South, Central and West
Commissioning Support Unit

Hampshire Hospital Foundation Trust and NHS North Hampshire CCG

Restricted Treatments, Procedures, and Interventions April 2021

For provider contracts led by North Hampshire and/or West Hampshire CCGs and their associates

Version Number: 36 (April 2021)

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Version control for policy adoption of Hampshire Commissioners

NB Contract variations will include relevant coding and updated ruleset

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

Issue Date	Implementation Date	Approved By	Description of Change(s)
			clinical variation (tranche 3 monitoring only).
May 2012		Board of Clinical Commissioners	Formal endorsement of finalised policy in line with above changes
February 2013		CCG clinical execs	Amendments to a headline policy for NHS South CSU for adoption/variation by individual CCGs Removal of cholecystectomy from 'thresholds list' Shift ganglions from 'thresholds' to 'restrictions' with clear criteria Hallux valgus criteria amended Skin lesions criteria amended Changes to management of prior approval for tonsillectomy All NHSCB-designated specialised services as well as dentistry **removed** from exclusions and restrictions lists
March 2013		CCG clinical execs	Amendments to policies on adult and children grommet insertions
May 2013		NICE Technology Appraisal 279	Kyphoplasty and vertebroplasty removed from exclusions/ restrictions lists provided NICE criteria met
		CCG clinical execs	Amendment to hallux valgus pathway (podiatry not essential as long as MSK triage in place)
January 2014		CSU	Amendments to update CCG Priorities Committee details, ethical framework and prior approval arrangements
February 2014		SE Hants, Ports and F&G CCGs	Removal of dilatation & curettage and sympathectomy from appendix 2
December 2014		Hampshire CCGs	Draft revised criteria in appendix 2 and revised description of prior approval arrangements
March 2015		P/SE/F&G CCGs	Updated p.13 table, p17 re response times and criteria re septo-rhinoplasty
December 2015		SHIP8	Draft changes to PLCVs – appendix 2 Inclusion of penile prosthesis – appendix 1

Issue Date	Implementation Date	Approved By	Description of Change(s)
January 2016		CCGs and CSU leads	Some re-wording of preamble, new policy title and criteria changes to both appendices 1 and 2. Clarification of exclusions and restrictions criteria
February 2016		CCG clinical execs	Minor amendments to criteria re tonsillectomy and high BMI hip and knee replacements
April 2016		CCG clinical execs/Board	Implementation of Priorities Committee policy statements related to hip arthroscopy, continuous glucose monitoring, functional electrical stimulation, intensive decongestive therapy, adenoidectomy, surgery for 'snoring' and arthroscopy in knee pain. Amendment to clarify inguinal hernia policy changing 'all' to 'one' criteria to be met
September 2016		CCG clinical execs/ Board	Second eye cataracts from 'prior approval' to 'thresholds' (WH & NHCCG) Benign skin lesions from 'exclusion' to 'prior approval' (WH & NHCCG) Asymptomatic inguinal hernia from 'prior approval' to 'exclusions' (WHCCG & NHCCG) Addition of policies on patellar knee resurfacing and subacromial shoulder decompression Addition of bariatric thresholds
January 2017		WHCCG/ NHCCG	Tonsillectomy to 'trust and verify'/audit
March 2017		WHCCG /NHCCG	Adoption of 'traffic light scheme' with pre-existing policies embedded in the policy table
June 2017		SHIP Priorities Committee as endorsed by SHIP CCGs	Addition of policies related to laser therapy in pilonidal sinus, faecal microbiota transplants, balloon catheter sinus dilation (ENT) and functional endoscopic sinus surgery. Introduction of revised pain pathway.
September 2017		SHIP Priorities Committee as endorsed by SHIP CCGs	Minor changes to carpal tunnel and functional nasal airways criteria

Issue Date	Implementation Date	Approved By	Description of Change(s)
November 2017		RTAP steering group for NH and WHCCGs	Shift of carpal tunnel from ‘amber’ to ‘green’ – i.e. no longer requiring prior approval
January 2018		SHIP Priorities Committee as endorsed by SHIP CCGs	Addition of policies related to - Autologous Blood injections - Chronic Anal Fissure and - Hydrocele surgery
February 2018		SHIP Priorities Committee as endorsed by SHIP CCGs RTAP steering group for NH and WHCCGs	Addition of policies related to - Liothyronine in the Treatment of Primary Hypothyroidism - The prescribing of ‘flash’ glucose monitors in diabetes in patients 4 years and above and - Surgical management of pelvic organ prolapse. Addition of Appendices: 6: Stop Before the Op’ guidance (for information only. Not yet accepted into policy) 7: NICE Guidance Statement
May 2018		SHIP Priorities Committee policies 30-32	Addition of policies to - Cryopreservation options for patients undergoing NHS treatment which might render infertility - Revision bariatric surgery - Cataract surgery
September 2018		SHIP Priorities Committee	Policies 36 and 37 – revisions to grommet insertion and tonsillectomy policies
October 2018		CSU/HHFT	Mutually agreed amendments to coding. Removal of appendices related to ‘daycase-to-outpatients’ procedures and ‘optimising ahead of elective surgery’ to SDIP/Transformation schemes
November 2018	1 April 2019	SHIP Priorities Committee	Policies 39 (hysterectomy in heavy menstrual bleeding), 40 (haemorrhoids), 41 (rotator cuff tears) and 42 (knee revision – interim)

Issue Date	Implementation Date	Approved By	Description of Change(s)
January 2019	1 April 2019	SHIP Priorities Committee	Policy 43 (circumcision) Policy 44 (knee revision final) superseding policy 42
April 2019	April 2019	CCG and HHFT	New Policy Management arrangements between WHCCG/ NHCCG and associates
June 2019	July 2019	SHIP Priorities Committee	Policies 45 (female sterilisation), 46 (Dupuytren's contracture), 47 (trigger finger release), 48 (Ganglion excision), 49 (dilation and curettage), 50 (primary hip and knee replacement) and 51 (hallux valgus/bunions)
August 2019	September 2019	SHIP Priorities Committee	Policies 52 (eyelid surgery for ptosis), 53 (Entropion and ectropion), 54 (Chalazia) and, 55 (Arthroscopic surgery for meniscal tears)
Nov 2019	November 2019 6th December 2019	RTAP steering group for NH and WHCCGs SHIP Priorities Committee	Shift of procedures from 'amber' to 'green' – i.e. no longer requiring prior approval; Arthroscopic hip surgery in impingement Chalazia, Eyelid surgery/ Blepharoplasty, Hip resurfacing, Treatment of ganglions, Trigger finger surgery, Gastric fundoplication for chronic reflux oesophagitis and Chronic anal fissure Policy revisions to; 002 (Assisted Conception Services), 56 (Excision of skin following massive weight loss), 57 (Removal of benign skin lesions) and 58 (Gastric Fundoplication in reflux Oesophagitis)
March 2020	September 2020 (TBC)	SHIP Priorities Committee	Policy revisions to; 001, 008 & 013 related to • Varicose veins • Adenoidectomy • Bariatric surgery

Issue Date	Implementation Date	Approved By	Description of Change(s)
October 2020	October 2020	SHIP Priorities Committee	Policy revisions related to 61 – 65, 014 & 029 • Negative Pressure Wound Therapy • Foetal Alcohol Spectrum Disorders • Erectile Dysfunction and Penile Rehabilitation following radical prostatectomy • Sativex • Low Intensity Pulsed Ultrasound (Exogen) in delayed and non-union fractures • Subacromial shoulder decompression • Pelvic Organ Prolapse
November 2020	April 2021	SHIP Priorities Committee	Policy revisions related to 22, 23, 36, 60, 16, 55, 37 & 66. • Carpal Tunnel Syndrome • Nasal Surgery for nasal blockage and or deformity • Tonsillectomy adults and children • Spinal Pain • Laser therapy for Recurrent Pilonidal Sinus • Arthroscopic surgery for Meniscal Tears • Grommets insertion – adults and children • Treatment of LUTS as a result of Benign Prostatic Hyperplasia

Introduction

As well as North Hampshire (10J) and West Hampshire (11A) CCGs, prior approval arrangements for all procedures are in line with **Hampshire policy only** and will apply to the following commissioners where they are an **Associate** to the relevant contracts:

- South Eastern Hampshire CCG (10V)
- Portsmouth CCG (10R)
- Fareham & Gosport CCG (10K)
- Berkshire West (15A)

Patients from any other associate CCGs should be treated in line with the criteria but prior approval arrangements will not apply. Applications to be sent electronically to scwcsu.ship.ifrrequests@nhs.net

The current procedures/treatments and interventions can be broadly classified into three categories:

- **RED**: **Excluded** – procedures not routinely funded by The Commissioner (formerly known as, including and not limited to, Low Priority, PLCV and Never Dos)
- **AMBER: Procedures that require prior approval** by electronic communication through the IFR Service who manage these requests on behalf of the Commissioner
- **GREEN**: **Procedures that are routinely funded subject to meeting certain criteria** and not requiring prior approval – these will be subject to a 'trust & verify' process which will result in audits of an agreed sample of activity. (formerly known as threshold dependent procedures (TDP)

Red - Procedures not routinely funded (excluded)

These are procedures that will not be funded by the commissioning CCG due to a lack of evidence for clinical benefit, limited resource or the responsibility of specialised commissioning. Other management options should be considered. In exceptional circumstances, individual funding requests (IFR) may be made to the patient's CCG for consideration. Policy criteria and pro forma can be found on the following website: http://www.fundingrequests.cscsu.nhs.uk/then click 'Hampshire'. The IFR Panel will be held on the first Tuesday and third Thursday of every month

Amber - Procedures that require prior approval

For these procedures, it has been judged that the intervention is of sufficient value in terms of benefit and outcome when the patient meets the criteria, as outlined in the criteria and on the website. Prior approval is required for all procedures, treatments and interventions in this category. Where available a pro forma/checklist is to be completed providing the required detail. http://www.fundingrequests.cscsu.nhs.uk/

Green - Funded and Subject to Audit

For these procedures to be funded, the patient must meet the criteria as outlined in the Policy and on the following website http://www.fundingrequests.cscsu.nhs.uk/

These 'green' categories could be subject to verification process, similar to audit, for assurance of compliance against the clinical criteria. Where patients do not meet the criteria, alternative management options should be considered. In exceptional circumstances, an individual funding request (IFR) may be submitted for consideration.

Health System Responsibility

The NHS and local health system must ensure that procedures and treatments are only carried out where there is likely to be a clinically beneficial outcome to the patient. In the context of procedures of clinical value limited by criteria, the local health economy needs to demonstrate assurance and adherence to the local Policy. As part of working together in a whole system approach, the focus should be about reinforcing the policy, developing further improvements to support system sustainability, to provide the right care to the right patients and ensuring that payment is for legitimate activity where appropriate criteria is met.

Trust and Verify

A verification process will support assurance and cover selected 'green' or 'amber' procedures or treatments completed within a quarter year period, as part of an agreed and pre-determined assurance program. This will determine if procedures carried out meet the threshold criteria included within the CCG Policy. It may become apparent or necessary in year to review and verify specific procedures and in such a case the CCG will give the provider at least 30 days' notice with rationale for verification audit.

The provider must ensure that conditions meeting the clinical criteria are clearly and accurately documented. The commissioner will use available written and electronic evidence and the specific procedure and treatment access criteria to inform the verification assurance process.

The verification findings from this process will be used to inform clinical quality improvement; procedure of treatment classification and quarterly financial reconciliation.

Verification Process

The sample will be derived at a specialty level across all procedures.

