CCG JOINT COMMITTEE MEETING

Date:  Friday 6 April 2018
Time:  3.45pm – 5.15pm
Venue: Committee Room 1, Civic Offices, New Road, Grays
       Essex  RM17 6SL

This is a meeting held in public of the Mid and South Essex STP CCG Joint Committee. Questions from the public will be permitted at the discretion of the Chair. In order to ensure that as many attendees as possible have an opportunity to raise any issues, it is requested that questions are submitted in advance or are put in writing at the start of the meeting.
Mid and South Essex STP Joint Committee¹
Friday 6 April 2018, 3.45pm – 5.15pm
Committee Room 1, Civic Offices, New Road, Grays, Essex RM17 6SL

PART I AGENDA

<table>
<thead>
<tr>
<th>Item</th>
<th>Time</th>
<th>Title</th>
<th>Lead</th>
<th>Action</th>
<th>Papers</th>
<th>Page No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>3.45 – 3.50 pm</td>
<td>Welcome, apologies for absence and declarations of interest</td>
<td>Mike Bewick</td>
<td>To note</td>
<td>Attached</td>
<td>1 - 4</td>
</tr>
<tr>
<td>2.</td>
<td>3.50 – 4.00 pm</td>
<td>Questions from the Public</td>
<td>Mike Bewick</td>
<td>To receive</td>
<td>Verbal</td>
<td>-</td>
</tr>
<tr>
<td>3.</td>
<td>4.00 – 4.05 pm</td>
<td>Minutes of Previous Meeting</td>
<td>Mike Bewick</td>
<td>To approve</td>
<td>Attached</td>
<td>5 - 9</td>
</tr>
<tr>
<td>4.</td>
<td>4.05 – 4.10 pm</td>
<td>Action Log from Previous Meeting and Matters Arising (not on agenda)</td>
<td>Mike Bewick</td>
<td>To approve</td>
<td>Attached</td>
<td>10</td>
</tr>
<tr>
<td>5.</td>
<td>4.10 – 4.25 pm</td>
<td>Value Based Commissioning Policies</td>
<td>Karen Wesson</td>
<td>To approve</td>
<td>Attached</td>
<td>11-177</td>
</tr>
<tr>
<td>6.</td>
<td>4.25 – 4.40 pm</td>
<td>IFR Policy</td>
<td>Karen Wesson</td>
<td>To approve</td>
<td>Attached</td>
<td>178-242</td>
</tr>
<tr>
<td>7.</td>
<td>4.40 – 4.50 pm</td>
<td>Cancer Alliance Update</td>
<td>Carol Anderson</td>
<td>To approve</td>
<td>Attached</td>
<td>243-258</td>
</tr>
<tr>
<td>8.</td>
<td>4.50 – 5.00 pm</td>
<td>Contracts Update</td>
<td>Louis Kamfer</td>
<td>To note</td>
<td>Attached</td>
<td>259-262</td>
</tr>
<tr>
<td>9.</td>
<td>5.00 – 5.10 pm</td>
<td>Commissioning Support Services procurement outcome and mobilisation update</td>
<td>Louis Kamfer</td>
<td>To note</td>
<td>Attached</td>
<td>263-281</td>
</tr>
<tr>
<td>10.</td>
<td>5.10 – 5.15 pm</td>
<td>Any Other Business</td>
<td>Mike Bewick</td>
<td>To note</td>
<td>Verbal</td>
<td>-</td>
</tr>
<tr>
<td>11.</td>
<td>5.15 pm</td>
<td>Close of Meeting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td>Date and time of next Joint Committee Meeting in Public:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.15-5.15 pm on 1 June 2018 in the Boardroom, 2nd floor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Education Centre, 55-57 Eastwood Road Rayleigh SS6 7JF</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

