pathological phimosis where inability to retract the foreskin is due to permanent scarring of the preputial orifice. In boys with lower urinary outflow obstruction and/or with recurrent urinary tract infection (particularly where high grade vesico-ureteric reflux is present) circumcision as an option for potentially reducing further infection should be discussed with parents and boys able to give informed consent. In the absence of medical urgency, the procedure should not be undertaken until the boy is old enough to give informed consent. Circumcision may also occasionally be required in the management of penile carcinoma.</p>
Pain management	Facet Joint Injections (FJI) for Chronic Low Back Pain	V544	<p>Facet joint injections are not routinely commissioned for patients with diagnosed chronic non-specific low back pain.</p> <p>Medial branch blockade of the nerve to the facet joint will be funded for the diagnosis of cervical, thoracic and lumbar back pain when all the following criteria are met:</p> <ul style="list-style-type: none"> - The pain has resulted in moderate to significant impact on daily functioning; AND - All conservative management options including psychologically based treatments have been attempted or a patient may not be suitable due to: <ul style="list-style-type: none"> o communication difficulties o cognitive impairment o documented difficulty in tolerating medicines - The pain has lasted for more than one year <p>Repeat injections: Repeat injection will only be supported if the patient has benefitted by</p>

Specialty	Low priority procedure	OPCS code(s)	Guidance on exceptions / exceptions criteria
			maintaining function for > 6 months.
	Radio-frequency / thermal denervation of facet joint	A604 V48	<p>Radiofrequency lesioning of the medial branch of the nerve to the facet joint preceded by a positive medial nerve diagnostic block will be funded at this point and the patient is part of a comprehensive pain management programme including physiotherapy, psychosocial support, medication and patient education.</p> <p>Facet joint pain is confirmed by controlled diagnostic local anaesthetic block; and</p> <ul style="list-style-type: none"> • The pain has lasted for more than one year; and • The pain has resulted in moderate to significant impact on daily functioning; and • Distress, disability, drug issues, dependency • The patient is part of a comprehensive management plan that addresses pain.
	Portsmouth, SE Hants and Fareham & Gosport CCGs only Repeat pain injections		Facet joint injections, radio-frequency denervation, steroid injections to joints, transforaminal lumbar epidurals and other therapeutic injections to manage pain that are offered on a repeat basis can be obtained via prior approval only . The GP or pain clinician should detail the duration of benefit between injections and indications of a long-term management plan for the patient
Orthopaedics/ MSK	Trigger finger surgery	T723	<p>In line with Map of Medicine guidelines: Surgery will be commissioned for patients diagnosed with trigger finger:</p> <ul style="list-style-type: none"> • who fail to respond to conservative treatment, including no response following one corticosteroid injection; and • moderate to severe pain/locking sufficient to cause interference with hand function; and • persistent symptoms > 3 months
	Carpal tunnel release/ nerve entrapment at wrist	A65	<p>In line with Map of Medicine guidelines</p> <p>Consider surgical management if</p> <ul style="list-style-type: none"> • All conservative measures (e.g. wrist splint, anti-inflammatories or