The sample should represent at least 30% of a procedure undertaken or at least 30 sets of notes per procedure (if less than 30 - all of the procedures undertaken) to a maximum of 150 sets of notes. The findings following this process will be used for clinical education and further opportunities to further improve the process and support financial reconciliation. A maximum of 1 audit will be pre-planned for review each quarter.

Each verification will follow the below process;

1. CCG will give a minimum of 30 days' notice of verification request on a selected procedure or treatment.
2. The DSCRO team will provide a randomly selected list of patients, having had the selected procedure or treatment undertaken within a given period, at least 4 weeks in advance of the verification visit date so that notes can be sourced. The verification process will be based on flex data and outcome applied to the freeze data set and informing financial reconciliation.
3. The practitioner with DSCRO accreditation will attend the Provider for 1 day to complete the verification review of sample cases.
4. Case notes should contain the evidence to reflect the policy criteria and allow the CCG to determine if thresholds/criteria are met
5. The CCG will provide a case level report to show the outcome of the review within 30 days and where possible will include recommendations to improve the process.
6. Providers can then challenge the outcome within 20 working days of receipt of the report, by providing further evidence that must have been present prior to procedure being carried out, at which point the CCG will involve clinicians as necessary to conclude on unresolved cases.

7. In respect to the final audit report carried out under the verification process (or as a result of the Commissioner contesting payment in accordance with SC36.45) for procedures funded and subject to audit, the Parties shall act in accordance with the guidance as stated in GC15 and GC20 of the NHS Standard Contract 2017-19 or any updated version and duly complies with the auditor's final report.

Amber procedures

Amber procedures are routinely reviewed at least twice per year by the CCG with a view to understanding system behaviour change and emerging clinical evidence.

The CCG will review system performance information on the number of procedures undertaken in the local health economy by provider, versus the number of prior approval applications to ensure compliance with Policy criteria. Where Policy adherence is variable the CCG will look to address areas of non- compliance with local clinicians and providers.

Activity in the listed restricted treatments and procedures Policy or notifications which have not received prior approval within agreed timescales will be challenged by the commissioner as part of the monthly reconciliation process. The challenge report needs to reference when the patient was referred.

The CCG will use the following principles in consideration of moving prior approval 'amber' procedures to 'trust and verify' (green) or other classification:

- Where prior approval requests are received for 90% or greater of the total activity in the provider for a given procedure **and** where >95% is consistently approved within a provider.
- The CCG to give due consideration to the NHS technical guidance. NHS technical guidance

Amber procedures can also be put forward by providers for review, subject to the above principle and verification process, to inform CCG decisions as to whether to move the procedure to 'trust and verify' or other arrangements, at which point the rules above would apply.

For all categories - procedures carried out that do not follow the above outlined processes will not be accepted as evidence for change to the Commissioner's policy. Unless deemed clinically urgent in line with national policy service condition 29.27, retrospective funding requests are not accepted and will not be funded.

A list of procedures, treatments and interventions can be found in table 1 and clinical criteria detail can be found in the appendices.

Table 1 – Procedure, Treatment or Intervention List

Please see below but also specific policies relating on http://www.fundingrequests.cscsu.nhs.uk/

Procedure / Treatment	Excluded	Prior Approval	Funded Subject to Audit	Funding requests for prior approval may normally come from …
All specialties				
Appliances and devices for cosmetic purposes (high-grade silicon cosmesis and/or prosthesis)				
Functional Electrical Stimulation for Upper and Lower Limb Dysfunction 005 FES Policy recommendation polic				
Intensive decongestive therapy for patients with lymphoedema 004 CDT for Lymphoedema Policy				GP/ lymphoedema specialist
General Surgery				
Treatment of chronic anal fissure 25 Policy Recommendation Tre				Consultant
Asymptomatic hernia surgery (inguinal, incisional, umbilical) NB symptomatic cases have **no** restrictions SHIP Policy 148 - Asymptomatic inguina				
Laparoscopic fundoplication for chronic reflux oesophagitis 51 - Gastric fundoplication policy s				Consultant

Procedure / Treatment	Excluded	Prior Approval	Funded Subject to Audit	Funding requests for prior approval may normally come from …
Laser therapy for recurrent pilonidal sinus Policy 16 Laser therapy for recurrent pilonidal sinus				
Faecal Microbiota Transplants 017 Faecal Microbiota Transplant	(If not for refractory C.difficile)			
Negative Pressure Wound Therapy 61 Negative Pressure Wound Ther				
Foetal Alcohol Spectrum Disorders 62 Foetal Alcohol Spectrum Disorders.p				
Low Intensity Pulsed Ultrasound (Exogen) in delayed and non-union fractures 65 Exogen policy FINAL v1.0 250820.p				
Management of haemorrhoids 40 Management of Haemorrhoids final dr				Consultant
Bariatric Surgery				
Severe and complex obesity – eligibility for bariatric surgery, Tier 4 bariatric surgery procedures 013 Bariatric Surgery June 2016 reviewed .				Consultant / Tier 3 service
Revision bariatric surgery	Other	In		Consultant

Procedure / Treatment	Excluded	Prior Approval	Funded Subject to Audit	Funding requests for prior approval may normally come from …
31 Bariatric Surgery Revision.pdf	indications	mechanical failure of previous surgery		
Complementary medicine / alternative therapies				
Prescribing of **Sativex** for symptom improvement in adult patients with moderate to severe spasticity due to multiple sclerosis 64 Sativex.pdf				
Complementary therapy (including acupuncture, aromatherapy, Chinese medicines, chiropractic therapy, clinical ecology, herbal remedies, homeopathy, hydrotherapy, hypnotherapy, massage, osteopathy, reflexology)				
Cosmetic/ plastic procedures statement cosmetic plastic surgery statement.dc				
Abdominoplasty, apronectomy (NB see separate line related to massive weight loss)				
Female cosmetic genital surgery				
Buttock lift, thigh lift, upper arm lift (brachioplasty)				
Botulinum Toxin - for cosmetic reasons (see DPC guidance on agreed indications) Botulinum_Toxin-_list_of_agreed_indicatio				
Breast and nipple procedures				
Correction of male pattern baldness				

Procedure / Treatment	Excluded	Prior Approval	Funded Subject to Audit	Funding requests for prior approval may normally come from …
Excision of skin tag of anus (not including fistulas)				
Facelift				
Correction of Alopecia including Intralace hair loss system for abnormal hair loss				
Hair Transplantation / hair grafting/ hair replacement				
Irregularities of aesthetic significance				
Laser Treatment – warts , rosacea, haemangioma, scars, thread veins/venous flares, spider naevi, telangiectasia plus HHT, Seborrhoeic keratosis, port wine stains, benign lesions, hair removal, skin removal or destruction, surgical shaving, chemical destruction of skin, resurfacing, and other cosmetic dermatological conditions				
Liposuction				
Male breast reduction (Gynaecomastia)				
Pectus anomaly surgery – including excavatum, carinatum, arcuatum				
Plastic operation on umbilicus				
Pinnaplasty/ plastic operations of external ear				
Reconstruction/Revision of nose including rhinophyma				
Reconstruction/ revision of body (excess skin removal for all areas) post massive weight loss including abdominoplasty/ apronectomy, mammoplasty and removal of skin folds from inner thighs 56 Excision of skin following massive wei				GP/consultant
Removal of Tattoos				
Skin graft for scars				

Procedure / Treatment	Excluded	Prior Approval	Funded Subject to Audit	Funding requests for prior approval may normally come from …
Traumatic /chronic clefts due to avulsion of body piercing				
Xanthelasmas				
Removal of benign skin lesions and blemishes anywhere on the body: 57 Removal of benign skin lesions fin **These are not routinely funded by the NHS.** These also include but not exhaustive of: cysts, 'lumps and bumps', lipomata (recognised as subcutaneous) benign lesions, verruca, warts, acne vulgaris, rosacea, scars, thread veins, venous flares, spider and congenital naevia, haemangioma, port wine stains, HHT, telangiectasia, sebaceous cysts, seborrhoeic keratoses, resurfacing blemishes and skin tags anywhere on the body excluding anal, but including other irregularities of aesthetic significance.				GP/GPSI/ Consultant
Curettage or Cryotherapy of lesion of skin (unless undertaken in primary care as part of PMS/GMS contract) is not a funded procedure in secondary care				
ENT procedures				
Adenoidectomy offered in isolation 008 Adenoidectomy revised March 2020.p				
Adenoidectomy in children with chronic rhinosinusitis (CRC) 008 Adenoidectomy revised March 2020.p				
Grommets /myringotomy for adults and children over 12; and children under 12. Policy 37 Grommet insertion - adults and children				ENT Consultant

Procedure / Treatment	Excluded	Prior Approval	Funded Subject to Audit	Funding requests for prior approval may normally come from …
Nasal surgery for nasal blockage and or deformity Policy 23 Nasal surgery for nasal blockage and or deformity				ENT Consultant
Tonsillectomy for adults and children Policy 36 Tonsillectomy for adults and children				
Surgery for snoring				
Balloon catheter sinus dilation in chronic sinusitis 018 Balloon Catheter Sinus Dilation for Chr				
Functional Endoscopic Sinus Surgery 019 Functional endoscopic sinus surg				
Endocrinology				
Continuous glucose monitoring (CGM) for adults with Type 1 Diabetes Mellitus 007 Continuous Glucose Monitoring_ F	Without insulin pump	With insulin pump		Consultant
'Flash' libre glucose monitoring in diabetes 028 'Flash' Glucose monitoring.pdf				
Liothyronine in the treatment of hypothyroidism 027 Liothyronine in hypothyroidism.pdf		DPC Proforma		Consultant
Gynaecology				

Procedure / Treatment	Excluded	Prior Approval	Funded Subject to Audit	Funding requests for prior approval may normally come from …
Dilation and curettage in heavy menstrual bleeding 49 Dilation and curettage in HMB.docx				Consultant
Female Sterilisation 45 Female Sterilisation.docx				GP/ Consultant
Female Sterilisation Reversal				
Hysterectomy (excludes Cancer) for menorrhagia and dysmennorhea 39 Hysterectomy for Heavy Menstrual Bleec				Consultant
Pelvic organ prolapse surgery 29 Policy Pelvic Organ Prolapse FINAl				Consultant
Infertility treatments				
Assisted Conception IVF and ICSI for infertile couples NB West Hampshire patients are not offered a frozen embryo transfer 002 Assisted Conception Services I		A23		GP/ NHS Fertility Service

Procedure / Treatment	Excluded	Prior Approval	Funded Subject to Audit	Funding requests for prior approval may normally come from …
Cryopreservation ahead of NHS treatment likely to render infertility 30 Cryopreservation of fertility.pdf			Notification will be required for invoice validation	Consultant
Mental Health				
In patient treatment for chronic fatigue syndrome / Myalgic Encephalomyelitis				
Inpatient psychotherapy				
Mental Health (non-NHS residential placements)				
Non-NHS residential placements				
Ophthalmology				
Blepharoplasty – (upper and lower eye lid surgery) 52 Eyelid surgery for ptosis and dermatoch 53 Entropion and Ectropion.pdf				GP/ Ophthalmology
Cataract removal in adults (first and second eye) 32 Cataract Removal.pdf				
Chalazia (meibomian cysts) 54 Chalazia.pdf				
Short sight or long sight corrective (laser) surgery (refractive keratoplasty)				

