Policy and Procedure for Non-Contractual Referrals Guidance for clinical practice

Title:	Policy and Procedure for Non-Contractual Referrals	
Policy Reference Number:	COR/CMG.06/V2.01	
Summary:	This document sets out the Policy and Procedure for Hampshire PCT with respect to treatments which are not normally funded, In general this policy covers - low priority procedures/ treatments - healthcare not normally purchased or routinely commissioned - drugs outside of national tariff	
Associated Documents:	The PCT will comply with mandatory Technology Appraisal Guidance published by the National Institute for Health and Clinical Excellence (NICE)	
Target Audience:	All staff of Hampshire Primary Care Trust	
Document Version:	Version 2.01	
Date of this Version:	1 March 2010	
Date Issued:	1 March 2010	
Author's Name:	C Ashdown, Contracting Manager (NCRs)	
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Approved by:	PCT Management Committee (Operations)	Date of meeting: 27/01/2009
Ratified by:	Hampshire Primary Care Trust Board	Date of meeting 29/01/2009:
Signature of **Chief Executive:**		Date:

POLICY DEVELOPMENT DOCUMENT CONTROL PANEL

Policy Title: Policy and Procedure for Non-Contractual Referrals		
Policy Reference Number: COR/CMG.06/V2.01		
Version Number: 2.01	**Date of Issue: 1 March 2010**	**Review Date: May 2010**
Policy Custodian: Dr M Ashton-Key		
Designation: Area Director of Public Health (North and East		
Email Address: Martin.Ashton-Key@hampshirepct.nhs.uk		
Is this a new policy?		**No**
If 'Yes', why is it required? *Hampshire-wide update*		
How does the Policy link to:		
Standards for Better Health	*Core Standards*	
NHSLA PCT Risk Management Standards	*Standards:*	
National Service Framework		
Other (please specify):	*NICE Technology Appraisal Guidelines*	
If 'No', name of previous policy and reason for replacement:		
Who has been involved/consulted in order to develop this Policy? Amendments: Hampshire PCT PEC – 12/12/2006		
For review at Area Panels, Area Professional Advisory Committees and NCR leads		
Approval: Hampshire PCT PEC – 12/02/2007		
Review history dates: Hampshire PCT PEC – 12/02/2007 1.5.07 amendment to orthopaedic exclusions 18.9.07 varicose vein procedures – all procedures not 'stripping' only Change to Healthcare Commission deadlines for patients – 2 to 6 months December 2008 – policy review PCT Professional Advisory Committee January 2009 – policy review PCT Management Committee (Operations)		
Has the Trust's Legal Services Manager checked this policy?		**No**
Summary of significant changes made:		
May 2009	Policy reviewed at PCT Management Committee (Operations) Version 2.00 produced and logged with Compliance Unit	
Sept 2009	Review of nomenclature following Panel changes (V2.01 logged with Compliance Unit)	
Approval Route:	PCT Management Committee (Operations)	**Date: May 09**
Ratification Route:	N/A	**Date:**

1 INTRODUCTION

This document sets out the Policy and Procedure for Hampshire PCT with respect to treatments which are not normally funded. 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 Non-Contractual Referrals (NCRs). In general this policy covers

- low priority procedures/ treatments
- healthcare not normally purchased or routinely commissioned
- drugs outside of national tariff

NCRs are addressed by a lead manager, commissioning colleagues, members of the public health directorate and a structure of Referrals Panels.

NB. The PCT will comply with mandatory Technology Appraisal Guidance published by the National Institute for Health and Clinical Excellence (NICE)

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

2 REFERRALS TO BE DEALT WITH UNDER THE POLICY

If, as a clinician you believe that the case of an individual patient is so singular as to justify funding for an NCR, you may apply for the case to be considered individually by the PCT. All requests should be in writing using the PCT NCR funding request form (found at appendix 1 and available on the PCT website at http://www.hampshire.nhs.uk/about-us/346-commissioning-policies) and supported by;

- 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.