Specialty	Low priority procedure	OPCS code(s)	Guidance on exceptions / exceptions criteria
			<p>injection into the carpal tunnel) have failed; OR</p> <ul style="list-style-type: none"> • Evidence of neurological deficit such as sensory blunting or weakness of thenar (thumb base) abduction: OR • There have been symptoms for longer than 6 months
	Palmar fasciectomy /Dupuytren's contracture	T521/2 T541	<p>In line with Map of Medicine guidelines</p> <p>Referral for surgical opinion should only be made in the following circumstances:</p> <ul style="list-style-type: none"> • patient has a contracture and cannot flatten their fingers or palm on a table; and • there is functional impairment
	Treatment of bunions (hallux valgus)	W791/2 W151-4	<p>In line with Map of Medicine guidelines</p> <p>Agreed guidelines have been developed as follows:- Patients must have first been managed via MSK or podiatry services first before consideration of orthopaedic surgery AND The patient has documented functional impairment AND Inability to wear suitable footwear AND Patient is fully aware of pros and cons of surgery</p>
	Arthroscopic lavage and debridement of the knee in patients with osteoarthritis	W852	<p>In accordance with the South Central Priorities Committee policy statement no 26. http://www.southcsu.nhs.uk/documents/ifr</p> <p>Will be considered:</p> <ol style="list-style-type: none"> a. Where the patient has clear mechanical symptoms (not gelling, 'giving way' or X-ray evidence of loose bodies). b. When information is required regarding the degree and distribution of joint damage, enabling informed decision making regarding the type of knee replacement that could be performed (partial or total knee replacement). This can be of particular help in young patients with osteoarthritis

Specialty	Low priority procedure	OPCS code(s)	Guidance on exceptions / exceptions criteria
	Hip resurfacing	W580/1/2 + Z843	Commissioned in line with SHIP Policy Recommendation 105 on Metal on Metal (MOM) hip resurfacing http://www.southcsu.nhs.uk/documents/ifr Funding should be available for resurfacing as an alternative to hip replacement in men younger than 55 years of age provided the risks and benefits have been explained and the patient is keen to proceed. In older men and in women of all ages, funding for hip resurfacing is a low priority.
	Portsmouth, SE Hants and Fareham & Gosport CCGs only Primary hip and knee replacement in patients with a BMI above 35	W371/381 (hip) W401 (knee)	Applications for lower limb joint replacement in patients with a BMI above 35 must be made via prior approval on a named patient basis. Consideration should also have been made for referral to the commissioned 'tier 3' obesity management programme prior to offering surgery.
Ophthalmology	Chalazia (meibomian cysts)	C121	Chalazia (meibomian cysts) are benign, granulomatous lesions that will normally resolve within 6 months. Treatment consists of regular (four times daily) application of heatpacks. Excision of chalazia will be funded when all of the following criteria are met: - The chalazia has been present for more than 4 months - Where it is situated on the upper or lower eyelid - Where it is causing blurring of vision Any suspected malignancy should be referred for treatment without reference to the above criteria

Specialty	Low priority procedure	OPCS code(s)	Guidance on exceptions / exceptions criteria
Cosmetic/Plastic /Aesthetic surgery	Eyelid surgery/ blepharoplasty	C13, C16,C18	Where affecting visual fields.
	Abdominoplasty/Excision of skin of abdominal wall/ abdominolipectomy	S02	<p>Removal of excess skin including abdominoplasty, mammoplasty and removal of skin folds from the inner thighs following bariatric /weight loss surgery is an exception to this policy and may be considered if patients meet <u>all</u> of the following criteria:</p> <ol style="list-style-type: none"> 1. The patient's starting BMI before weight loss must have been no less than 45kg/m² (the threshold for access to bariatric surgery in HIOW). 2. The patient's BMI must be less than 30kg/m². (In some patients a BMI of less than 30kg/m² may not be achievable, due the weight of excess skin. In these circumstances an exception to the policy may be considered, provided that the patient has lost at least 50% of their excess weight, and their clinician confirms that no further reduction in BMI will be possible without removal of excess skin.) 3. The patient's weight must have been stable for a minimum of 2 years, 4. There must be documented evidence of clinical pathology or disability due to the skin fold in question (eg recurrent infection, intertrigo, cellulites, restricted mobility, inability to undertake physical exercise to maintain cardiovascular fitness). Purely cosmetic procedures, such as removal of surplus skin from the arms, will not be considered.