¹ The Mid and South Essex Sustainability & Transformation Plan (STP) Joint Committee is a collaborative commissioning partnership of NHS Basildon & Brentwood CCG, CastlePoint & Rochford CCG, Mid Essex CCG, Southend CCG, and Thurrock CCG
<table>
<thead>
<tr>
<th>First Name</th>
<th>Surname</th>
<th>Current Position</th>
<th>Declared Interest (Name of the organisation and nature of business)</th>
<th>Type of Interest Declared</th>
<th>Is the interest direct or indirect?</th>
<th>Nature of Interest</th>
<th>Date of Interest</th>
<th>Actions taken to mitigate risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicola</td>
<td>Adams</td>
<td>Head of Corporate Governance - Thurrock CCG</td>
<td>Aston Russell Limited, Business Consultancy</td>
<td>x</td>
<td>Direct</td>
<td>Managing Director</td>
<td>Ongoing</td>
<td>I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented</td>
</tr>
<tr>
<td>Lisa</td>
<td>Allen</td>
<td>Acting Accountable Officer, Basildon &amp; Brentwood CCG</td>
<td>Nil</td>
<td>Direct</td>
<td>Non-Executive Director</td>
<td>01/05/17</td>
<td>Ongoing</td>
<td>Interest to be declared at appropriate time should a conflict arise.</td>
</tr>
<tr>
<td>Mandy</td>
<td>Ansell</td>
<td>Thurrock CCG Accountable Officer VSM</td>
<td>Nil</td>
<td>Direct</td>
<td>Senior Clinical Advisor</td>
<td>07/07/17</td>
<td>10/11/17</td>
<td>No current assignments in Essex but would preclude me from bidding as part of local Essex based work.</td>
</tr>
<tr>
<td>Vivienne</td>
<td>Barnes</td>
<td>Director of Governance &amp;</td>
<td>Nil</td>
<td>Direct</td>
<td>Director and Founder</td>
<td>01/04/15</td>
<td>Ongoing</td>
<td>Interest to be declared at appropriate time should a conflict arise.</td>
</tr>
<tr>
<td>Mike</td>
<td>Bewick</td>
<td>Chair of Sustainability and Transformation Partnership CCG Joint Commissioning Committee</td>
<td>Medica Group.</td>
<td>x</td>
<td>Direct</td>
<td>Non-Executive Director</td>
<td>01/09/16</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