Exceptionality - this is best expressed by the question 'On what grounds can the PCT justify funding a particular patient over and above others from the same patient group who are not being funded?'

The following is an excerpt from the NHS Confederation guide 'Priority setting: managing individual funding requests' 2008 which clarifies this:

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

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

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

In the event that the PCT approves an NCR, this does not necessarily set any precedent and relates to the individual patient only. The PCT holds no contingency reserve to meet in-year calls on resources. Therefore it must be understood that any funding will lead to a withdrawal of resource elsewhere within the health economy.

3 REFERRAL AND POLICY SCOPE

- The patient should be registered with a GP practice belonging to the PCT or, if not registered with any GP, lives within the geographical responsibility of the PCT and is eligible for NHS treatment. If this is not clear then the Responsible Commissioner guidance from the Department of Health should be consulted and applied
- The provider can meet the PCT waiting time target and quality standards as per Healthcare Assurance Standards guidelines
- **Only an NHS GP, NHS GDP or NHS Consultant** can make a funding request. Allied health professionals and specialist nurses can also make referrals though these should be endorsed by a GP or consultant.
- The procedure/treatment is not already purchased under existing service agreements.
- (NB. Referrals for a second opinion should be made to an alternative provider with whom the PCT holds a contract.)
- Patient Choice guidelines will apply where relevant.
- Where contracts do not offer a specific procedure/treatment, but the PCT has a contract covering a relevant specialty, the referral should be made by a consultant of the same specialty to a provider with whom the PCT holds a contract.

The NHS Confederation definition of an individual funding request in " Priority setting: managing individual funding requests."
Is 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"*

In addition, the PCT may have considered a treatment to be a low priority against other competing healthcare priorities within a limited resource envelope. This can often be on the advice of the Hampshire & Isle of Wight Priorities Committee.

Where a Non-Contractual Referral is required, referrers are asked to consult with the PCT to see if there is a contract in place with the provider.

The PCT 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 this includes any future continued treatment by the private provider.

4 PROCESS

Referrals must be submitted on the appended 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. Appropriate NCRs will be considered by the NCR Lead or the Hampshire Referrals Panel (PANEL) which meets every two weeks. Referrals leading to a possible policy change, those in an area of contention, or appeals against a Panel decision will be considered by the Hampshire PCT Appeal Panel.

The referral should be clinically led and the PCT 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. The referring clinician should act as the patient's representative and responses to funding requests will be made direct to the referrer.

Before reaching the Panel, all requests will be addressed by the NCR Lead and, in cases where the referral clearly does not meet the exceptional circumstances set out within the exceptions policy, set out in Paragraph 2 above will be declined with a letter of explanation. The NCR Lead 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 PCT's Non-Contractual Referral 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 PCT policy should refer such cases to the 'parent' Hampshire PCT Appeals Panel.

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. In exceptional circumstances or where an urgent decision is required it may be necessary for the Panel to consider a case virtually i.e. e-mail, telephone discussion, fax etc.

The NCR Lead will share Panel decisions with neighbouring PCTs in Hampshire and the Isle of Wight to maintain consistency via a monthly report made to the Hampshire and Isle of Wight Priorities Committee.

5 HAMPSHIRE PCT REFERRAL PANEL

In order to meet the demand from the volume of referrals, the PCT has a structure of the Hampshire PCT Referral Panel and a 'parent' Hampshire Appeal Panel.

Panel remit

It is important that all decisions made by Panels are transparent, defendable and consistent, observing PCT corporate principles, available NICE guidance, advice from the Hampshire and Isle of Wight Priorities Committee and the available evidence base. After a decision has been made, a full written explanation will be provided to the referrer.

All referrals should be directed to the NCR Lead. All referrals received via other routes should be passed to the NCR Lead. No member of the Panel should make decisions on their own outside of the Panel

Membership (Hampshire Referrals Panel)

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

Senior GP/Area Professional Advisory Committee Chair (Chair)
Public Health Consultant
Associate Director / Key Contracting Manager (Contracting)
At least 3 locality clinicians/ GP Advisors (possibly nominated via the APAC)
Nursing/pharmacy representation (as and when required)
Commissioning/ NCR lead

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.