Procedure / Treatment	Excluded	Prior Approval	Funded Subject to Audit	Funding requests for prior approval may normally come from …
Children's services				
Bursledon House - Assessment and admission for in-patient treatment				
Pain management				
Policy 60 Spinal Pain Policy 60 Spinal Pain		When treating sciatica		
Trauma and Orthopaedics				
Arthroscopic lavage and debridement with or without partial meniscectomy of the knee in patients over 40 with non-traumatic and persistent knee pain 010 Knee Arthroscopy_April 20				MSK Service/GP or Consultant
Arthroscopic surgery for meniscal tears Policy 55 Arthroscopic surgery for meniscal tears				
Autologous blood injections in MSK conditions 24 Policy Recommendation Use				Consultant
Carpal tunnel syndrome/nerve entrapment at wrist Policy 22 Carpal tunnel syndrome				MSK Service/GP or Consultant
Dupuytren's contracture (palmar fasciectomy) 46 Dupuytrens.pdf				MSK Service/GP or Consultant
Femoro-acetabular (hip) impingement (arthroscopic and open approaches) surgery				MSK Service/ consultant

Procedure / Treatment	Excluded	Prior Approval	Funded Subject to Audit	Funding requests for prior approval may normally come from …
006 Arthroscopic Femero-Acetabular S				
Ganglion (treatment of) 48 Ganglion excision.pdf				All clinicians
Hip and knee replacement surgery (primary) 50 Primary joint replacement for hip ar Primary hip replacement in patients with BMI above 35 must be referred to weight loss management programme		**BMI 35+**		MSK Service/GP or Consultant
Hip resurfacing for advanced arthropathy SHIP Policy 105 - Hip resurfacing recommen				Consultant
Patella resurfacing as part of total or partial knee replacement 015 patella resurfacing v0.1.pdf				
Revision of knee replacement 44 Revision of Knee Replacement.pdf				
Rotator cuff tear surgery 41 Management of Rotator Cuff Tears fin				Orthopaedic Choice/MSK
Sports limbs				

Procedure / Treatment	Excluded	Prior Approval	Funded Subject to Audit	Funding requests for prior approval may normally come from …
Subacromial decompression of the Shoulder 014 subacromial shoulder decompressi				MSK Service/GP or Consultant
Treatment of bunions (hallux valgus) 51 Bunions.docx				MSK Service/GP or Consultant
Trigger finger (treatment of) 47 Trigger finger.docx				MSK Service/GP or Consultant
Respiratory				
Short Burst Oxygen Therapy (SBOT) for the relief of episodic breathlessness				
Urology				
Circumcision 43 Circumcision final.pdf				GP/ Consultant
Treatment of LUTS as a result of Benign Prostatic Hyperplasia Policy 66 Treatment of LUTS as a result of Benign Prostatic Hyperplasia				GP/ Consultant
Hydrocele surgery 26 Policy Recommendation Tre				
Vasectomy reversal				
Vasectomy under general anaesthesia				GP/ Community Vasectomy Service

Procedure / Treatment	Excluded	Prior Approval	Funded Subject to Audit	Funding requests for prior approval may normally come from …
Vascular Surgery				
Varicose vein treatments 001 Varicose veins policy recommendatio				GP/ Consultant

Addendum 1 – Historical and new Priorities Committee statements not previously included in the Hampshire-wide 'Policy and Procedure for Individual Funding Requests'

Procedure / Treatment	Excluded	Prior Approval	Funded Subject to Audit	Funding requests for prior approval may normally come from …
Botulinum toxin Type A (Botox) – in line with DPC guidance for both the licensed and unlicensed indications listed Botulinum_Toxin-_list _of_agreed_indicatio				
Electrolysis for hair removal				
Erectile Dysfunction treatments – Including: Erectile pumps/devices, the drugs sildenafil, vardenafil and tadalafil outside of policy and psychosexual interventions SHIP policy 96a - Erectile Dysfunction.p				
Erectile Dysfunction treatments – Including: the drugs sildenafil, vardenafil and tadalafil – within policy as above				
Excess Treatment Costs (ETCs) for non-commercial clinical trials https://www.england.nhs.uk/wp-content/uploads/2015/11/etc-guidance.pdf				
NHS Transfers to Private Treatment Providers https://www.england.nhs.uk/wp-content/uploads/2013/04/cp-12.pdf				
Non pharmacological services for dementia patients SHIP Policy 118 - Non-pharmacological				
The Anti-cholinesterase inhibitors (AChEIs) donepezil, galantamine and rivastigmine for the treatment of dementia associated with Parkinson's disease or Lewy Bodies Dementia				

25 AChEIS for Parkinsons' or Lewys'				

Appendix 1

Process for managing individual funding requests related to excluded procedures or restricted procedures that fall outside policy criteria

This document includes the absolute criteria which must be met in order for the patient to be treated and the associated charges to be paid by the commissioning CCG. It is important to note that the case for an individual's treatment should be assessed on its own merits and if a patient does not meet the criteria for funding, other management should be considered and only in cases of exceptionality should an application be considered for an Individual Funding Request (IFR).

The NHS Confederation document "Priority setting: managing individual funding requests", drafted for Primary Care Trusts in 2008, gives a clear definition of an individual funding request as follows:-

"An Individual Funding Request (IFR) is a request to a CCG (formerly PCT) to fund healthcare for an individual who falls outside the range of services and treatments that the CCG (formerly PCT) has agreed to commission.

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

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

Such requests should not be confused with

- Decisions that are related to care packages for patients with complex healthcare needs which include Continuing Health Care packages of care. "

The above list is not exhaustive and is at the sole discretion of the Commissioners.

Where patients do not meet criteria in the Amber category, or are under the Red category, Individual Funding Requests will usually be considered on the basis of 'exceptionality'. A guide to what constitutes 'exceptionality' or 'exceptional health need', can be found here: http://www.fundingrequests.cscsu.nhs.uk/wp-content/uploads/2013/10/Exceptional-Health-Need-guide-for-patients-and-clinicians-April-2013.pdf

Central to the CCG's consideration of IFRs, is the question:

"Why should this treatment be provided for this patient, when it would not be funded for other patients who have the same, or a substantively similar, condition?"

If funding is to be agreed for the proposed treatment, there must be some unusual, unpredictable or unique factor about the patient's clinical circumstances, which suggests that:

- the presentation/effect of the condition in the patient differs significantly from that found in the general population of patients with the condition and as a result,
- the patient is likely to gain significantly more benefit from that treatment than might generally be expected for these patients.

In addition to this:

There should be sufficient evidence of the effectiveness of the treatment in bringing about the expected benefit for the patient.

IFR must be supported by a summary statement of clinical evidence for the proposed treatment.

NB: It is the requesting clinician's responsibility, where relevant, to set out the case for an exception to be made.

Please note: It is not possible to predict in advance what might provide a basis for exceptional funding, given the individual nature of each patient's clinical circumstances.

Meeting the accepted indications for a treatment does not, in itself, provide a basis for an exception.

The fact that a patient is likely to respond to the requested treatment does not, in itself, provide a basis for an exception.

Non-medical or social factors will rarely be considered as a basis for an exception.

Social value judgements will not be considered as a basis for an exception.

For a further explanation of exceptionality, please refer to the UK Faculty of Public Health document available at http://www.fph.org.uk/policy_reports (accessed 15/01/15) and http://www.fundingrequests.cscsu.nhs.uk/wp-content/uploads/2013/10/Exceptional-Health-Need-guide-for-patients-and-clinicians-April-2013.pdf

Appendix 2

Process for managing Prior Approval requests

There is joint recognition of the guidance as set out in NHS Technical Guidance, Service Conditions 2017/19 - 29.21-29.27 which provides specific detail on how to manage Prior Approval Schemes.

https://www.england.nhs.uk/wp-content/uploads/2016/11/7-contract-tech-guid.pdf

Figure 1 – Process for Managing Funding Requests – IFR/Prior Approvals.

Process for interventions subject to policy restrictions

Description of Prior Approval Process – All Providers:

N.B.

For clinically urgent requests which require prior approval, there is a 'fast-track' process which manages these requests within 48 hours of receiving an appropriately completed application. Therefore these should not delay clinically urgent treatments where the patient meets the criteria but the 'rule of rescue' will always apply and retrospective funding considered in such extreme cases. As referenced in service condition 29.27, it is expected that these procedures are not non-elective in nature and will not be subject to this.

This process applies for referrals into All Providers where funding restrictions apply for procedures, treatments and interventions as outlined in Table 1.

The process:

1. Check whether the planned procedure is on the list (Table 1).
2. Check the Policy for this procedure and assess the patient against the policy as per the categories below:

RED	AMBER	GREEN
Red procedures without Individual Funding Requests must not be treated as they are not routinely commissioned or funded. Consider other options and communicate with patient and referrer If there are exceptional individual circumstances an IFR may be considered.	Check prior approval has been granted. If yes, proceed. If none, check criteria and apply for Prior Approval If not Approved, consider other options and communicate with patient and referrer If there are exceptional individual circumstances an IFR may be considered.	Check criteria. If patient meets the criteria, proceed with treatment documenting how patient meets criteria (pro forma / patient notes). CCGs to verify through audit and review compliance with process. If criteria not met, consider other options and communicate with patient and referrer If there are exceptional individual circumstances an IFR may be considered.

3. If Approval is in place for Red / Amber categories or if patient meets criteria for Green, patients can proceed to treatment.

   PLEASE NOTE: Where consideration is required for assessment of the patient's health needs (and which can only be determined by the consultant in an outpatient assessment) then the patient may be invited for an assessment for an opinion only. This should not preclude from primary care seeking approval when it is known whether or not criteria are met.

4. **Amber Policies** – Electronic transfer of communication for Prior Approval must be submitted to the IFR Service (working on behalf of the CCGs), completing the appropriate pro forma and detailing the patient's need for treatment and compliance with the criteria in the Policy. The team will respond within 8 working days of receipt with an approval or a decline, should a request for further information be made, the clock will pause until that information is provided. The Provider and IFR Service will

jointly work to reduce/minimise needing to require further information to support an application approval/decline. Outcomes:

   a. **Approved** – Where patients are approved, proceed with treatment. Providers must treat patients within 12 months of approval date for procedures/interventions.
   b. **Not Approved** – Where patients are not approved the treatment will not be funded. We recommend that you **DO NOT** proceed with the restricted treatment and consider other management options.

5. **Green Policies** – Does the patient meet the criteria within the policy?
   a. **Yes** – Proceed with treatment. Document in pro forma / patients notes where criteria have been met according to the individual policy.
   b. **No** – If the patient does not meet the criteria in the policy, The Commissioner will not fund the procedure. We recommend that you **DO NOT** proceed with the restricted treatment and consider other management options in recommendation to the patient's GP.

Applications for IFR should only be made if it is believed the patient has clinically exceptional circumstances and will benefit exceptionally from the proposed procedure/ treatment/ intervention.

PLEASE NOTE: Aside from clinically urgent cases referenced above, retrospective funding will not be considered or agreed to.

Appendix 3

Policy criteria schedule for contracts led by North Hampshire CCG and West Hampshire CCG and their associates. Please see www.fundingrequests.cscsu.nhs.uk then click 'Hampshire'. Please note that changes will include relevant coding and gleaned from an updated ruleset/SQL.

EXCLUDED PROCEDURES – MARKED AS RED ON TRAFFIC LIGHT SCHEME

These are procedures that will not be funded by the commissioning CCG due to a lack of evidence for clinical benefit, limited resource or the responsibility of specialised commissioning. Other management options should be considered. In exceptional circumstances, individual funding requests (IFR) may be made to the patient's CCG for consideration.