From To
<table>
<thead>
<tr>
<th>First Name</th>
<th>Surname</th>
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<th>Nature of Interest</th>
<th>Date of Interest</th>
<th>Actions taken to mitigate risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mike</td>
<td>Bewick</td>
<td>Chair of Sustainability and Transformation Partnership CCG Joint Commissioning Committee</td>
<td>Lexington Communications, independent public affairs agency.</td>
<td>X</td>
<td>Direct</td>
<td>Advisory Board Member</td>
<td>TBC</td>
<td>Any projects that might impact upon STP CCG JC Chair role to be discussed with STP Governance lead and mitigating actions agreed either at the project onset or when a potential conflict of interest becomes apparent during the course of a project.</td>
</tr>
<tr>
<td>Anand</td>
<td>Deshpande</td>
<td>Thurrock CCG Chair</td>
<td>Multiconsortium, Thurrock/Basildon Ltd. General Medical Practice Activities</td>
<td>X</td>
<td>Direct</td>
<td>Director</td>
<td>07/07/2017 Ongoing</td>
<td>I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented.</td>
</tr>
<tr>
<td>Anand</td>
<td>Deshpande</td>
<td>Thurrock CCG Chair</td>
<td>Director, Commissioning Group T/B Ltd</td>
<td>X</td>
<td>Direct</td>
<td>Director</td>
<td>07/07/2017 Ongoing</td>
<td>I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented.</td>
</tr>
<tr>
<td>Anand</td>
<td>Deshpande</td>
<td>Thurrock CCG Chair</td>
<td>Medical Defence Shield Ltd. Professional Membership organisation.</td>
<td>X</td>
<td>Direct</td>
<td>Director</td>
<td>07/07/2017 Ongoing</td>
<td>I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented.</td>
</tr>
<tr>
<td>Anand</td>
<td>Deshpande</td>
<td>Thurrock CCG Chair</td>
<td>Member of South Essex Local Medical Committee (LMC)</td>
<td>X</td>
<td>Direct</td>
<td>Member of LMC</td>
<td>07/07/2017 Ongoing</td>
<td>I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented.</td>
</tr>
<tr>
<td>Anand</td>
<td>Deshpande</td>
<td>Thurrock CCG Chair</td>
<td>British Medical Association (BMA) Referral Council – Cambridge</td>
<td>X</td>
<td>Direct</td>
<td>Executive Member</td>
<td>07/07/2017 Ongoing</td>
<td>I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented.</td>
</tr>
<tr>
<td>Anand</td>
<td>Deshpande</td>
<td>Thurrock CCG Chair</td>
<td>MCG lead practice for hubs in the Thurrock CCG Area</td>
<td>X</td>
<td>Direct</td>
<td>Practice is contract holder for the Thurrock HUB</td>
<td>07/07/2017 Ongoing</td>
<td>I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented.</td>
</tr>
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</tr>
<tr>
<td>Caroline</td>
<td>Dollery</td>
<td>CCG Chair &amp; Elected GP</td>
<td>Danbury Medical Centre</td>
<td>x</td>
<td>Direct</td>
<td>Salaried GP</td>
<td>01/09/15</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Caroline</td>
<td>Dollery</td>
<td>CCG Chair &amp; Elected GP</td>
<td>East of England Strategic Clinical Network for Mental Health, Learning Disability and Neurology</td>
<td>x</td>
<td>Direct</td>
<td>Clinical Director</td>
<td>01/04/12</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Caroline</td>
<td>Dollery</td>
<td>CCG Chair &amp; Elected GP</td>
<td>Eastern Region Collaborations for Leadership in Applied Health Research &amp; Care</td>
<td>x</td>
<td>Direct</td>
<td>Non-Executive Director</td>
<td>01/07/15</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Caroline</td>
<td>Dollery</td>
<td>CCG Chair &amp; Elected GP</td>
<td>Health Education England</td>
<td>x</td>
<td>Direct</td>
<td>Leadership Courses</td>
<td>07/12/16</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Caroline</td>
<td>Dollery</td>
<td>CCG Chair &amp; Elected GP</td>
<td>Local Workforce Action Board (LWAB)</td>
<td>x</td>
<td>Direct</td>
<td>Chair of Local Workforce Action Board (LWAB)</td>
<td>14/12/17</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Jose</td>
<td>Garcia Lobera</td>
<td>Southend CCG Chair and Clinical Lead for Mental Health</td>
<td>GP Partner at Pall Mall Surgery</td>
<td>x</td>
<td>Direct</td>
<td></td>
<td>07/07/17</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Jose</td>
<td>Garcia Lobera</td>
<td>Southend CCG Chair and Clinical Lead for Mental Health</td>
<td>Trustees of Southend United Community and Education Trust</td>
<td>x</td>
<td>Indirect</td>
<td></td>
<td>07/07/17</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Arv</td>
<td>Guniyangodage</td>
<td>Basildon and Brentwood CCG Chair</td>
<td>New Surgery, Brentwood</td>
<td>x</td>
<td>Direct</td>
<td>GP Partner,</td>
<td>07/07/17</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Arv</td>
<td>Guniyangodage</td>
<td>Basildon and Brentwood CCG Chair</td>
<td>Health Education England</td>
<td>x</td>
<td>Direct</td>
<td>GP Trainer</td>
<td>TBC</td>
<td>Ongoing</td>
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</tr>
<tr>
<td>Margaret</td>
<td>Hathaway</td>
<td>Acting Accountable Officer at Castle Point and Rochford CCG and Southend CCG.</td>
<td>TBC</td>
<td>x</td>
<td>Direct</td>
<td>Spouse is a Partner in Dengie Medical Partnership</td>
<td>I will declare my interest if at any time issues relevant to the Surgery are discussed so that appropriate arrangements can be implemented</td>
<td></td>
</tr>
<tr>
<td>Donald</td>
<td>McGeachy</td>
<td>Medical Director</td>
<td>Spouse is a Partner in Dengie Medical Partnership</td>
<td>x</td>
<td>Indirect</td>
<td>Spouse is a Partner of the Practice</td>
<td>Interest recorded on Board Register and declared at meetings so that appropriate action can be implemented if decisions regarding the success regime are required</td>
<td></td>
</tr>
<tr>
<td>Donald</td>
<td>McGeachy</td>
<td>Medical Director</td>
<td>Secondment to Essex Success Regime as Medical Director</td>
<td>x</td>
<td>Direct</td>
<td>Seconded as Medical Director</td>
<td>Interest recorded on Register and declared at meetings so that appropriate action can be implemented if decisions regarding the Success Regime are required</td>
<td></td>
</tr>
<tr>
<td>Caroline</td>
<td>Rassell</td>
<td>Accountable Officer Mid Essex CCG &amp; Lead AO for Joint Committee / SRO - Mid and South Essex STP (Locality Health and Care)</td>
<td>Mid and South Essex Sustainability &amp; Transformation Partnership (STP)</td>
<td>x</td>
<td>Direct</td>
<td>SRO - Mid and South Essex STP (Locality Health and Care)</td>
<td>25/03/16 Ongoing</td>
<td>Interest recorded on Register and declared at meetings so that appropriate action can be implemented if decisions regarding the SRO are required</td>
</tr>
<tr>
<td>Caroline</td>
<td>Rassell</td>
<td>Accountable Officer Mid Essex CCG &amp; Lead AO for Joint Committee / SRO - Mid and South Essex STP (Locality Health and Care)</td>
<td>Mid and South Essex Sustainability &amp; Transformation Partnership (STP)</td>
<td>x</td>
<td>Direct</td>
<td>Lead Accountable Officer for Joint Committee</td>
<td>01/09/17 Ongoing</td>
<td>Interest recorded on Register and declared at meetings so that appropriate action can be implemented if decisions regarding the SRO are required</td>
</tr>
<tr>
<td>Caroline</td>
<td>Rassell</td>
<td>Accountable Officer Mid Essex CCG &amp; Lead AO for Joint Committee / SRO - Mid and South Essex STP (Locality Health and Care)</td>
<td>Care UK Limited</td>
<td>x</td>
<td>Indirect</td>
<td>Spouse is an employee of Care UK Limited</td>
<td>07/07/17 Ongoing</td>
<td>Interest recorded on Register and declared at meetings so that appropriate action can be implemented if decisions regarding Care UK are required</td>
</tr>
<tr>
<td>Kashif</td>
<td>Siddiqui</td>
<td>Castle Point and Rochford CCG Chair</td>
<td>Dr PJ Baker and partners, Rushbottom Lane, Benfleet - member of GP Healthcare alliance and Essex Clinical</td>
<td>x</td>
<td>Direct</td>
<td>GP Trainer</td>
<td>Ongoing Ongoing</td>
<td>I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented</td>
</tr>
<tr>
<td>Kashif</td>
<td>Siddiqui</td>
<td>Castle Point and Rochford CCG Chair</td>
<td>Vice chair of Essex Health and Wellbeing board</td>
<td>x</td>
<td>Direct</td>
<td>Vice chair of Essex Health and Wellbeing board</td>
<td>01/01/18 Ongoing</td>
<td>I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented</td>
</tr>
<tr>
<td>Ian</td>
<td>Stidston</td>
<td>Southend CCG Interim Accountable Officer, and Castle Point and Rochford CCG Accountable Officer</td>
<td>Nil</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Karen</td>
<td>Wesson</td>
<td>Director of Commissioning</td>
<td>Nil</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Rachel</td>
<td>Webb</td>
<td>Locality Director for Mid and South Essex STP (Locality Health and Care)</td>
<td>Nil</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
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</table>
Mid and South Essex STP Joint Committee (STPJC)
Public Meeting
Friday 2nd February 2018 3:15pm – 5:00pm
The Priory Suite, Southend CCG, 5-15 Harcourt Avenue, Southend on Sea, SS2 6HT