6 HAMPSHIRE PCT APPEALS PANEL

Draft terms of reference and membership
The Hampshire PCT Appeals Panel has the same remit of the Hampshire Referral Panel but receives funding requests/cases that have already been considered by the 'lower' Panel and are subject to first appeal or challenge, or the Panel has decided to refer 'upwards' to the Hampshire PCT Appeals Panel for one of the following reasons:
a) the treatment requested has not been previously considered by the PCT
b) there has been an appeal by the referrer against a Panel decision which the Panel believes should be considered on a PCT-wide basis;
c) any funding decision might impact on the exceptions policy or there might be a bearing on future commissioning decisions across Hampshire PCT.

Alternatively, if at the time of receiving the original request it is clear that either reason a) or c) apply then the request may be submitted directly to the Hampshire PCT Appeals Panel.

Membership
Suggested membership is as follows;

PCT Clinical Director (Chair)
Public Health doctor/ consultant
Pharmacy/ nursing lead (as and when appropriate)
1 locality clinician/ GP Advisor (possibly pooled from Area Referral Panels and attending on a rota basis)
Commissioning/ NCR lead (supporting Panel)

The quorum of the Appeals Panel is 3 members including 2 clinicians. Additional members may be co-opted as the need arises.
Consideration should also be given for involvement of a PPI/lay member (possibly nominated from area PPI Forums)

7 APPEALS

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 NCR Lead with additional supporting information/evidence. If the information provided contains new evidence the referral should be reconsidered at a meeting of the Hampshire Referral Panel. If their decision remains unchanged the referral will be directed to the Hampshire PCT Appeals Panel.

If the decision in an individual NCR request made by either the Panel or Appeals Panel is appealed against by the referring clinician, there is a further opportunity to appeal to the Hampshire PCT final appeals body. The Appeals Body comprises of:

- the Chief Executive of the PCT
- the Executive Director of Public Health
- a PCT non-executive Director / Chair of the PCT Board (chairing)

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.

The role of the Appeals Body is to judge whether the process and framework by which a funding decision is made 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. Should the Appeals Body overturn the decision of a 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 PCT 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 PCT Appeals Body is final.

Complaints

Patients have the right to raise a formal complaint with the PCT using the NHS Complaints Procedure should they be unhappy with the PCT's handling of their case (i.e. staff attitude, communication or the way in which the policy or procedure has been followed). 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 DECISION-MAKING FRAMEWORK

The PCT has the power to make decisions in commissioning services for its population. It 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.

The PCT's decision making is based on the document at Appendix B – 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 has been developed to support robust and transparent ethical decision-making and has been agreed and adopted by all nine PCTs in NHS South Central.

Assessing individual cases

The following information should be used by the PCT 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 PCTs within the Strategic Health Authority area)
- Advice from the Hampshire and Isle of Wight Priorities Committee
- Corporate view
- Views and position of interested parties (patient, patient body, carers, health professionals, politicians, media)

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9 IMPLEMENTATION OF NICE GUIDANCE

NICE guidance is published as a series of Technology Appraisal Guidance documents, 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 PCT accepts 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 the PCT 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 Trusts and the PCT. 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 PCT, 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.

The PCT commissions appropriate drug therapy as an integral part of patient care. Individual drugs should not be excluded from contracts as a separate cost item.

SECTION 2

HAMPSHIRE PCT NOT NORMALLY FUNDED PROCEDURES

The following list is not exhaustive and exceptions are **not** stated. It is for the referring clinician to provide detail of exceptional circumstances as per the appended form in light of the earlier definition of exceptionality provided by the NHS Confederation. Guidance notes are included where appropriate and only as a pointer towards consideration. A patient to whom the applicable guidance may apply is not automatically entitled to the treatment concerned.