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
Plastic/ cosmetic procedures surgery	**CCGs do not fund the provision of plastic/ cosmetic procedures for cosmetic reasons**				
	Liposuction	S621, S622	CCGs do not routinely fund this procedure		RED
	Facelift	S011, S012, S013, S014, S015, S016, 2018, S019	CCGs do not routinely fund this procedure		RED

	Buttock lift, thigh lift, upper arm lift (brachioplasty)	S031, S032, S033, S038, S039	CCGs do not routinely fund this procedure		
	Breast and nipple procedures	B291, B292, B293, B294, B295, B298, B299, B301, B302, B304, B308, B309, B311, B312, B313, B314, B318, B319, B351, B352, B353, B354, B355, B356, B358, B359, B361, B362, B363, B364, B368, B369,	CCGs do not routinely fund this procedure	Reconstructive procedures may go ahead as part of established pathways and must take place within one year of the last cancer treatment Implant removal (B303)	
	Pinnaplasty plastic operations on external ear	D031, D032, D033, D038, D039,	CCGs do not routinely fund this procedure		

	Female cosmetic genital surgery (labiaplasty)	P011, P012, P018, P019, P055, P056, P057, P153, P158, P159	CCGs do not routinely fund this procedure		
	Rhinoplasty/ reconstruction of nose	E025, E026, E028, E029, E072, E078, E079	CCGs do not routinely fund this procedure. Functional nasal airways surgery or endoscopic sinus surgery should not be confused for cosmetic rhinoplasty which is referenced separately	In cases of post-surgical reconstruction as part of the pathway following trauma and must be within 12 months of the trauma occurrence.	
	Treatment of **asymptomatic** inguinal hernias	T201, T202, T203, T204, T208, T209, T211, T212, T213, T214, T218, T219	**These procedures are not routinely funded** Consideration will be given via **individual funding request** in the following cases documented on imaging • History of incarceration of or real difficulty in reducing the hernia • An inguinal-scrotal hernia • An increase in size raising concern over malignancy	Emergency procedures recorded under admission method 21-28 Surgery for **symptomatic** hernias do not require approval	

Plastic surgery	Laser removal of skin and excessive hirsutism	E096, S091, S092, S093, S094, S095, S098, S099	**CCGs do not routinely fund this procedure.** Usually offered at Salisbury laser service – and only with supporting photography considered via IFR		
	Laser surgery in recurrent pilonidal sinus	S09* with ICD10 code L05*	**CCGs do not routinely fund this procedure.** In line with Priorities Committee policy statement 016 (June 2020)		
	Appliances and devices for cosmetic purposes (high-grade silicon cosmesis and/or prosthesis)		**CCGs do not routinely fund these appliances or devices.**		
Ophthalmology	Short sight/long sight corrective (laser) surgery (Refractive keratoplasty)	C461	CCGs do not routinely fund this procedure May be considered via IFR where laser or operative correction is the only treatment available to restore reasonable visual acuity/or where there are substantial other medical reasons that make correction by external visual aids inappropriate.	gill	

ENT	Adenoidectomy in children with upper respiratory tract disordrs	E201, E204 as a sole procedure	In line with Priorities Committee policy statement Feb 2016 and revised in March 2020 policy no. 8 CCGs do not routinely fund this procedure in isolation.	When offered in **combination** with myringotomy (grommet insertion) and/or tonsillectomy **which are subject to separate prior approval arrangements**	
	Surgery for 'snoring'	E651, E658, E659, F321, F322, F323, F324, F325, F326, F328, F329	In line with Priorities Committee policy statement Feb 2016 Any surgical procedure where. R06.5 (mouth breathing) is the primary diagnostic code will not be routinely funded routinely by CCGs.		

	Balloon catheter sinus dilation for chronic rhino-sinusitis	E131, E132, E133, E134, E135, E136, E137, E138, E139, E141, E142, E143, E144, E145, E146, E147, E148, E149, E151, E152, E153, E154, E158, E159, E161, E162, E168, E169, E171, E172, E173, E174, E178, E179	CCGs do not routinely fund this procedure In line with Priorities Committee policy statement 018 (Feb 2017)		
Urology	Reversal of sterilisation/ vasectomy	N181, N182, N188, N189, Q291, Q292, Q298, Q299, Q371, Q378, Q379	CCGs do not routinely fund this procedure May be considered via IFR on the death of a partner or only child or where sterilisation caused by proven surgical accident that was not a foreseen consequence of such a procedure.		

	Erectile Dysfunction and Penile Rehabilitation following radical prostatectomy		CCGs do not routinely fund this procedure Reference SHIP Priorities Committee Policy 63 and replaces policy statement 137		
Gynaecology	Dilation and curettage in heavy menstrual bleeding	Q103	CCGs do not routinely fund this procedure Priorities Committee policy statement 49 (March 2019) In line with NHS England's Evidence-based interventions guidance, D&C should not be used for diagnosis or treatment for heavy menstrual bleeding in women because it is clinically ineffective. Ultrasound and camera tests with sampling of the womb lining (hysteroscopy and biopsy) can be used to investigate heavy periods.		
General surgery	Faecal microbiota transplants	G488, G578, H218, H628	CCGs do not routinely fund this Priorities Committee policy statement 017 (Feb 2017)		

	Autologous blood injections in musculo-skeletal conditions	T746	CCGs do not routinely fund this Priorities Committee policy statement 24 (Dec 2017)		
	Negative Pressure Wound Therapy		In line with SHIP Priorities Committee Policy Statement 61 CCGs do not routinely fund this		
Alternative/ complementary/ homeopathic therapies	Complementary therapies/medicine	A705, A706, X611, X612, X613, X614 X618, X619	CCGs do not routinely fund this	When included as an adjunct to usual therapy e.g. acupuncture within physiotherapy or pain management services. **Not** funded as a separate procedure	
Mental Health	In patient treatment for severe chronic Fatigue/ME	n/a	CCGs do not routinely fund this. Severe cases require an IFR but mild-to-moderate cases are available in the commissioned outpatient service run by South Coast Fatigue.		
	Non-NHS residential placements	n/a	CCGs do not routinely fund this		
	Functional electrical stimulation in drop	n/a	In line with SHIP Priorities Committee policy statement 005		

	foot		Functional Electrical Stimulation may be considered as a second line treatment option for carefully selected patients with drop foot (most commonly due to multiple sclerosis or stroke) who have clearly failed trials of orthosis (for example due to pressure sores, spasticity). It should be considered a **low priority** for all other patients All cases must be sought via **individual funding request**		
Children's Services	Assessment and admission to Bursledon House in Southampton for in-patient treatment	n/a	**Admissions to Bursledon House are not routinely funded.** Children considered for referral to Bursledon House must have referrals prior approved before assessment is carried out and, if agreed, further approval must be sought after assessment where admission is requested		

Orthopaedics/ Spinal Pain **Orthopaedics/Spinal Pain**	Spinal Pain Spinal Pain Non-specific low		The following procedures are not routinely funded and should not be routinely offered, and a full **Individual Funding Request** would need to be raised demonstrating exceptionality. **Acupuncture** is not routinely commissioned **Spinal injections as a therapeutic intervention** including facet joint injections, medial branch blocks and epidural/ nerve root injections are not normally funded in non-specific neck pain **Imaging in a non-specialist setting** for patients with low back pain with or without sciatica, where there are no red flags or suspected serious underlying pathology following evaluation of medical history and examination **Epidural injections** for neurogenic claudication in patients who have central spinal canal stenosis are not normally funded **Therapeutic** medial branch blocks for facet joint pain are not		

Orthopaedics/ **Spinal Pain**	back/neck pain.		routinely commissioned **Imaging** in patients with low back pain with specific facet joint pain as a prerequisite for radiofrequency denervation is not normally funded **Prolotherapy** for sacroiliac joint pain is not normally funded due to a lack of evidence on clinical and cost of effectiveness **The following procedures are not normally funded in non-specific low back pain;** • Disc replacement • Spinal fusion and/ or discectomy **All local anaesthetic and steroid spinal injections including;** • Facet Joint Injections • Therapeutic medial branch blocks • Intradiscal therapy		

			• Prolotherapy • Trigger point injections with any agent, including botulinum toxin • Epidural steroid injections for chronic low back pain or got neurogenic claudication in patients with central spinal canal stenosis Any other spinal injections not specifically covered above.		
	Foetal Alcohol Spectrum Disorders		As there are locally commissioned services able to treat those with developmental difficulties associated with FASD funding is considered low priority and will not be routinely funded.		
	Low Intensity Pulsed Ultrasound (Exogen) in delayed and non-		Due to the lack of high quality evidence of clinical and cost effectiveness this intervention is		

	union fractures		NOT NORMALLY FUNDED.		

RESTRICTED PROCEDURES MARKED AS AMBER ON TRAFFIC LIGHT DOCUMENT

For these procedures, it has been judged that the intervention is of sufficient value in terms of benefit and outcome when the patient meets the criteria, as outlined in the criteria and on the website. **Prior approval is required for all procedures, treatments and interventions in this category.**

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
Various services	Intensive decongestive therapy for lymphoedema	n/a	In line with SHIP Priorities Committee policy statement 004 Assessment and treatment (particularly skincare, compression, remedial exercise, and self-management education) should be available for patients with lymphoedema within existing NHS services, irrespective of the		

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			cause. Patients who receive treatment which may cause lymphoedema in the short or medium term should be properly informed about the risk of lymphoedema (through consent arrangements) and educated in its management. Intensive courses of decongestive therapy for refractory lymphoedema must be sought via **individual funding request**		
Endocrinology	Liothyronine in hypothyroidism	n/a	In line with Priorities Committee statement 27 (Jan 2018) Treatment with liothyronine should not be initiated in primary care · Hypothyroidism should be treated first line with levothyroxine		

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			▪ Patients whose symptoms are inadequately treated with optimal doses of levothyroxine should be referred to an NHS endocrinologist using Advice and Guidance and eReferral systems ▪ Consultants wishing to consider treatment with liothyronine will be required to complete a proforma supplied by the District Prescribing Committee and submitted to the CSU prior to prescribing. ▪ Treatment with liothyronine will need to be reviewed by the specialist at 3 months before prescribing can be considered for transfer to primary care.		
ENT	Nasal surgery for nasal blockage and	E021, E022, E023, E024,	This procedure is not routinely	Emergency procedures recorded under admission	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
	or deformity	E027,E036, E037, E038 E039, E041, E042, E043, E044, E045, E046, E047, E048, E049, E073, E648, E649	funded In line with Priorities Committee policy no.23 Nasal septal deviation (NSD) can cause nasal obstruction (insufficient airflow through the nose) and lead to symptoms such as nosebleed, headaches and oral breathing. NSD occurs when the wall of cartilage between the two nasal cavities is displaced. Nasal surgery can be undertaken to straighten the nasal septum with the aim of alleviating symptoms. Septoplasty This procedure may be considered under the following conditions: • Obstruction of one or both nostrils causing significant symptoms **and**	method 21-28	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			• Conservative measures without success for > 3 months; **and** • Overuse of nasal sprays excluded as a cause of nasal congestion or ceased prior to referral and congestion persists **Septorhinoplasty** (Septo)rhinoplasty may be considered if secondary care deem it to be the most effective intervention for the patient's nasal obstruction and they fully detail the expected outcome in functional improvement, all of the following conditions have been met and why septoplasty alone is not indicated. Patients are required to meet all the criteria. In addition, requests must explain the improvement in		

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			functional outcome that is expected, and why septoplasty alone is not indicated. Surgery to address the effects of facial trauma as part of the initial care pathway for that trauma and the care for relevant cancer treatments are excluded from this policy		
	Adenoidectomy in children with chronic rhinosinusitis		In line with Priorities Committee policy statement Feb 2016 and revised in March 2020 policy no. 8 Treatment should be conservative in the first instance with intranasal corticosteroids, nasal saline douching, or ideally sinus rinses (but this may be poorly tolerated in younger children) for at least 3 months' management in primary care utilising secondary care Advice		