Specialty	Low priority procedure	OPCS code(s)	Guidance on exceptions / exceptions criteria
Gastro-enterology	Gastric fundoplication for chronic reflux oesophagitis	G241 and G243	<p>Funded exceptions are where adults have at least one of the following characteristics</p> <ul style="list-style-type: none"> - regular, significant symptoms of gastro-oesophageal reflux despite receiving at least one year of continuous pharmacological treatment up to the maximum dose licensed for reflux oesophagitis - significant volume reflux placing them at risk of aspiration - anaemia because of oesophagitis <p>Its use in other circumstances of reflux oesophagitis is a low priority Gastric fundoplication will be commissioned in accordance with the South Central Priorities Committees policy statement no 51. This applies in reflux oesophagitis only.</p>
Other Treatments/ Procedures/ Equipments/Devices			
Ophthalmology	Anti-vascular endothelial growth factors (VEGFs) for any indication and bevacizumab for diabetic retinopathy, diabetic macular oedema and retinal vein occlusion (central or branch)		<p>The use of anti-VEGFs for age-related macular degeneration is covered by NICE TAG155.</p> <p>The South Central Priorities Committees policy states that bevacizumab should be made available for all indications other than 'wet' age-related macular degeneration, diabetic retinopathy, diabetic macular oedema and retinal vein occlusion (central or branch), subject to clear arrangements for commissioning and evaluation of outcomes.</p>
	Second eye cataract surgery		<p>Second eye cataract surgery should be offered for patients who meet the following criteria;</p> <ul style="list-style-type: none"> • Visual acuity BELOW 6/9 in the second eye • Anisometropia +/- 2D or where symptomatic • Surgery indicated for control of glaucoma or to facilitate further surgery (as determined by consultant ophthalmologist) • Surgery indicated for view of diabetic retinopathy or retinal disease (where cataract impairs retinal view) • Severe glare <p>Optometrists and GP's are asked NOT to refer patients for assessment for second eye cataract surgery unless they demonstrate the above criteria.</p>

Specialty	Low priority procedure	OPCS code(s)	Guidance on exceptions / exceptions criteria
Infertility treatments	In vitro fertilisation (including the prescriptions of infertility drugs) and ICSI (intracytoplasmic sperm injection)		As per Priorities Committee policy statement 150 http://www.southcsu.nhs.uk/documents/ifr
Dermatology	Endoscopic thoracic sympathectomy (ETS) for hyperhidrosis or excessive facial blushing	A752, A762, A772, A782, A792	<p>Facial blushing is often a result of social phobia and is encouraged by an over-active sympathetic nervous system. There is limited evidence suggesting that Endoscopic Thoracic Sympathectomy can control the occurrence of facial blushing and sweating, however, the patient is likely to experience adverse side effects.</p> <ul style="list-style-type: none"> • It is recommended that other methods be sought to cure the symptoms. • If the procedure is performed the patient should be informed before operating that the probability of compensatory sweating is extremely high and very likely.
General surgery/ hand surgery/ dermatology	Treatment of ganglions	T59, T60	<p>For a relatively small number of ganglions, surgery may be considered if:</p> <ul style="list-style-type: none"> • the ganglion is the likely cause of persistent pain, either through local effects or likely pressure on a nerve • the ganglion is the cause of reduced function, perhaps through loss of range of movement or pain • there is persistent patient concern regarding the nature of the lesion <p>In accordance with SHIP Priorities Committee policy statement no. 52 http://www.southcsu.nhs.uk/documents/ifr</p>
Respiratory	Short Burst Oxygen Therapy(SBOT) for the relief of episodic breathlessness		<p>Low priority in accordance with the South Central Priorities Committee policy statement no 11. http://www.southcsu.nhs.uk/documents/ifr</p> <p>Patients should only be considered treatment with SBOT for the relief of episodic breathlessness</p> <ul style="list-style-type: none"> • If all other treatment options have been tried • When the diagnosis is clear and the underlying condition is already being treated optimally • Following objective assessment including a record of oxygen saturation by a clinician with a special interest and training in the management of respiratory diseases • Existing patients on SBOT will need to be properly reviewed and assessed by a Specialist Respiratory Assessment Service so that the home