The recommendations and policy notes of the Hampshire and Isle of Wight Priorities Committee will supersede or add to this list as well as NICE Technology Appraisal Guidance. The list below is under constant review and development.

Specialty	Policy exclusion	Guidance on exceptions
Gynaecology	Reversal of sterilisation	In circumstances of the death of a partner or only child or where sterilisation caused by proven surgical accident that was not a foreseen consequence of such a procedure.
	Dilatation and Curettage	*Dilatation and Curettage alone should not be used as a diagnostic tool and should not be used as a therapeutic procedure.* Hampshire PCT will fund dilatation and curettage if either of the following criteria is met: The patient has had outpatient negative pressure endometrial sampling (e.g. Pipelle™ sampling) with an unsatisfactory histological result Or The patient has had a hysteroscopy and endometrial biopsy with an unsatisfactory histological result
	Hysterectomy	1. Hampshire PCT will fund hysterectomy for heavy menstrual bleeding or dysmenorrhoea if all the following criteria are met: Other treatments for heavy menstrual bleeding (in accordance with NICE Clinical Guideline 44 “Heavy Menstrual Bleeding”) or dysmenorrhoea have failed or are contraindicated And There is a wish for amenorrhoea And

Specialty	Policy exclusion	Guidance on exceptions
		The woman no longer wishes to retain her uterus and fertility 2. Hampshire PCT will fund hysterectomy for the treatment of uterine problems amenable to surgery that are <u>not</u> related to heavy menstrual bleeding or dysmenorrhoea.
Infertility treatments	In vitro fertilisation (including the prescriptions of infertility drugs) and ICSI (intracytoplasmic sperm injection)	As per the Hampshire & IOW policy criteria
Ophthalmology	Short sight/long sight corrective (laser) surgery	May be considered where laser or operative correction is the only treatment available to restore reasonable visual acuity/or where there are substantial other medical reasons that make correction by external visual aids inappropriate.
ENT/Oral	Wisdom teeth extraction	As per NICE guidance

Specialty	Policy exclusion	Guidance on exceptions
	Grommets	1. Hampshire PCT will fund treatment with grommets in children with disabilities such as Downs Syndrome and Cleft Palate where the insertion of grommets is part of an established pathway of care. 2. Hampshire PCT will fund treatment with grommets in children to treat a tympanic membrane retraction pocket. 3. Hampshire PCT will fund treatment with grommets in 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: There has been a period of watchful waiting for three months in primary care from diagnosis of OME in primary care, followed by a further period of watchful waiting for up to three months in ; secondary care; and OME persists after the three-six months of watchful waiting; and The child has documented speech or language delay or behavioural problems; and The child has a documented hearing level in the better ear of 25-30dBHL or worse averaged at 0.5, 1, 2 and 4kHz (or equivalent dBA where dBHL not available)

Specialty	Policy exclusion	Guidance on exceptions
	Tonsillectomy	1. Hampshire PCT will fund tonsillectomy in children and adults for cancer or suspected cancer. 2. Hampshire PCT will fund tonsillectomy in children and adults for cases of quinsy. 3. Hampshire PCT will fund tonsillectomy in children and adults for obstructive sleep apnoea where other treatments have failed or are inappropriate. 4. Hampshire PCT will fund tonsillectomy in children and adults for tonsillitis if all of the following criteria are met: • Sore throats are due to tonsillitis • There are 5 or more episodes of sore throat per year (confirmed in Primary Care) • There have been symptoms for at least a year • Episodes of sore throat are disabling and prevent normal functioning
	Bone-anchored hearing aids	Considered in patients over the age of 5 years who: • Have abnormalities of the middle, outer or external parts of the ear or a chronic ear infection, which makes wearing a conventional hearing aid difficult or impossible. • Have a hearing loss in both ears that cannot be operated on and for which conventional hearing aids are not felt to be suitable. • Can hear sounds well via bone conduction. • Can understand 60% or more of speech on a standard test using bone conduction. • Are able to keep the area around the fixture clean, alone or with help.
Plastic/ cosmetic procedures surgery (see appendix for further detail)	**Any procedure carried out for primarily cosmetic reasons is excluded i.e. not funded**	**See Appendix C**
	Rhinoplasty	Only in cases of post-surgical reconstruction following trauma or for congenital malformation
	Dermabrasion	Only for disfiguring burnt out acne where there has been previous specialist treatment
	Tattoo removal	
	Varicose vein procedures	This will be commissioned in accordance with