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			and Guidance where appropriate. If this fails AND symptoms interfere significantly with daily life, then referral for ENT review and consideration of surgical adenoidectomy is supported.		
Gynaecology	Hysterectomy in heavy menstrual bleeding/ dysmennorhea	Q071, Q072, Q073, Q074, Q075, Q078, Q079, Q081, Q082, Q083, Q088, Q089	In line with Priorities Committee policy statement 39 (Sept 2018) Hysterectomy for heavy menstrual bleeding (HMB) is not normally funded. Treatment should begin in primary care with non-hormonal and hormonal methods being trialled. Each method should be used for a minimum period of 3 months and preferably 6 months. Patients who do not respond to pharmacological treatment should ideally be referred to a "One Stop" menstrual disorder or similar clinic. Referral should	Hysterectomy for uterine problems amenable to surgery and not related to heavy menstrual bleeding or dysmenorrhoea will be funded and do not require prior approval. This policy does not related to suspected malignancies or trauma	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			include a recent full blood count. Ferritin levels are no longer recommended. Patients should be counselled extensively by an appropriately trained healthcare professional, on the risks and benefits of intervention, including; • affect on libido • impact on fertility • bladder function • need for further treatment • treatment complications • her expectations • alternative surgery • psychological impact. Information aids such as the Shared Decision Making tool (https://www.england.nhs.uk/right		

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			care/shared-decision-making/) should be considered. Patients who have failed all other interventions and are proceeding to surgery should be offered laparoscopic interventions where clinically viable.		
Urology	Male circumcision	N303	This procedure is not routinely funded Prior approval will be considered under the following conditions - Pathological phimosis due to lichen sclerosus (formerly known as balanitis xerotica obliterans) - Pathological phimosis due to balanitis/balanoposthitis resistant to conservative treatment. - Congenital urological abnormality where skin grafting is required.	Patients coded with a cancer diagnosis Patient is suspected with cancer and has been referred via the two-week wait referral form	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			- Recurrent splitting and scarring of the prepuce which affects sexual function and does not respond to at least two months of conservative management. - balanophosphitis resistant to antibiotics **Balanitis/balanophosthis** can be caused by a range of different conditions affecting the penile skin and/or the foreskin. Treatment includes hygiene measures, using an emollient (such as emulsifying ointment) as a soap substitute and topical treatments as per the underlying diagnosis, such as topical steroids, anti-fungals and oral antibiotics. (Clinical Knowledge Summaries (2018) Balanitis – management)		

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			Treatment of lichen sclerosus (LS) is guided by the British Association of Dermatologists - BAD (2018) Guidelines for the management of LS. Children: Offer a trial of an ultrapotent topical steroid applied once daily for 1–3 months combined with emollients and barrier preparations to all male children and young people with phimosis caused by LS. Adults initial treatment: Offer all male patients with genital LS clobetasol propionate (CP) 0.05% ointment once daily for 1–3 months with an emollient as a soap substitute and as a barrier preparation Circumcision for cultural or religious indications will not be commissioned. Circumcision for		

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			paraphimosis and physiological phimosis are not normally funded and requests need approval through the Individual Funding Request Process.		
	Treatment of LUTS as a result of Benign Prostatic Hyperplasia		In line with Priorities Committee policy statement 66 (APR 2021). Benign prostatic hyperplasia (BPH) is a condition in which the flow of urine is blocked due to the enlargement of the prostate gland. This enlargement can cause lower urinary tract symptoms (LUTS) including hesitancy on urination, interrupted or decreased urine stream, nocturia, incomplete voiding and urinary retention. Red flag symptoms are excluded from this policy and patients should be referred via the 2 week	Any surgical modality offered should take into account the latest published NICE guidance and the NHS England Evidence Based Interventions Programme: **The following interventions are NOT NORMALLY FUNDED:** • Transurethral needle ablation • Transurethral microwave thermotherapy • High-intensity	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			wait criteria. Men with BPH may be referred for a specialist surgical opinion if the following criteria are met: Severe voiding symptoms Conservative and lifestyle interventions have been undertaken for a period of 3 months (for example advice on fluid intake and urethral milking) and symptoms persist Appropriate pharmacological therapy for LUTS has been trialled and symptoms persist, for example: • Trial of an alpha	focused ultrasound • Transurethral ethanol ablation of the prostate	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			blocker for 6 weeks for moderate to severe LUTS (for example an IPSS score between 8-19 for moderate symptoms and 20-35 for severe symptoms). • Trial of an anticholinergic for 6 weeks, for symptoms of over active bladder. • Trial of an alpha reductase inhibitor for 3 months for LUTS, when there is evidence of prostatic hypertrophy and		

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			the patient is considered to be at high risk of progression. • Combination of an alpha blocker and a 5-alpha reductase inhibitor for bothersome moderate to severe LUTS when there is evidence of prostatic hypertrophy Men are involved in shared decision making including which surgical modality is appropriate and when or whether surgery should be undertaken. Any surgical modality offered should take into account the		

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			latest published NICE guidance and the NHS England Evidence Based Interventions Programme: • The UroLift system relieves lower urinary tract symptoms while avoiding the risk to sexual function. This should be considered as an alternative to current surgical procedures for use in a day-case setting in men who are aged 50 years and older and who have a prostate of less than 100ml without an obstructing middle lobe. • TURP, TUVP (including laser prostatic vaporisation)		

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			or HoLEP should be offered to men with voiding LUTS presumed secondary to BPH. HoLEP should be performed within centres specialising in the technique or where mentorship arrangements are in place. • TUIP should be offered to men with a prostate estimated to be smaller than 30ml. • Open prostatectomy should only be offered as an alternative to endoscopic surgery, to men with prostates estimated to be larger than 80-100ml.		

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
Spinal Pain		Please See Policy 60	Referenced Priorities Committee policy statement 060 (Apr 2021) Interventions are undertaken using a multi-disciplinary team approach and that conservative therapies, including a course of structured physiotherapy and exercise with or without psychological therapy have been offered as first line treatment Assessment should include the biopsychosocial impact on the individual such as with EQ-5D or STarT back tool for low back pain. Patients receiving any surgical intervention should be registered	See **GREEN** interventions. Emergency admissions for severe pain Interventions related to pain arising from cancer (C&D codes), fractures (S12*, S220/1, S32*), infection or inflammatory disease processes (M468/9)	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
	Cervical neck Pain (neck)		on the British Registry and the providers are expected to participate in the Regional Spinal Network. Prior Approval may be considered for the following interventions providing criteria is met: **Repeat epidural/nerve root injection for sciatica or for cervical radiculopathy** • Please provide documented evidence that the patient's co-morbidities exclude surgery or that less invasive treatment is not possible and that the previous injection offered at least 70% improvement in pain sustained for at least 6 months.		

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
	Lumbar (low back pain)		**Spinal decompression (sciatica) with or without fusion** • Please provide documented evidence that all non-operative options have been tried or are contraindicated **Lumbar discectomy (for sciatica) in the presence of concordant MRI changes** • Please provide documented evidence the patient has compressive nerve root signs and symptoms lasting 3 months (except in severe cases) despite best efforts with non-operative		

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
	Facet joint pain		management **Radio-frequency denervation (for facet joint pain)** • The main source of pain is thought to come from structures supplied by the medial branch • All non-surgical and alternative treatments have been tried and failed • The patient does not have radicular symptoms • There is moderate to severe chronic pain that has improved in response to diagnostic medial branch block **Repeat radiofrequency**		

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
	Sacroiliac (SIJ) pain		**denervation (for facet joint pain)** • The patient has received a previous successful response with benefits lasting >12 months. **Radiofrequency denervation (for sacroiliac joint pain)** • The patients has received a diagnostic injection with a successful response **iFuse device (sacroiliac joint pain)** • Please provide documented evidence that all other treatments has failed		

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Orthopaedics/ MSK	Treatment of bunions (hallux valgus)	W151, W152, W153, W154, W791, W792, W131, W132, W133, W134, W139, W157, W158, W593, W594, W595, W596, W798	In line with Priorities Committee policy statement 51 (April 2019) These procedures are not routinely funded However, patients with **significant** functional impairment that do not respond to conservative measures must be assessed through the MSK triage service to ascertain if they are likely to benefit from intervention. In this instance 'significant' is taken to mean; • Symptoms of significant functional impairment that prevent them from properly fulfilling work, domestic or carer duties or educational	Management of patients with bunions and peripheral neuropathy or diabetes is outside of the scope of this policy.	

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			responsibilities; AND • Significant functional impairment is present more than half the time; AND • This impairment happens frequently over the preceding 30 days		
	Arthroscopic lavage and debridement with or without partial meniscectomy of the knee in patients over 40 with non-traumatic and persistent knee pain	W801, W802, W803, W808, W809, W821, W822, W823, W828, W829, W851, W852, W858, W859, W871, W879	These procedures are not routinely funded Reference SHIP Priorities Committee policy statement no 010 - April 2016 as reviewed in July 2018 and by policy statement 55 referencing meniscal tears (July 2019) The Priorities Committee has reviewed the evidence for knee arthroscopy as part of treatment for generalised knee pain in the		

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			over 40's and recommend that arthroscopic lavage and debridement with or without partial-meniscectomy in non-traumatic and persistent knee pain with no clear history of recurrent mechanical locking resulting in appreciable loss of function is low priority. This includes any approach for diagnostic purposes. Further detail can be found here http://www.fundingrequests.cscsu.nhs.uk In addition, the committee recommends that: Arthroscopic surgery should be offered to patients with meniscal tears after 3 months of conservative treatment which have failed to resolve and which have occurred as a result of trauma or injury.		

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			Arthroscopic surgery for patients with degenerative meniscal tears and no clear history of recurrent mechanical locking, resulting in appreciable loss of function, is low priority. This is due to lack of evidence of positive long term outcomes over conservative treatments such as physiotherapy.		
	Primary hip and knee replacement in patients with a BMI above 35	W371, W381, W931, W938, W939, W941, W948, W949, W951, W958, W959, W401, W408, W409, W411, W418, W419, W421, W426, W428, W429, O181, O188, O189	These procedures are not routinely funded for patients with a BMI above 35 Prior approval will be considered under the following conditions a) In patients whose pain is so severe and/or mobility compromised that they are at risk of losing their independence and that joint replacement would	Emergency procedures recorded under admission method 21-28	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			relieve this risk b) In patients whose destruction of the joint is of a severity that delaying surgery would increase the technical difficulty of the procedure **Referral should also have been made for to the commissioned tier 2 or tier 3 obesity management programme prior to offering surgery.**		
	Subacromial decompression of shoulder	O291, W844	In line with SHIP Priorities Committee policy statement 014 Open subacromial decompression is not routinely funded Prior approval is required for arthroscopic subacromial decompression if all the following criteria are fulfilled	Emergency procedures recorded under admission method 21-28	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	The exclusion does not apply in the following circumstances and patients may be treated without prior approval	Colour on traffic light scheme
			• Symptoms for at least 6 months • Symptoms are intrusive and debilitating (e.g. waking at night, pain when putting on a coat) • Patient compliant with physiotherapy intervention for at least 6 weeks • There has been a positive response to a steroid injection		
	Management of rotator cuff tears	T791, T793, T794, T795	In line with Priorities Committee statement 41 (Sept 2018) The place of surgery for rotator cuff syndrome is limited and rarely a first line treatment. The majority of tears are degenerative and often relatively	Traumatic tears should be considered for surgery without delay	