Specialty	Low priority procedure	OPCS code(s)	Guidance on exceptions / exceptions criteria
			<p>oxygen therapy that they receive is the most appropriate for their condition, for the right period of time and with appropriate flow rates to obtain optimal benefits and reduce the chance of adverse effects. Specialist assessment is essential prior to any changes in oxygen therapy service being suggested or implemented. These changes may mean that some patients are assessed for LTOT/ambulatory oxygen therapy.</p>

THRESHOLDS COMMISSIONING

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

<p>Ophthalmology</p>	<p>First eye cataract surgery (threshold criteria)</p>	<p>C71,C72, C73, C74, C75</p>	<p>GPs should refer patients with cataracts in the first eye in line with the following criteria. Optometrists will have carried out the appropriate assessments and referred back to GP for onward referral to secondary care. A copy of the optometrist report (GOS18 or suitable referral form) must be included with the referral.</p> <p>Patients should be referred where best corrected visual acuity as assessed by high contrast testing (Snellen) is: Binocular visual acuity of 6/10 or worse for drivers, OR Binocular visual acuity of 6/12 or worse for non-drivers, OR Reduced to 6/18 or worse irrespective of the acuity of the other eye OR: The patient wishes to/is required to drive and does not meet Driving and Licensing Authority (DVLA) eyesight requirements</p> <p>Any suspicion of cataracts in children (e.g. altered or absence of red reflex at neonatal or 6 week check) should be referred urgently</p> <p>Exceptionally, patients who have significant glare, asymmetrical refraction or monocular diplopia affecting work or quality of life, but do not meet the thresholds above, should be referred for assessment</p>
<p>Orthopaedics</p>	<p>Primary hip replacement</p>	<p>W371/381</p>	<p>In line with MOBBB Priorities Committee policy http://www.berkshire.nhs.uk/priorities/policies/be_policy_28.pdf and agreed by West Hampshire and Southampton CCGs RECOMMENDED in patients in whom the following criteria are met: 1. Moderate or severe arthropathy confirmed on X-ray. 2. A minimum of 6 months' conservative, primary care-based, management appropriate to their condition and needs (eg supported self-management, exercise, weight loss and analgesia) without improvement in symptoms. 3. Persistent severe joint pain, particularly night pain sufficient to disturb sleep, despite optimum analgesia.</p>

			<p>4. Persistent and significant impact on activities of daily life which has been clearly documented by the referring clinician.</p> <p>5. The risks and benefits of surgery applicable been explained to the patient, and they are willing to be referred for surgery.</p> <p>6. The patient is fit for surgery at the time of referral.</p> <p>In all other circumstances, funding should be LOW PRIORITY.</p>
	Primary knee replacement	W401	<p>http://www.berkshire.nhs.uk/priorities/admin/policy-up/policies/MOBBB_Policy_36_Primary_Knee_Replacement.pdf and agreed by West Hampshire and Southampton CCGs</p> <p>RECOMMENDED in patients in whom the following criteria are met:</p> <ol style="list-style-type: none"> 1. Moderate or severe arthropathy confirmed on X-ray. 2. A minimum of 6 months' conservative, primary care-based, management appropriate to their condition and needs (eg supported self-management, exercise, weight loss and analgesia) without improvement in symptoms. 3. Persistent severe joint pain, particularly night pain sufficient to disturb sleep, despite optimum analgesia. 4. Persistent and significant impact on activities of daily life which has been clearly documented by the referring clinician. 5. The risks and benefits of surgery applicable to them have been explained to the patient, and they are willing to be referred for surgery. 6. The patient is fit for surgery at the time of referral

Appendix 3: SOUTH CENTRAL ETHICAL FRAMEWORK

Background

The Priorities Committee is a committee of representatives of Clinical Commissioning Groups (CCG) across Hampshire, Southampton, Isle of Wight, Portsmouth and Surrey. 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:

1. EVIDENCE OF CLINICAL AND COST EFFECTIVENESS

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 Committee. Choice of appropriate clinically and patient-defined outcome needs to be given careful consideration, and where possible quality of life measures and cost utility analysis should be considered.