Specialty	Policy exclusion	Guidance on exceptions
		the Hampshire and Isle of Wight Priorities Committee policy statement. Hampshire PCT will fund varicose vein surgery in people with a body mass index less than 32 who satisfy at least one of the following criteria: • a recurrent venous ulcer (OR) • a first venous ulcer which persists despite a six-month trial of conservative management (compression stockings, exercise and daily elevation two to three times a day) (OR) • haemorrhage from a superficial varicosity Treatment in all other circumstances is LOW PRIORITY and not routinely commissioned. Surgical treatment may be with ligation and stripping, phlebectomy and/or foam sclerotherapy. All techniques which involve heating the vein (whether by laser, radio-frequency, microwave or any other means) are LOW PRIORITY and not routinely commissioned.
	Treatment of ganglions	This procedure will not be routinely commissioned for new patients from 01 July 2009. Any requests for the procedure will have to made using the Non-Contractual Referral Request process based on exceptionality.
	Liposuction/lipectomy (including apronectomy)	
	Mastopexy (repositioning of nipple)	Only as part of post-surgical reconstruction
	Buttock lift	
	Breast augmentation surgery or correctional procedures	As per the HIOW Priorities Committee policy statement
	Breast reduction surgery	
	Pinnaplasty	
	Eyelid surgery	Where affecting visual fields.

Specialty	Policy exclusion	Guidance on exceptions
	Removal of benign asymptomatic skin lesions and blemishes including skin tags anywhere on the body	
Alternative/ complementary/ homeopathic therapies	Complementary medicine	
Gender dysphoria	• Psychological assessment • Gender reassignment Laser hair removal • Vocal chord shaving	Consideration following full psychiatric assessment by local services. Referrals, where agreed, made to Charing Cross Gender Identity Service only (meeting ICD10 criteria)
Mental health	Inpatient psychotherapy	
	Inpatient treatment for chronic fatigue syndrome	As per the HIOW Priorities Committee policy statement
	Non-NHS residential placements	
	Adult ADHD and Aspergers'	Should be covered by Hampshire Partnership Trust's own out-of-area budget and only where accompanied by serious mental health illness
Orthopaedics	Sports limbs	
	Appliances and devices for cosmetic purposes (high-grade silicon cosmesis and/or prosthesis)	
	Arthroscopic lavage and debridement of the knee in patients with osteoarthritis	This will be commissioned in accordance with the Hampshire and Isle of Wight Priorities Committee policy statement.
	Facet Joint Injections for Chronic Low Back Pain	This procedure will only be commissioned in line with NICE guidance CG88 May 2009. Any requests outside this guidance must be made using the Non-Contractual Referral request process based on exceptionality.
Others	Hyperbaric treatment	Emergency decompression is the only funded exception
	Insulin pump therapy	As per NICE Technology Appraisal Guidance.