Present:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Mike Bewick (MB)</td>
<td>Independent Chair</td>
</tr>
<tr>
<td>Dr Anand Deshpande (AD)</td>
<td>Chair, NHS Thurrock CCG</td>
</tr>
<tr>
<td>Dr Caroline Dollery (CD)</td>
<td>Chair, NHS Mid Essex CCG</td>
</tr>
<tr>
<td>Dr Arv Guniyangodage (AG)</td>
<td>Chair, NHS Basildon &amp; Brentwood CCG</td>
</tr>
<tr>
<td>Dr Jose Garcia Lobera (JG)</td>
<td>Chair, NHS Southend CCG</td>
</tr>
<tr>
<td>Dr Kashif Siddiqui (KS)</td>
<td>Chair, NHS Castle Point &amp; Rochford CCG</td>
</tr>
<tr>
<td>Lisa Allen (LA)</td>
<td>Acting Accountable Officer, NHS Basildon &amp; Brentwood CCG</td>
</tr>
<tr>
<td>Mandy Ansell (MA)</td>
<td>Accountable Officer, NHS Thurrock CCG</td>
</tr>
<tr>
<td>Margaret Hathaway (MH)</td>
<td>Chief Finance Officer, NHS Castle Point &amp; Rochford CCG &amp; NHS Southend CCG</td>
</tr>
<tr>
<td>Caroline Rassell (CR)</td>
<td>Lead Accountable Officer, STPJC and SRO Local Health &amp; Care Accountable Officer, NHS Mid Essex CCG</td>
</tr>
</tbody>
</table>