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.

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. It will consider technical cost-benefit calculations (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 topic.

2. EQUITY

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 Committee 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.

3. HEALTH CARE NEED AND CAPACITY TO BENEFIT

CCGs need to consider the Joint Strategic Needs Assessment in developing their Commissioning Plans. This ensures that the healthcare needs of the population enables them to maximise the impact of the healthcare they commission within available resources. The committee will consider the health needs of people and the population in terms of their capacity to benefit from health care interventions. So far as possible it will look to support the opportunity for people to choose between different clinically and cost effective treatment options, subject to the support of the clinical evidence.

This approach leads to three important principles:

- In the absence of health need, treatment will not generally be given solely because a person requests it.
- A treatment of little benefit will not be provided simply because it's the only treatment available
- Treatments/interventions for "life time" or long term chronic conditions will be considered equally to urgent or life prolonging treatments.

4. COST OF TREATMENT AND OPPORTUNITY COSTS.

Because each CCG is duty bound to live within its budget, costs of interventions/treatment need to be considered. The cost is significant as money spend on one area of healthcare diverts resources from other issues. This is the opportunity cost and defined as the benefit forgone or the value of opportunities lost that would accrue from investing in the best possible alternative. The concept derives from the notion of the scarcity of resources. A single episode of treatment may be expensive or the cost of treating the whole community may be high.

5. NEEDS OF THE COMMUNITY

The committee will seek to make recommendations that consider the needs of the community which may sometimes conflict with the needs of individuals. Decisions are difficult when considering interventions or treatments that are expensive but have little clinical benefit, e.g. that do little to improve the patient's condition, or to stop or slow the progression of disease.

6. POLICY DRIVERS

The Department of Health issues guidance and directions to NHS commissioners which need to be taken into consideration alongside local needs-informed commissioning plans, as part of the process.

7. EXCEPTIONAL NEEDS

There can be no blanket ban on treatment since there may be cases in which a patient has special circumstances which present an exceptional need for treatment. Each such case will be considered on its own merits in light of the available clinical evidence by the CCG using its individual case processes.

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8. PREVIOUS PRIORITIES COMMITTEE POLICY STATEMENTS

Between 2008 and 2012, the Priorities Committee issued policy statements for commissioners across the old South Central SHA area. The majority of these are related to drugs or procedures that have since been picked up by NHS England specialised services. Some of those remaining relevant to CCGs are found in appendix 2 above or as part of the 'high cost drugs commissioning intentions' document derived from the Hampshire area District Pharmacy Committees. All these statements can be found on the CSU's website at www.southcsu.nhs.uk/documents/ifr under 'SHIP Priorities Committee clinical policies 2008-2012'

The list below relates to policies that remain relevant to CCGs, but that are not included in either appendix 2 above or the 'high cost drugs' document. These all would have been circulated to providers at the time and commissioners would expect should remain adhered to unless superseded by subsequent national or local policies.