Specialty	Policy exclusion	Guidance on exceptions
	Bariatric surgery for morbid obesity	In accordance with service specification managed by Central South Coast Specialist Services Confederation and their own separate funding application form (**see Appendix D**)
	Single-incision sub-urethral short tape insertion for stress urinary incontinence in women	Excluded as per NICE Interventional Procedures Guidance 262
	Electronic spinal cord stimulator implants for management of pain	Considered only following failure of other interventions for chronic pain in patients with non-reconstructable chronic critical leg ischaemia, complex regional pain syndrome and patients with angina who are not suitable for revascularisation.
	Silver releasing dressings for management of chronic wounds	
	Male circumcision	This will be commissioned in accordance with the Hampshire and Isle of Wight Priorities Committee policy statement.
	Botox injections	
Dentistry	Secondary orthodontic treatment	As per Hampshire NHS Orthodontic Care Pathway (see NHS Orthodontic Care – Area Referral Panels, Guidance for General Dental Practitioners).
	Advanced restorative dental	Considered to replace permanent teeth missing post major trauma, post cancer treatment or significant congenital absence to allow patient to masticate effectively.
Laser treatments	Warts	
	Rosacea	
	Scars	
	Thread veins / venous flares	
	Spider naevi	
	Telangiectasia	
	Tattoo removal	
	Seborrhoeic keratoses	

Specialty	Policy exclusion	Guidance on exceptions
	Inflammatory acne vulgaris	
	Port wine stains / benign facial lesions	Exceptional disfigurement considered
	Hair removal	
	Resurfacing	Possible alternative to dermabrasion

Appendix A

NON-CONTRACTUAL REFERRAL – FUNDING REQUEST FORM

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

On completion the request form and all supporting materials as defined within this request form should be posted, faxed or emailed to Chris Ashdown, Contracting Manager (NCRs) – contact details included at the end of this form.

*All sections are to be completed in requests from secondary care and specialist provider services. In recognition of the nature of requests from primary care those sections denoted by an asterisk **(*)** are to be completed at the discretion of the requesting general practitioner.*

CONTACT INFORMATION

Trust / General Practice Surgery Name		
1. Address		
2. Applicant Details	***Name:***	
	Designation:	
	Tel:	
	Email:	
3. Patient Details	***Name:***	
	Hospital ID number:	
	NHS Number:	
	DoB:	
	Registered Consultant:	
	Registered GP name:	
	Registered GP postcode:	
	Referred by (other than GP):	
	Referred from:	
	Date of referral:	
4. Application reviewed by	***Name:***	

Chief Pharmacist or nominated deputy (in the case of a drug intervention)	***Signature or email confirmation:***	

INTERVENTION REQUESTED *(NB: Intervention refers to requested treatment, investigation, etc)*

5. Patient Diagnosis (for which intervention is requested)		
6. Details of intervention (for which funding is requested). ***If the intervention forms part of a regimen, please document the full regimen*** *(e.g. Drug X as part of regimen Y (consisting of drug V, drug W, drug X and drug Z).* *Regarding anticipated cost Acute Trusts to provide this from finance departments and primary care to seek advice from their Practice Based Commissioning Locality Manager.*	***Name** of intervention:*	
	***Dose and frequency (*)**:*	
	Planned duration (*) *Of intervention:*	
	***Route of administration (*)**:*	
	Anticipated cost (inc VAT)	
	Are there any offset costs? (*)	*Delete as appropriate: **Yes/No** (refer to pharmacy if required)*
	Describe the type and value of the offset costs (*)	
	Funding difference being applied for (*)	
7. Is requested intervention part of a clinical trial?	*Delete as appropriate: **Yes / No*** *If **Yes**, give details (e.g. name of trial, is it an MRC/National trial?)*	
	Is the drug funded through a clinical trial? *Delete as appropriate: **Yes / No***	
8. (a) What would be the standard intervention at this stage?		
(b) What would be the expected outcome from the standard intervention?		
(c) What are the exceptional circumstances that make the standard intervention inappropriate for this patient?		
(d) Please explain how this individual has an exceptional ability to benefit from the requested intervention over and above another individual with the same condition.		
(e) If the requested intervention was not available what would your next planned intervention be?		
*9. (a)In case of intervention for **cancer**:*	*What is disease status? (e.g. at presentation,1st/2nd or 3rd relapse)*	