In Attendance:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Donald McGeachy (DM)</td>
<td>Medical Adviser, STP JC</td>
</tr>
<tr>
<td>Carol Anderson (CA)</td>
<td>Director of Nursing, STP JC</td>
</tr>
<tr>
<td>Viv Barnes (VB)</td>
<td>Interim STPJC Secretary, NHS Mid Essex CCG</td>
</tr>
<tr>
<td>Karen Wesson (KW)</td>
<td>Director of Commissioning, STPJC</td>
</tr>
<tr>
<td>Louis Kamfer (LK)</td>
<td>Chief Finance Officer, STPJC</td>
</tr>
<tr>
<td>Simon Ashley Cross</td>
<td>Member of the Public</td>
</tr>
<tr>
<td>Lawrence Davies</td>
<td>Councillor, Southend Borough Council</td>
</tr>
<tr>
<td>Maureen Henes</td>
<td>Member of the Public</td>
</tr>
</tbody>
</table>

Apologies

<table>
<thead>
<tr>
<th>Name</th>
<th>Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rachel Webb</td>
<td>NHS England</td>
</tr>
</tbody>
</table>

1. **Welcome, Apologies for Absence and Declarations of Interest**

MB welcomed all to the meeting. There were no apologies from the membership, but apologies were received from attendee Rachel Webb, NHS England.
MB welcomed members of the public.

MB presented the Register of interests and asked members to declare any interests not already recorded in the Register of Interests. Members confirmed there were none.

Declarations of interest from sub committees

N/A.

Declarations of interest from today’s meeting

None declared.

MB advised that a complaint had been lodged from a member of the public in relation to the vote on whether to proceed to a public consultation at the public meeting on 29 November 2017. MB advised that previous discussions of the PCBC had not indicated that voting members were anything other than supportive of a public consultation and so he checked this assumption before an actual vote was taken. When several members indicated they wished to abstain, MB felt that it was important to advise what this meant in relation to the voting process and to give time for individual CCG Chairs and the AOs to discuss their respective positions. He also asked members to explain what their concerns were and whether these were their personal views or the agreed position of their CCG Boards. Following a short adjournment, a vote was taken with each voting member being given an opportunity to explain the reason for their vote. No pressure was put upon members to alter their voting intentions and the ensuing discussion enabled the STPJC to focus on the additional plans going forward to support ‘out of hospital’ services.

2. Questions from the Public

MB introduced this item by advising that the STPJC was a meeting held in public, but was not a public meeting. It was noted that members of the public were able to observe the proceedings and were given the opportunity to ask questions under this agenda item.

MB stated that a number of questions had been received in advance, some of which might need further enquiry and so would receive a written response after the meeting. In order to enable the Committee to keep to its agreed agenda, members of the public were asked to limit any verbal questions to one per person but were welcome to submit any additional questions using the forms provided for this purpose.

MB read out a question submitted in advance by Mr Simon Cross asking for clarification to be provided that the £118 million in capital funding to support the proposed changes to hospital services were subject to a further bidding process. MB advised that the STPJC was happy to reiterate this point, which had already been made in the minutes of the meeting held on 29 November 2017. CR confirmed that the £118 million set aside for the system to bid against was subject to public consultation and the development of Outline and Full Business Cases, as was customary for the NHS capital allocation process.

CR advised that Maureen Henes had made a number of suggestions how the approach to the Equality Impact Assessment of the STP public consultation could be made more inclusive and confirmed that these would be taken into account.

Cllr Lawrence Davies also raised a question in relation to the STP public consultation, asking whether it was correct that emergency orthopaedic surgery would go to Basildon but planned orthopaedic operations would remain in Southend and, if so, what the rationale was for this.

DM explained that there were considerable benefits to be obtained from splitting emergency and planned orthopaedic surgery. Creating a dedicated emergency ward and theatre would give access to services much quicker and cancellations of elective surgery as a result of emergency pressures would be reduced. DM clarified that patients from Southend requiring complex elective surgery would be returned to their local hospital for recuperation. In response to a request from
Cllr Davies to explain how resources would be split between the two hospitals, DM advised that this would be clarified if the proposals were agreed as part of the consultation outcome, however part of the £118m bid was intended to create additional surgery space at Southend Hospital.

### Minutes of Previous Meeting

It was noted that the minutes of the public meeting held on 29 November 2017 had been agreed at the STPJC’s last meeting on 12 January 2018 and were being received today for information only.