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			asymptomatic. **First line options should begin with** Physiotherapy and analgesia for 6 weeks with a further 6 weeks of physiotherapy if there has been incomplete resolution, at which point the patient, if not already managed under MSK services, should be referred Imaging with MRI is no better than ultrasound. Ultrasound should not be used as a diagnostic investigation in primary care but should be reserved for confirmation of diagnosis and assist management plans and only by referral from MSK services. Whilst longer term issues related to injection of corticosteroids it		

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			was considered reasonable to inject once, repeating once more only if there had been considerable but temporary relief in symptoms.		
	Surgical management of pelvic organ prolapse		In line with Priorities Committee policy statement 29 (Jan 2018 reviewed July 2020) For women who wish to be referred for specialist surgical opinion, a full range of conservative and pharmacotherapy should been tried and failed before referral, including lifestyle interventions, supervised pelvic floor muscle training for at least 3 months (only in women with stage 1-2 prolapse); trial of topical vaginal oestrogen and pessary in appropriate patients. Mesh should not be used trans-vaginally for pelvic organ		

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			prolapse unless the operation is part of a research trial. Other abdominal pelvic organ prolapse mesh procedures can only be carried out under high-vigilance reporting regimes. For women considering surgery, the use of appropriate patient decision aids is highly recommended.		
	Revision bariatric surgery	G251, G310, G313	In line with Priorities Committee policy statement 31 (April 2018) Revision surgery should only be undertaken in specialised centres with a multi-disciplinary team (MDT) approach which are directly commissioned to provide this service. Providers not commissioned to provide this service should ensure patients are redirected to locally commissioned services (Spire Southampton and Portsmouth		

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			Hospitals NHS Trust). Procedures carried out by other providers will not be reimbursed for any such procedure. Patients whose primary surgery fails due to mechanical failure such as obstruction, band slippage etc. (**Group 1** patients) should be offered revision following granting of prior approval (Amber). Patients who have had primary surgery but fail to achieve expected weight loss or regain their pre-operative weight (**Group 2** patients) should **not** be routinely offered revision surgery unless they fall into **Group 3** below when the case will be considered via the IFR process Patients who have been fitted with a gastric band and whose weight does not fall consistently but whose clinical condition		

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			deteriorates developing multiple, severe and life threatening co-morbidities (**Group 3** patient) will not be routinely offered revision surgery but, because of the small numbers involved, will be considered using the IFR route Patients who have funded their own primary bariatric surgery (**Group 4** patients) should be eligible for treatments, following the same pathway and with the same thresholds as NHS patients. This includes meeting the criteria for primary surgery including input from tier 3 obesity management services **NB** Such revision surgery should be attempted as a single stage-procedure. A planned two stage procedure requires a full IFR application		

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Infertility treatments	**In vitro fertilisation** (including the prescriptions of infertility drugs) and ICSI (intracytoplasmic sperm injection)	n/a	This Treatment is not routinely funded Prior approval will be considered in line with the SHIP Priorities Committee policy statement 002 - September 2014 where endorsed by individual CCGs http://www.fundingrequests.cscsu.nhs.uk/		

‘TRUST AND VERIFY’ – PROCEDURES SUBJECT TO AUDIT - GREEN

These **Treatment will not be subject to prior approval but will be subject to ‘trust and verify’ assurance arrangements. Findings from the verification process will be extrapolated against all activity for that procedure, so that the proportion of procedures considered inappropriate i.e. not meeting the clinical or threshold criterion will not be reimbursed.** . .

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	Colour on traffic light scheme
Ophthalmology	Cataract surgery (first and second eye)	C712, C751	Following Priorities Committee policy statement 32 (April 2018) The pathway for patients must include a form of community-based validation and assessment. This would need to include a holistic assessment of their vision and the effect the cataract is having on them as well as explaining the risks and benefits of intervention and understanding the patient’s wishes. A functional impact scoring scale could be considered in the assessment process. Several scoring systems were discussed such as cat-PROM5 and VF-14 but there was no consensus other than that this should not be on visual acuity (VA) alone but VA would be an important factor, as would driving status and glare. Patients should be fit for surgery at the time of referral The thresholds for first and second eye cataract extraction should be the same. Bilateral cataract extraction is preferable where clinically appropriate.	

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			North and West Hampshire CCGs have not yet agreed for visual acuity to be removed as a criterion for access to NHS funded cataract removal. This is under review and will remain in place until such time that a community based validation and assessment service function is established. Therefore, North and West Hampshire CCG patients must continue to meet the visual acuity threshold as set out below, and these should be recorded in the patient record to progress to cataract surgery. Best corrected visual acuity of 6/9 or worse in the second eye Best corrected binocular visual acuity of 6/18 or worse irrespective of the visual acuity of the first eye	
	Chalazia (meibomian cysts)	C121, C124	Chalazia (meibomian cysts) are benign, granulomatous lesions that will normally resolve within 6 months. Treatment consists of regular (four times daily) application of heat packs. These procedures are not routinely funded Prior approval will be considered under the following conditions - The chalazia has been present for more than 6 months - Where it is situated subcutaneously in the upper or lower eyelid - Where it is causing impairment of vision	

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	Blepharoplasty	C131, C132, C133, C134, C138, C139	These procedures are not routinely funded Prior approval will be considered under the following conditions • There is significant effect on visual fields as documented by formal clinical photography or a visual field test which should be provided with the prior approval application; or • for relief of ectropion or entropion; or • other demonstrated complications causing visual dysfunction as detailed by the referring clinician	
Orthopaedics	Spinal Pain		**A single epidural/ nerve root injection for sciatica or for cervical radiculopathy** not responding to conservative therapy can be considered as part of a rehabilitation pathway or as one-off diagnostic intervention to inform surgical management **does not** require prior approval. **A single medial branch nerve block for diagnostic purposes** is supported as part of potential radio frequency denervation for facetogenic low back pain ***does not*** require prior approval. **Steroid and local anaesthetic injections of the sacroiliac joint (to treat SIJ pain)** may assist in the diagnosis as well as allowing physiotherapy and therefore ***does not*** require prior approval.	

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			Imaging in low back pain should be offered if serious underlying pathology is suspected. Serious underlying pathology includes but is not limited to; cancer, infection, trauma, spinal cord trauma (full or partial loss of sensation and/ or movement of part(s) of the body) or inflammatory disease **does not** require prior approval.	
Orthopaedics	Primary hip and knee replacement	W371, W381, W931, W938, W939, W941, W948, W949, W951, W958, W959, W401, W408, W409, W411, W418, W419, W421, W426, W428, W429, O181, O188, O189	Treatment funded subject to 'trust and verify', verification process as detailed in section one of this document. In line with Hampshire Priorities Committee policy statement 50 The committee have considered the current thresholds for operative interventions for primary joint replacement of hips and knees. It heard from a variety of orthopaedic consultants, both directly and by message as well as an in-depth evidence review. The committee makes the following recommendations: • **Obesity** is an important factor in the aetiology of joint disease as well as being detrimental to the outcomes. Consequently, the committee recommends that weight management has an important role throughout the patient's life, and this should be reflected in prevention strategies • There is clear evidence that there are poorer outcomes for patients with increased body mass index. The committee therefore recommends that primary replacement should be	

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			reserved for patients with a BMI below 35. • **Patients with a BMI of 35 or above: Separate prior approval criteria** are in place to manage access to surgery for patients with a BMI of 35 and above, namely under the following conditions prior approval may be granted: ➢ In patients whose pain is so severe and/or mobility compromised that they are at risk of losing their independence and that joint replacement would relieve this risk; ➢ In patients whose destruction of the joint is of a severity that delaying surgery would increase the technical difficulty of the procedure; ➢ Referral should also have been made for referral to the commissioned tier 2 or tier 3 obesity management programme prior to offering surgery. • **Smoking** is the most important factor for the development of postoperative cardiopulmonary and wound-related complications in elective surgery and the most important risk factor for the development of serious post-operative complications in patients undergoing elective hip and knee replacement. • Stopping smoking should be encouraged for at least 8 weeks prior to operation and patients should be referred to	

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			a structured smoking cessation programme prior to or at time of referral for surgical assessment or there should be documented informed dissent. • With reference to **Policy Statement 21**: Smoking and Non-Urgent Surgery (July 2017); ➢ Prescribing smoking cessation medication outside of supported programmes is low priority; ➢ All clinicians have a responsibility to undertake patient education and offer brief intervention with every contact; ➢ Use of e-cigarettes is less harmful and is preferable to cigarette smoking. • **Shared decision making** was seen to be helpful and effective at improving outcomes and should be started in Primary Care or in the Community based MSK service using resources such as the Joint replacement Decision Aid (https://www.cimauk.org/science-update/national-joint-registry-patient-decision-supp) **There should be a period of 3 months** for patients to consider the risk and benefits to them of knee replacement surgery and to address issues such as weight loss or smoking cessation if required.	

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	Knee revision surgery	Revisions O183/4, W403/4, W413/4, W423/4/5 or W433, 443, W453, 523, W533, W543/4, W582 (combined with Z844/5/6, Z787, Z765 or Z774) or Y032/7	In line with SHIP Priorities Committee statement 44 (Dec 2018) Knee revision surgery can be considered where; The patient has persistent pain which is suggestive of the presence of joint infection **OR** Where infection is not suspected but the patient has all of the following • Persistent joint pain with or without significant loss of range of movement and function • X-ray confirms the presence of aseptic loosening and wear of the prosthesis OR has had significant malalignment or malrotation diagnosed by a multi-disciplinary team that is likely to be improved • Has had the evidence for outcome from revision surgery explained to them and understands that the outcomes from revision surgery are not likely to be as good as those from primary replacement surgery. • Has a BMI below 35 • Is fit for surgery at the time of referral	
	Arthroscopic surgery for		In line with SHIP Priorities Committee policy statement 055 Patients with **persistent mechanical knee symptoms** should be referred	

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	meniscal tears		to secondary care and should have an MRI scan of the knee to investigate for a meniscal tear and/or other pathology. Arthroscopic meniscal repair is supported for patients with treatable (BASK guidance) lesions who are suitable candidates, after 3 months of conservative treatments and which have failed to resolve.	
	Arthroscopic hip surgery in impingement	W084, W085, W091, W831, W832, W837, W839, W841, W842, W843, W844, W845, W846, W847, W848, W849, W868, W891, X228	In line with SHIP Priorities Committee policy statement 006 Arthroscopic femero-acetabular surgery for hip impingement should be considered as a second line treatment option for patients who are symptomatic, have significant impaired activities of daily living and have undergone activity modification as part of conservative treatment. Patients with evidence of osteoarthritis in the hip joint are not suitable for arthroscopic hip impingement surgery. All arthroscopic surgery for hip impingement procedure data should be submitted to the registry set up by the British Hip Society Registry (in line with NICE guidance).	
	Hip resurfacing	W580, W581, W582	These procedures are not routinely funded Prior approval will be considered under the following conditions	

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Bariatric surgery	Primary bariatric surgery for obesity including gastric bypass and gastric banding (see policy for techniques allowed)	G251, G28*, G30*, G31* (except G314), G321, G331, G38*	In line with Priorities Committee policy statement 13 (June 2016)# Bariatric surgery (limited to adjustable gastric banding, sleeve gastrectomy and Roux-en-Y gastric bypass performed at a recognised specialist centre with a multi-disciplinary team) will be prioritised as a treatment option for people with obesity if all the following criteria are fulfilled: • They have a BMI of 40 kg/m^2 or more (or between 35 and 40 with either type 2 diabetes mellitus or uncontrolled hypertension (after all medical therapies have been tried)) that may be improved if they lost weight. • All appropriate non-surgical measures (including Tier 2 and Tier 3 interventions) have been tried for at least 12 months continuously but the person has not achieved or maintained adequate, clinically beneficial weight loss. • The person is generally fit for anaesthesia and surgery. • The person commits to the need for long-term lifestyle modification and follow-up. **Other types of procedures e.g. gastric plication (G251), intragastric balloon (G485/6), and biliopancreatic diversion with duodenal switch (G284) are not routinely funded and will**	