	*What is the WHO performance status? **(*)***		
	How advanced is the cancer? (stage)		
	Describe any metastases:		
*(b) In case of intervention for **non-cancer**:*	*What is the patient's clinical severity? (Where possible use standard scoring systems e.g. WHO, DAS scores, walk test, cardiac index etc.)*		
*(c) In case of intervention for **all conditions** (i.e. cancer and non-cancer)*	*Please summarise the current status of the patient in terms of quality of life, symptoms etc*		
10. Summary of previous intervention(s) this patient has received for the condition. *Reasons for stopping may include (not exclusively):* ▪ *Course completed* ▪ *No or poor response* ▪ *Disease progression* ▪ *Adverse effects/poorly tolerated*	***Dates***	***Intervention (e.g. drug / surgery)***	***Reason for stopping / Response achieved***
11. Anticipated start date	*Processing a request **usually takes up to 2 weeks** from the date received by the PCT. If the case is more urgent than this, please state why:*		

EVIDENCE OF CLINICAL EFFECTIVENESS

12. Where the intervention is a drug / medicine is the requested drug / medicine licensed for the requested indication in the UK?	*Delete as appropriate: **Yes / No** (refer to pharmacy if required)*
*13. Has the Trust Drugs and Therapeutics Committee or equivalent Committee approved the requested intervention for use? (if drug or medical device) **(*)***	*Delete as appropriate: **Yes / No*** *If **No,** Committee Chair or Chief Pharmacist approved: **Yes / No***
*14. Give details of National or Local Guidelines / recommendations or other published data / evidence base supporting the use of the requested intervention for this condition? **(*)***	***PUBLISHED[1] trials / data** (Please forward papers / web links for peer-reviewed papers where available. **This needs to be supplied for all secondary care and specialist provider requests – the request will not be considered if these have not been included.**)*
15. (a) How will you monitor the clinical effectiveness of this intervention?	

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

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

PCT use only

Record of communication:	
Points for Discussion	
▪	
Recommendation:	
▪	
Date:	

Contact details for Non-Contractual Referral Submissions

All Non-Contractual Referral submissions should be made using the Hampshire Primary Care Trust Non-Contractual Referral – Funding Request Form **and provide all the required information as outlined in the Funding Request Form**. The form should be completed electronically / typed – hand written submissions will not be accepted.

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

Chris Ashdown
Contracting Manager (NCRs)
Hampshire PCT
Omega House
112 Southampton Road
Eastleigh
Hants SO50 5PB

Tel: 02380 627444
Fax: 02380 620343
E-mail: hampshire.ncrs@nhs.net

Appendix B

SOUTH CENTRAL ETHICAL FRAMEWORK

Berkshire East PCT	Berkshire Priorities Committee (BPC)
Berkshire West PCT	
Buckinghamshire PCT	Buckinghamshire and Milton Keynes Priorities Committee (BMKPC)
Milton Keynes PCT	
Oxfordshire PCT	Oxfordshire Priorities Forum (OxPF)
Hampshire PCT	Hampshire and Isle of Wight Priorities Committee (HIOWPC)
Isle of Wight PCT	
Portsmouth City Teaching PCT	
Southampton City PCT	
South Central Specialised Services Commissioning Group (SCG)	
Central South Coast and Thames Valley Cancer Networks (CN)	

Background

The Priorities Committees are committees of representatives of the NHS organisations across all nine South Central NHS Primary Care Trusts (PCTs) and include lay members as well as clinicians and managers. The purpose of the 'Priorities Committees' is to advise the local NHS health economy as to the health care interventions and policies that should be given high or low priority.

Primary Care Trusts are under a statutory duty to promote the health of the local community. They are also under a duty not to exceed their annual financial allocation. These legal requirements mean that, from time to time, difficult choices have to be made. The Priorities Committees help PCTs choose how to allocate their resources to promote the health of the local community. Individual cases are considered by each respective PCT.

A review of the existing ethical frameworks of the Thames Valley and Hampshire and Isle of Wight has contributed to the development of a South Central wide ethical framework to support decision making across all of South Central both within the established Priorities Committees and also within the SCG/networks or individual PCTs. For the purposes of this document, all the above organisations will be referred to collectively as the 'Committees'.