These are listed in order of publication, latest first

Balloon catheter sinus dilation for chronic rhinosinusitis
Functional endoscopic sinus surgery for chronic rhinosinusitis and nasal polyps
Therapeutic transforaminal epidural injection for sciatica
Repair of asymptomatic inguinal hernia in adults
Speech and language therapy for people with Parkinson's disease
Bone morphogenetic protein (BMP) and low-intensity pulsed ultrasound (LIPUS) in delayed and non-union fractures
Penile rehabilitation following prostate surgery
Cryopreservation options for patients about to undergo NHS treatment which might impair future fertility
Corticosteroid injections for knee osteoarthritis, knee rheumatoid arthritis and patellar tendinopathy
Corticosteroid injections into the shoulder joint for rotator cuff disorders and adhesive capsulitis
Aesthetic surgery in children
Routine follow-up after primary hip or knee replacement surgery
Surgical treatment of femero-acetabular (hip) impingement (arthroscopic and open approaches)
Evaluation of treatments for erectile dysfunction
Functional electrical stimulation in drop foot of central origin
Spinal surgery (fusion or discectomy) for the treatment of chronic, non-specific low back pain
Spinal manipulation for the treatment of chronic, non-specific low back pain
Acupuncture for the treatment of chronic, non-specific low back pain

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	Name:	

<i>Pharmacist or nominated deputy (in the case of a drug intervention)</i>	Signature or email confirmation:	
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STATEMENT CONFIRMING APPROPRIATENESS FOR CONSIDERATION AS AN IFR

If it is foreseeable that there are one or more other patients within the local 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.

<p>5. <i>I confirm that it is not expected that there will be more than one patient from within the CCG's population who is or is likely to be in the same or similar clinical circumstances as the requesting patient in the same financial year and who could reasonably be expected to benefit to the same or a similar degree from the requested treatment unless similar patients are expected to be from the same family group.</i></p>	<p>Tick box as appropriate <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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DIAGNOSIS AND PATIENT'S CURRENT CONDITION

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

INTERVENTION REQUESTED (NB: Intervention refers to requested treatment, investigation, etc)		
<p>7. Details of intervention (for which funding is requested).</p> <p>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)).</p> <p>Regarding anticipated cost Acute Trusts to provide this from finance departments</p>	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 (*)		
<p>8. Is requested intervention part of a clinical trial?</p>	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	
<p>a) What would be the standard intervention at this stage?</p> <p>b) What would be the expected outcome from the standard intervention?</p> <p>c) What are the exceptional circumstances that make the standard intervention inappropriate for this patient?</p> <p>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.</p>		

<p>e) If the requested intervention was not available what would your next planned intervention be?</p>			
<p>10. Summary of previous intervention(s) this patient has received for the condition.</p> <p>Reasons for stopping may include (not exclusively):</p> <ul style="list-style-type: none"> ▪ Course completed ▪ No or poor response ▪ Disease progression ▪ Adverse effects/poorly tolerated 	<p>Dates</p>	<p>Intervention (e.g. drug / surgery)</p>	<p>Reason for stopping / Response achieved</p>
<p>11. Anticipated start date</p>	<p>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:</p>		

EVIDENCE OF CLINICAL EFFECTIVENESS

<p>12. Where the intervention is a drug / medicine is the requested drug / medicine licensed for the requested indication in the UK?</p>	<p>Delete as appropriate: Yes / No (refer to pharmacy if required)</p>		
<p>13. Has the Trust Drugs and Therapeutics Committee or equivalent Committee approved the requested intervention for use? (if drug or medical device) (*)</p>	<p>Delete as appropriate: Yes / No</p> <p>If No, Committee Chair or Chief Pharmacist approved: Yes / No</p>		
<p>14. Give details of National or Local Guidelines / recommendations or other published data / evidence base supporting the use of the requested intervention for this condition? (*)</p>	<p>PUBLISHED² 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.)</p>		
<p>(a) How will you monitor the clinical effectiveness of this intervention?</p>			
<p>(b) Detail the current status of the patient according to these measures.</p>			

² Full published papers, rather than abstracts, should be submitted

<p>(c) What would you consider to be a successful outcome for this intervention in this patient?</p>	
<p>(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)</p>	
<p>15. What is the anticipated toxicity of the intervention for this patient?</p>	
<p>16. Are there any additional clinical factors of the patient that need to be considered not already included in 8c or 8d?</p>	<p>Delete as appropriate: Yes / No If Yes, please give details:</p>
<p>17. Form completed by</p>	<p>Name:</p>
	<p>Signature or email confirmation:</p>