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			need prior approval through the CSU.	
Orthopaedics/ MSK	Trigger finger surgery	T723	These procedures are not routinely funded In line with Priorities Committee statement 47 (Feb 2019) Prior approval for surgery will be considered under the following conditions for patients diagnosed with trigger finger: • who fail to respond to conservative treatment, including no response from up to two corticosteroid injections; or • the finger is permanently locked in the palm; or • two other trigger digits have been previously treated unsuccessfully with appropriate non-operative methods; or patient has diabetes	
	Carpal tunnel release/ nerve entrapment at wrist	A651, A658, A659, A692	In line with Priorities Committee policy statement 22 and appendix 7 statement where applicable. Treatment funded subject to 'trust and verify', verification process as detailed in section one of this document Carpal tunnel decompression may be offered under the following conditions: In moderate symptoms which regularly interfere with activities or	

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			sleep All conservative measures (e.g. wrist splint and a corticosteroid injection into the carpal tunnel) have failed; and • There have been symptoms for longer than 6 months In severe symptoms • With severe symptoms where there is evidence of severe disease causing permanent reduction in sensation in the median nerve distribution or muscle wasting or weakness of thenar abduction.	
	Palmar fasciectomy /Dupuytren's contracture	T521, T522, T525, T526, T541, T561, T562, T568, T569	These procedures are not routinely funded In line with Priorities Committee statement 46 (Feb 2019) Prior approval for fasciectomy will be considered under the following conditions • patient has loss of extension of 30 degrees o r more in the metacarpophalangeal joint (MCPJ) or 20 degrees at the proximal interphalangeal joint (PIPJ) resulting in functional loss or	

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			• patient has severe thumb contractures interfering with function Collagenase should only be offered as part of ongoing clinical trials or without prior approval in adults with palpable cords if the following criteria are met: Moderate disease (functional problems and MCPJ contracture of 30-60 degrees and PIPJ contracture of less than 30 degrees or first web contracture) plus up to two affected joints; AND Needle fasciotomy is not considered appropriate but limited fasciectomy is considered appropriate by the treating hand surgeon	
General surgery	Treatment of chronic anal fissure	H562, H564	In line with Priorities Committee Policy statement 25 (Dec 2017) The majority of cases will be treated in primary care. Advice about diet and avoidance of constipation is imperative. ▪ First line pharmacological therapy is GTN (glyceryl trinitrate) rectal ointment. ▪ Diltiazem should only be used if there is continued intolerance to GTN after education on proper application of extremely small amounts. ▪ Medical therapies should be tried for at least a month. ▪ Injection of botulinum toxin should be restricted to one injection and offered to women and anally receptive men	

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			due to the increased risk of incontinence from surgery. · Lateral sphincterotomy is supported for cases where all the aforementioned options have failed. Other interventions are considered low priority and therefore require a full IFR.	
	Treatment of ganglions	T591, T592, T598, T599, T601, T602, T608, T609	In line with Priorities Committee statement 48 (Feb 2019) Most ganglia resolve on their own. Interventions are not routinely funded Prior approval will be considered in the following circumstances: **Wrist ganglion –** in **significant neurological symptoms** and only if aspiration fails to resolve pain and there is restricted hand function **Seed ganglion** – in the palm of the hand at the base of the fingers. Only if there is **significant pain and loss of function** where aspiration fails and ganglion persists **Mucoid cysts** – just below the nail coming from the last joint of the finger relating to degeneration in that joint. Surgery considered only where there are **recurrent spontaneous discharges of fluid or disrupting nail growth causing significant functional impairment or pain**	

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	Management of haemorrhoids	H511, H512, H513, H518, H519	In line with Priorities Committee statement 40 (Sept 2018) The majority of cases resolve spontaneously with advice regarding diet and bowel habits. The guidance in the NHSE Evidence Based Interventions document reflects good practice. It is recommended that: • Surgical interventions for Grade 1 and 2 haemorrhoids should not be commissioned except where there is a coagulation deficit e.g. use of Warfarin or NOACs and the repeated bleeding is causing anaemia. • Persistent grade 1 or 2 haemorrhoids which have not responded to dietary changes and conservative measures may be managed with banding or injections in an outpatient setting. • Skin tags are considered cosmetic and removal is not routinely commissioned and will not normally be funded. Such skin tags should be considered in the context of a benign skin lesion and clinicians should refer to this policy for criteria for prior approval. • Surgical removal of recurrent grade 3 or 4 haemorrhoids with persistent pain should be available with the most suitable procedure being decided by the surgeon.	

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Vascular Surgery	Varicose vein procedures	L841, L842, L843, L844, L845, L846, L848, L849, L851, L852, L853, L858, L859, L861, L862, L863, L868, L869, L871, L872, L873, L874, L875, L876, L877, L878, L879, L881, L882, L883, L888, L889,	This procedure is not routinely funded Prior approval will be considered under the following conditions Reference: SHIP Priorities Committee policy statement no. 001 http://www.fundingrequests.cscsu.nhs.uk/ People with a body mass index less than 32 kg/m2 who satisfy at least one of the following criteria may be considered for interventions to treat varicose veins: • a first venous ulcer • a recurrent venous ulcer • haemorrhage from a superficial varicosity	
Gastroenterology	Gastric fundoplication for chronic reflux oesophagitis	G241, G243, G461	These procedures are not routinely funded Prior approval will be considered for adults who have at least one of the following characteristics; - Regular, significant symptoms of gastro-oesophageal reflux despite receiving at least one year of continuous pharmacological treatment up to the maximum dose licensed for reflux oesophagitis or in those where long term pharmacological intervention is contraindicated.	

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			- Significant volume reflux placing them at risk of aspiration - Significant difficulty sleeping due to gastro-oesophageal reflux symptoms - Anaemia because of oesophagitis Reference: South Central Priorities Committees policy statement no 51.	
ENT	Tonsillectomy adults and children	F341, F342, F343, F344, F345, F346, F347, F348, F349, F361	Tonsillectomy should only be performed when the following conditions are met: • - in children and adults for cases of two or more quinsy requiring hospital intervention; or • in children with diagnosed obstructive sleep apnoea where other treatments have failed or are inappropriate; or • in children and adults for tonsillitis if all of the following criteria are met: Sore throats are due to tonsillitis and There are 7 or more episodes per year of sore throat requiring treatment such as antibiotics or 5 or more episodes a year for two years or 3 or episodes a year for three years and There have been symptoms for at least a year and Episodes of sore throat are disabling and preventing normal	

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			functioning GP referrals must include the practice record detailing frequency of reported episodes and prescribing in line with the criteria above. Providers should alert commissioners/CSU where this is not being included.	
	Tonsil stones (tonsilloliths)		Tonsil stones are caused by debris becoming calcified in the crevices of the tonsils. They may cause symptoms such as halitosis, sensation of a foreign body and irritation of the throat. Self-management can include gargling and prevention of the formation of tonsil stones by the use of good oral hygiene. Due to a lack of robust evidence of clinical and cost effectiveness, tonsillectomy for symptoms arising from tonsil stones is an intervention NOT NORMALLY FUNDED.	
	Myringotomy/ grommet insertion for children under 12 years old	D151	This procedure is not routinely funded. The possible option of a hearing aid and the use of nasal balloons such as Otovent must be discussed Prior approval will be considered under the following conditions:	

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			• Children to treat a tympanic membrane retraction pocket. • Children aged over 3 years old with Otitis Media with Effusion (OME) and without a second disability (such as Downs Syndrome or Cleft Palate) when: o There has been a period of watchful waiting for three months in primary care from diagnosis of OME in primary care, followed by a further period of watchful waiting for up to three months after referral; and o OME persists after the period of watchful waiting; and o The child has reported speech or language delay or behavioural problems; and o The child has a documented hearing level in the better ear of 25-30dBHL or worse averaged at 0.5, 1, 2 and 4kHz (or equivalent dBA where dBHL not available)	
	Myringotomy/ grommet insertion for adults and children over 12 years old	D151	This procedure is not routinely funded Prior approval will be considered under the following conditions This procedure is not routinely funded for adults and children ≥ 12 years old except where prior approval is granted under the following conditions:	