Purpose of the Ethical Framework

The purpose of the ethical framework is to support and underpin the decision making processes of constituent organisations and their Priorities Committees to support consistent commissioning policy through:

- Providing a coherent structure for discussion, ensuring all important aspects of each issue are considered
- Promoting fairness and consistency in decision making from meeting to meeting and with regard to different clinical topics, reducing the potential for inequity
- Providing a means of expressing the reasons behind the decisions made.
- Reducing risk of judicial review by implementation of robust decision-making processes that are based on evidence of clinical and cost effectiveness and an ethical framework
- Supporting and integrating with the development of PCT Commissioning Plans

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

community. The Committees recognise that their discretion may be affected by National Service Frameworks, National Institute for Health and Clinical Excellence (NICE) technology appraisal guidance and Secretary of State Directions to the NHS.

The Ethical Framework is especially concerned with the following:

1. EVIDENCE OF CLINICAL AND COST EFFECTIVENESS

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

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

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

2. EQUITY

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

3. HEALTH CARE NEED AND CAPACITY TO BENEFIT

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

This approach leads to three important principles:

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

4. COST OF TREATMENT AND OPPORTUNITY COSTS.

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

5. NEEDS OF THE COMMUNITY

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

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

6. POLICY DRIVERS

The Department of Health issues guidance and directions to NHS organisations which may give priority to some categories of patient, or require treatment to be made available within a given period. These may affect the way in which health service resources are allocated by individual PCTs. The Committees operate with these factors in mind and recognise that their discretion may be affected by National Service Frameworks, NICE technology appraisal guidance, Secretary of State Directions to the NHS and performance and planning guidance.

Locally, choices about the funding of health care treatments will be informed by the needs of each individual PCT and these will be described in their Local Delivery Plan.

7. EXCEPTIONAL NEED

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

Authors:	South Central Priorities Support Unit Steering Group
Date of Issue:	12th February 2008
Review Date:	1st February 2011

APPENDIX C

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 and this should only be sought at the specific request of the PCT. We would expect psychiatrists to treat related problems through established procedures that the PCT commissions from the mental health trust and this would not include surgery.

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

APPENDIX D

Bariatric surgery

The consideration of the Hampshire & IOW Clinical Priorities Advisory Forum (CPAF) in December 2005 and its policy note endorsed by all Chief Executives led to the following service specification.

1 PCTs should commission specialist bariatric surgery in the context of a care pathway. Bariatric surgery alone will have little impact on the total burden of morbidity attributable to obesity.

2 HIOW should phase implementation of the NICE technology appraisal[2] on obesity surgery, taking account of service capacity, competing priorities, and financial recovery plans.

3 Access to bariatric surgery should be via referral from a specialist obesity management service or in collaboration with a consultant in a relevant clinical specialty such as endocrinology. Surgery should be commissioned only from an agreed provider (or providers) who is (are) able to meet the standards and safety criteria within the service specification.

4 CPAF recommends the following access criteria:

The patient should have a Body Mass Index of 60 kg/m^2 or more, or of 45 kg/m^2 or more in the presence of serious co-morbidity which will be improved by surgery. The following conditions will be accepted as serious co-morbidity:

- Established ischaemic heart disease
- Type 2 diabetes requiring oral medication or insulin
- Life-threatening sleep apnoea
- Severe uncontrolled hypertension
- Benign intracranial hypertension
- History of transient ischaemic attacks or stroke
- Severe lower limb major joint disease requiring orthopaedic intervention which is precluded on safety grounds due to patient's BMI

These criteria will be continually reviewed.

5 Plastic surgical correction of redundant skin following weight loss will not be funded from NHS resources except in exceptional circumstances against the guidance protocol.

Referrals for bariatric surgery should be made on a separate application form available on request and submitted to the South Central Specialised Commissioning Group