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 Commissioning Support Unit
Omega House
112 Southampton Road
Eastleigh
Hants SO50 5PB

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

INDIVIDUAL FUNDING REQUEST FOR USE IN PRIMARY CARE

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 Commissioning Support Unit
Omega House
112 Southampton Road
Eastleigh
Hants SO50 5PB

Tel: **02380 623253/5/6**

Fax: 02380 620343

E-mail: southcsu.ifrs@nhs.net

General guidance on completion

We recognise that the IFR application form is not easy to complete and that you may not complete it often. We have therefore devised a shorter format than the application form previously available which is now reserved for secondary care. The guide below should avoid requests for additional information and delays in decision-making. As set out above, please contact the team on the details above if you have any queries.

The list below details some of the top 10 referrals received and the information required by the CSU to make an informed decision

Breast reduction – this will require details of patient’s BMI, breast 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. Psycho-social issues and distress are consistently not supported by the clinical Panel as a deciding factor on 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 – will be required by the Panel as part of an application. 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.

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.

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

Bariatric surgery – CCGs no longer commission this surgery as this comes under NHS England 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.

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 three years of attempting to start a family where there is no clear diagnosis. Referrals meeting the criteria should be made by a secondary care fertility specialist. Cases outside the criteria that you deem exceptional can be made to the CSU using the form on their website www.southcsu.nhs.uk/documents/ifr

Asperger’s/autism diagnosis in adults – these are now accessible via direct referral to the Winchester Autism & Asperger’s Assessment Centre aka the Micklen Centre. <http://www.autismassessment.co.uk/>

Functional electrical stimulation (FES) – this is a particularly common request to treat ‘dropped foot’ for neurological problems (eg 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 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.

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. <i>Address inc. postcode</i>		
2.	Position:	
	Tel:	
	Email:	
3. <i>Patient Details</i>	Name:	
	NHS Number:	
	DoB:	
	Date of referral:	

DIAGNOSIS AND PATIENT'S CURRENT CONDITION

4. Patient Diagnosis (for which intervention is requested)	Diagnosis <i>Please summarise the current status of the patient in terms of quality of life, symptoms etc</i>
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INTERVENTION REQUESTED (<i>NB: Intervention refers to requested treatment, investigation, etc</i>)

<p>5. <i>Details of intervention (for which funding is requested)</i> <i>If costs are known, please state (optional)</i></p>	<p>Name of intervention:</p>
<p>6 <i>Is the requested treatment available locally? (state where if possible)</i></p> <p>7 <i>Are there any clinical factors that need to be considered that would set this patient out as exceptional?</i> The following is an excerpt from the NHS Confederation guide 'Priority setting: managing individual funding requests' 2008 which clarifies this:</p> <p><i>In making a case for special consideration, it needs to be demonstrated that:</i></p> <ul style="list-style-type: none"> - <i>the patient is significantly different to the general population of patients with the condition in question, and</i> - <i>the patient is likely to gain significantly more benefit than might be normally expected for patients with the same condition</i> <p><i>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.</i></p>	<p>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?'</p> <p>THIS IS THE MOST IMPORTANT PART OF THE APPLICATION AND WOULD EXPECT THE MOST DETAIL TO BE INCLUDED HERE</p>

<p>8 Summary of previous intervention(s) this patient has received for the condition.</p> <p>▪</p>	Dates	Intervention	Reason for stopping / Response achieved
<p>9 Please summarise any additional supporting information and <u>attach all relevant clinical correspondence in support of the application</u></p>			
<p>10 Form completed by</p>	Name:		
	Signature or email confirmation:		

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.

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 to be accompanied by suitable clinical photography that demonstrates the extent of the problem. Though this is subject to patient consent, photography will be stored securely, and viewed only by the Panel and the administrative team, it is clear that, should consent not be given, then it would be extremely unlikely that an informed decision can be taken.