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			- A middle ear effusion causing measured conductive hearing loss, persisting for 3 months and resistant to medical treatments. The patient must be experiencing disability due to deafness. The possible option of a hearing aid may be discussed, at the discretion of the clinician. - Persistent Eustachian tube dysfunction resulting in pain (e.g. flying) – 3-month wait not required - As one possible treatment for Meniere's disease. - Severe retraction of the tympanic membrane if the clinician feels this may be reversible and reversing it may help avoid erosion of the ossicular chain or the development of cholesteatoma – 3-month wait not relevant - Grommet insertion as part of a procedure for the diagnosis or management of head and neck cancer and/or its complications NB It is important that conductive unilateral hearing loss present for 4 weeks should be referred to an ENT surgeon without delay	
	Functional endoscopic sinus surgery in chronic rhino-sinusitis and/or nasal polyps	E131, E132, E133, E134, E135, E136, E137, E138, E139, E141, E142, E143, E144, E145,	This procedure is not routinely funded. In line with Priorities Committee policy statement 019 (Feb 2017) Functional endoscopic sinus surgery is recommended ONLY for patients with chronic rhinosinusitis and/or nasal polyps in whom the following criteria are met:	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	Colour on traffic light scheme
		E146, E147, E148, E149, E151, E152, E153, E154, E158, E159, E161, E162, E168, E169, E171, E172, E173, E174, E178, E179	The patient has had severe and persistent symptoms despite treatment for at least twelve months AND Symptoms on optimal medical therapy have a significant impact on the patient's quality of life AND The following medical therapies have been tried with inadequate response or are contra-indicated • Regular use of saline douching and nasal steroid AND • For patients with nasal polys, attempts at medical polypectomy using prednisolone or a topical steroid AND/OR • For patients with chronic rhinosinusitis, an oral antibiotic + douche + topical steroids	
Cosmetic/Plastic/ Aesthetic surgery	Excision of skin following massive weight loss	S021, S022, S028, S029,	These procedures are not routinely funded Removal of excess skin including abdominoplasty, mammoplasty and removal of skin folds from the inner thighs following significant weight loss may be considered under all the following conditions : 1. The patient's starting BMI before weight loss must have been no less than the access criteria for bariatric surgery. 2. The patient's BMI must be less than 30kg/m2 or the patient has lost at least 75% of the excess weight.	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	Colour on traffic light scheme
			3. The patient's target weight has both been documented as being achieved and maintained for a period of at least six months, 4. The patient is proven to be a non-smoker. 5. The patient is experiencing significant functional disturbance with a measurable reduction in the "Barthel ADL Score" due to the excess skin which is likely to improve with its removal.	
Dermatology/ general surgery removal of benign 'lumps and bumps'	Surgical removal of skin lesions.	C122, C123, C125, C126, C128, C129, C191, C198, D021, D022, D028, D029, E094, S048, S049, S051, S052, S053, S054, S055, S058, S059, S061, S062, S063, S064, S065, S066, S067, S068, S069, S081, S082, S083,	CCGs do not routinely fund these procedures Treatments carried out are subject to 'trust and verify' verification process as detailed in section one of this document. Referrals to secondary care for skin lesions should **only be made directly to dermatology/general surgery** where there is suspicion of malignancy. All other referrals for benign lesions including lipomas **are not routinely funded**. Removal will only be considered if all reasonable self –care has been attempted and at least one of the following criteria is met: - The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires 2 or more courses of antibiotics (oral or intravenous) per year. - The lesion bleeds in the course of normal everyday activity.	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	Colour on traffic light scheme
		S088, S089, S101, S102, S103, S104, S105, S108, S109, S111, S112, S113, S114, S115, S118, S119, S601, S602, S603, S604, S605, S606, S607, S608, S609	- The lesion causes regular pain which affects daily functioning. - The lesion is obstructing an orifice or impairing field vision to the extent that the person does not meet DVLA standards for driving. - The lesion significantly impacts on function and causes a reduction in the Barthel ADL Score which is likely to improve after intervention. - The lesion causes pressure symptoms such as on a nerve. - If left untreated, more invasive intervention would be required for removal. - Lipomas on the body > 5cms, or in a sub-facial position, with rapid growth and/or pain. These should be referred to a Sarcoma clinic.	
Orthopaedics	Patellar knee resurfacing as part of total knee replacement	W401	In line with Priority committee statement 015. Treatments carried out are subject to ‘trust and verify’ verification process as detailed in section one of this document.	
Urology	Treatment of	N111, N112,	In line with Priorities Committee policy statement 26	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	Colour on traffic light scheme
	hydrocele	N113, N114, N115, N116, N118, N119, T193	Surgery for hydrocele should only be offered under the following conditions • Interventions in children should be delayed until at least 2 years of age • Surgical treatment should only be offered where there is significant discomfort preventing voiding, sexual function, mobility or dressing Ultrasound may be of value in initial assessment where there is diagnostic uncertainty but should not be repeated	
	Vasectomy (under general anaesthesia)	N17*	Vasectomy under general anaesthesia should only be offered following referral from tier 2 urology services where absolutely clinically necessary	
Endocrinology/ diabetes	'Flash' libre glucose monitoring in diabetes	n/a	In line with Priorities Committee statement 28 (Jan 2018) Flash' glucose monitoring systems such as the Freestyle Libre may be recommended in patients with Type 1 diabetes or those with Type 1 or 2 diabetes who are pregnant and who fulfil one or more of the criteria below: • Patients who are clinically required to undertake intensive monitoring with 8 or more finger prick blood tests daily. • Those who meet the current NICE criteria for insulin pump	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	Colour on traffic light scheme
			therapy (HbA1c >69.4mmol/mol) or disabling hypoglycaemia as described in NICE TA151 where a successful trial of flash glucose monitoring may avoid the need for pump therapy • Those who have recently developed impaired awareness of hypoglycaemia, when it may be used as an initial tool in its management with a review at 6 months. • Frequent (>2 per year) hospital admissions with diabetic keto-acidosis or hypoglycaemia where other management plans have failed. Those requiring third parties to carry out monitoring or where conventional blood testing is not possible. This method of monitoring must not to be initiated in a primary care setting and should only be initiated or recommended by the consultant-led service.	
Gynaecology	Female sterilisation	Q271, Q272, Q278, Q279, Q281, Q282, Q283, Q284, Q288, Q289, Q351, Q352, Q353, Q354, Q358, Q359, Q361, Q362, Q368, Q369	This procedure is not routinely funded In line with Priorities Committee statement 45 (Jan 2019) Prior approval will only be funded as a standalone or during a caesarean section in women who meet all the following criteria • The woman understands the procedure is irreversible and attempts at reversal will not be routinely funded • She is certain her family is complete.	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	Colour on traffic light scheme
			• She understands that vasectomy in her partner is the preferred option but that the male partner is unwilling or unable to consent or where vasectomy is not feasible. • She has been counselled on all other forms of contraceptives and has either undergone an unsuccessful trial of Long Acting Reversible Contraception (LARC) or where LARC is contra-indicated or inappropriate • She understands the requirement to avoid sex or use effective contraception until her menstrual period following the procedure and that sterilisation does not prevent risk of sexually transmitted infection • She has been counselled before caesarean section in order to reduce incidence of regret	
	Sativex for symptom improvement in adult patients with moderate to severe spasticity due to multiple sclerosis		In line with Priorities Committee Policy Statement 64 The CCG supports the restricted use of Sativex in line with NICE Clinical Guideline number 144 (November 2019), and in accordance with its recommendations. Prescribing should be initiated by the specialist and continued for 3 months, after which time the patient should be reviewed. If the individual's response remains in line with the criteria above, consideration of transfer to GP prescribing may be appropriate with specialist symptom review after the first 6 months, and then periodically as normally required.	

The specialties listed below are a guide only and patients may be treated under different treatment function codes	Procedure	OPCS codes	Guidance notes	Colour on traffic light scheme
Infertility Treatments	Cryopreservation		Prior approval may be considered ahead of NHS treatment that is likely to render the patient infertile.	Notification will be required for invoice validation

Appendix 4

NOTES ON COSMETIC/ PLASTIC SURGERY

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

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

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

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

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

Social and psychological circumstances (adopted from Dorset CCG policy, 2015)

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

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

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

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

Appendix 5

Restricted Treatments and Procedures Reference Framework

This schedule sets out the key meeting forums where the evidence for procedures, treatments and interventions is considered, recommendations made and decisions about local criteria based restrictions for access to NHS funded treatment.

	Hampshire Priorities Committee Meeting	Joint Commissioner - Provider Meeting	Commissioner – RTAP Steering Group	Commissioner Governance Process – Cabinet/CEG
Propose Of Group and Terms of Reference	The Priorities Committee operates as an advisory body to the eight Clinical Commissioning Groups [CCGs] across SHIP. Its role is to provide them with evidence based, carefully considered recommendations to inform the commissioning policies of the constituent CCGs. HPC - Term of Reference.pdf HPC - Ethical Decison Making Framework.pc	Commissioners and provider leads will meet at regular intervals throughout the year to discuss proposed commissioning decisions and consider changes to the operational Policy. Provider RTAP Engagement Meeting:	The Restricted Treatment and Procedure Steering Group is a Commissioner forum to provide clinical and strategic leadership on the development and evaluation of proposals for inclusion as a treatment or procedure which is restricted by clinical criteria for NHS Funding. The Group has a key function in the review of prior approval request outcomes. This is to determine appropriate future classification of listed procedures, ensure system learning and reduce unnecessary burden on providers. RT&PSG-Terms of Reference 2017-18.p	West Hampshire Clinical Cabinet and North Hampshire Clinical Executive Committee provide clinical and strategic leadership to their respective CCG Executive teams and Governing bodies.

Outcomes	Recommendations on procedures and treatments which should be considered ‘low priority’ for NHS Funding.	Action planning in preparation for new procedures and changes to Policy.	Review of Hampshire Priorities Committee recommendations and make recommendation to Clinical Cabinet and Governance Committees on the adoption (or not) by the CCG into local Policy. Oversight of Policy development and implementation. Assurance of due process and adherence to local Policy.	Assurance of clinical oversight of and review of recommendations to adopt clinical criteria which restrict access to specified treatments and procedures in the local health economy. Provide Clinical direction to CCG Policy. Support for adoption or not of RTAP Steering Group and/or Hampshire Priorities Committee recommendations.

Appendix 6: NICE Guidance In Relation To Clinical Policies

NICE Technology Appraisals

West Hampshire Clinical Commissioning Group has a legal duty to provide funding for treatments recommended within NICE Technology Appraisals normally within three months of the date of publication unless the treatments have been exempted by the Secretary of State. This duty covers only the condition/s and clinical criteria stated within the Technology Appraisal. The duty does not cover treatments for which the commissioning responsibility lies with another NHS body such as NHS England Specialised Commissioning.

Where NICE Technology Appraisal exists this is the policy of the CCG.

NICE Guidelines and/or Interventional Procedures Guidance and other non-mandatory NICE guidance.

NICE clinical guidelines and public health guidelines relate to whole pathways of care and can make a large number of recommendations spanning all stages of care from diagnosis to treatment. In view of their complexity, NICE clinical and public health guidelines are not subject to statutory funding directions. **They are advisory and their local implementation is therefore at the discretion of NHS West Hampshire CCG**.

NHS West Hampshire CCG will carefully consider NICE and other guidelines when developing strategies, planning services and prioritising resources as part of its on-going work to improve the quality of care and health outcomes for the population of West Hampshire. However, the CCG reserves the right to depart from NICE guidance, if the CCG has good reason to do so.

NHS West Hampshire CCG reserves the right to develop a local policy based on the principles within the Restricted Treatments, Procedures, and Interventions Policy, and in accordance with local need. This Policy and procedures within it may or may not be consistent with such NICE Guidance.

Non-mandatory NICE guidance does not form CCG policy unless and until formally adopted as such.

NB: The adoption of non-mandated NICE guidance should be at least cost neutral and within the agreed West Hampshire CCG contract activity plan. Where the adoption of non-mandated NICE guidance is expected to increase the cost of care or deviate activity from the agreed activity plan, then the provider should present West Hampshire CCG with a full business case, through their Business Team and Contract Lead. Any such guidance should not be adopted or implemented until formally agreed by the CCG.

To be read in conjunction with the following documents;

The above policies, along with pro-forma where applicable will be published on the CSU website (www.fundingrequests.cscsu.nhs.uk then click 'Hampshire') and publically available through the CCG's website.

Appendix 7

Procedure for Individual Funding Requests, exceptionality, scope and remit of the IFR Referral Panel

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

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

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

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

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

Such requests should not be confused with

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

2 REFERRALS TO BE DEALT WITH UNDER THE POLICY - EXCEPTIONALITY

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

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

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

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

This statement still provides a rationale for decision-making as much now as it did then. Since 2008, further guidance was issued by the then NHS Commissioning Board (now NHS England) in preparation for new commissioning structures from 2013-14. This is quoted as follows from the draft generic commissioning policy used by NHS England Area Teams in addressing specialised services IFRs.

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

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

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

3 POLICY SCOPE

. In general this policy covers

- Priorities Committee recommendations
- healthcare not normally purchased
- drugs and devices outside of national tariff

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

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

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

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

Conditions for submission to the IFR panel

The patient should be registered with a GP practice belonging to the relevant CCG or, if not registered with any GP, lives within the geographical responsibility of the CCGs and is eligible for NHS treatment. If this is not clear then the Responsible Commissioner guidance from NHS England applies https://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf

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[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 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 normally be endorsed by a GP or consultant.
- The procedure/treatment is not already purchased under existing service agreements.
- Patient Choice guidelines will apply where relevant.
- For a treatment covered under this policy and the CCGs hold a contract covering a relevant specialty, the referral should be made by a consultant of the same specialty to a provider with whom the CCGs hold a contract.

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

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

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

4 PRIORITIES FRAMEWORK AND DECISION-MAKING

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

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

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

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

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

Assessing individual cases

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

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

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

5 PROCESS

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

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

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

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

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

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

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

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

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

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

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

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

Urgent cases

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

6 IFR REFERRAL PANEL

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

Panel remit

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

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

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

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

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

Membership (IFR Panel)

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

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

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

7 CCG APPEALS PANELS

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

Terms of reference and membership

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

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

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

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

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

Complaints

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

8 SERVICE DEVELOPMENTS

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

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

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

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

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

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

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

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

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

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

9 IMPLEMENTATION OF NICE GUIDANCE

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

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

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

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

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

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

10. MANAGING THE ENTRY OF NEW DRUGS

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

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

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

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

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