Appendix 7 – Dermatology Life Quality Index (DLQI) form

NHS No:

Date:

Name:

Score:

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 | <input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/> | |
| 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 | <input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/> | |
| 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 | <input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/> | Not relevant <input type="checkbox"/> |
| 4. | Over the last week, how much has their skin influenced the clothes they wear? | Very much
A lot
A little
Not at all | <input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/> | Not relevant <input type="checkbox"/> |
| 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 | <input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/> | Not relevant <input type="checkbox"/> |
| 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 | <input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/> | Not relevant <input type="checkbox"/> |
| 7. | Over the last week, has their skin prevented them from working or studying ? | Yes
No | <input type="checkbox"/>
<input type="checkbox"/> | Not relevant <input type="checkbox"/> |
| | 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 | <input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/> | |
| 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 | <input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/> | Not relevant <input type="checkbox"/> |
| 9. | Over the last week, how much has their skin caused any sexual difficulties ? | Very much
A lot
A little
Not at all | <input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/> | Not relevant <input type="checkbox"/> |
| 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 | <input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/> | Not relevant <input type="checkbox"/> |

Please check you have answered EVERY question. Thank you.

APPENDIX 8

**REFERRAL FOR ASSISTED CONCEPTION
CHECK LIST FOR ELIGIBILITY**

SOUTHAMPTON CCG
NE HAMPSHIRE & FARNHAM CCG
SOUTH EAST HAMPSHIRE CCG

WEST HAMPSHIRE CCG
PORTSMOUTH CCG

NORTH HAMPSHIRE CCG
FAREHAM & GOSPORT 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:

To be confirmed

Patients must not be offered an appointment until eligibility and funding has been confirmed by the xxxx 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. Name:	Dob:	Partner Details. Name:	Dob: F/M:
CCG:	Age:	CCG:	Age:
NHS No:		NHS No:	
Patient Reference:		Patient Reference:	
Home Address:		Home Address:	
Post Code:		Post Code:	
Tel/Mobile No:		Tel/Mobile No:	

Criterion	Yes / No	Eligibility
<p>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)</p> <p>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.</p>		No = excluded
<p>Duration of infertility a) Does the couple have infertility of > 3yrs duration? (The couple should have had no natural pregnancies or been using contraception within this timeframe – referring clinician should verify this with GP).</p> <p>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</p>		No to both = excluded
<p>Age of woman at time of cycle starting* At the time of commencing treatment will the female be below the age of 35 years?</p> <p>*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.</p>		No = excluded
<p>Previous infertility treatment Has the patient ever received previous IVF or ICSI treatment funded by the NHS?</p>		Yes = excluded
<p>Has the patient received more than 2 previous cycles of IVF or ICSI (irrespective of whether NHS or privately funded)?</p>		Yes = excluded
<p>Women in same sex couples or a woman not in a partnership Is the woman demonstrably sub-fertile? <i>(10 unsuccessful cycles of IUI will be accepted as evidence of unexplained infertility)</i></p>		No = excluded
<p>Childlessness Does either partner have a living child (including adopted) from their relationship, or from any previous relationship?</p>		Yes = excluded
<p>Sterilisation Has either partner been sterilised?</p>		Yes= excluded
<p>BMI Does the female have a BMI range between of 19 - 29.9 for at least the last six months?</p>		No = excluded
<p>Smoking Have both partners been non-smokers for at least the last six months?</p>		No = excluded

STATEMENT TO BE SIGNED BY THE REFERRING CONSULTANT / GP

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

Referrer's name _____
(Please print)

Referrer's signature: _____

Date of referral: _____

Designated Centres. Please circle as appropriate.

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

STATEMENT TO BE SIGNED BY THE COUPLE

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

First partner's signature: _____

Date: _____

Second partner's signature: _____

Date: _____

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