### Action Log from Previous Meeting

Members noted the updates against each of the action points, all of which had been completed.

### Matters Arising from last meeting (not on agenda)

There were no matters arising from the previous meeting.

### Transforming Care Programme

MH advised that Transforming Care was a national programme to enable a small cohort of learning disability patients to move out of long term care into a community setting. For the Essex CCGs (with the exception of Thurrock where the CCG and the council had entered into a separate agreement), this meant discharging 29 patients by March 2019.

As part of the programme, the CCGs of Essex, Southend and Thurrock recently agreed to collaborate on the re-commissioning of the current specialist learning disability health contracts in order to implement a new pan-Essex service from 2018. The proposal for a pooled budget being presented to the Committee today for approval built on this work and set the financial foundation for the shift in service delivery from in-patient to community based care. There was no risk share being proposed and the financial impact upon CCGs was cost neutral.

The Committee was asked to note that authority has been delegated to the Chief Finance Officers of the participating Mid and South Essex STP CCGs to enter into a Section 75 agreement with Essex County Council and Southend Borough Council to allow the proposed pooled budget to operate.

The following discussion and questions were raised:

CR advised that the CCGs were supportive of the intention to establish a pooled budget however there was a query about one of the patients on the list. Subject to this query being resolved, she proposed that the recommendation should be agreed by the STPJC.

**ACTION:** LA to confirm details of Basildon & Thurrock patients subject to the Transforming Care programme.

AD raised a question regarding the cost of providing healthcare to patients once they were transferred to a community setting. CA responded that these patients would already have significant care packages for life and that these costs would continue to be paid by CCGs but to a different provider.

It was noted that there was a potential impact upon local GP practices in the communities to which these patients were relocated. CD advised that these implications needed to be considered and the requirements for clinical support clarified.

The STPJC **APPROVED** the proposal to create a pooled budget for people with learning disabilities being discharged from hospital as part of the Transforming Care Programme, subject to confirmation that the patient list was correct, and **NOTED** the delegated authority to CCG Chief Finance Officers to enter into Section 75 agreements.

### Public Consultation – Equality Impact Assessment

CR presented a proposal outlining the approach to undertaking an Equality Impact Assessment
on the public consultation and outlined the discussions already held with key stakeholders (Directors of Public Health across the three local authorities and the Consultation Institute). CR advised that a steering group had been established to oversee this work.

Members were informed that the main purpose of the work was to identify groups that might be impacted by the proposed changes to hospital services and to work directly with people with protected characteristics to identify the potential benefits and drawbacks of these proposals together with potential mitigations. The approach taken would be both qualitative and quantitative.

CR advised that a question had been received about including members of the Polish community in the Equality Impact Assessment and this suggestion would be referred to the STP communications team.

**ACTION:** CR to forward suggestion to include the Polish community in the EIA to the STP communications team.

In response to a question from AG, MB confirmed that the Committee was only being asked to approve the process for undertaking the Equality Impact Assessment and agreed that it was likely that the list of affected groups would continue to be expanded upon as the assessment progressed.

The STPJC **APPROVED** the proposed approach for the Equality Impact Assessment for the STP public consultation.

### 8. Primary Care Strategy

CR reminded members that it had been agreed at the STPJC meeting on 29 November 2017 that the Committee would oversee the development of an overarching Primary Care strategy across the STP footprint. The work was intended to guide and be supportive of individual CCG plans, not to replace them, by providing an aggregated narrative to describe the future plans for Primary Care, including workforce, estates, locality development, and current and future investment requirements.

CR noted the progress that had been made to date in appointing Dr Brian Balmer (BB) to provide strategic advice and leadership, in securing additional support for data, analytics and strategic estates advice, and in setting up a steering group (chaired by JG). CR stated that the target was to have a finalised strategy by the end of April 2018.

JG informed members about the weekly steering group and bi-weekly leads meetings that were taking place and commended the progress that was being made.

CR advised that the analytical work being undertaken by BCG had already produced some powerful data on the workload across Primary Care. This data would support the case for change and the requirement for investment in Primary Care.

JG highlighted the importance of keeping CCG Chairs updated on the development of strategy so that they could provide feedback and put forward any ideas. It was noted that there was a need to ensure buy-in from individual practices and for confirmation that localities would have the freedom to deliver the strategy in slightly different ways to meet the needs of their patients.

CR advised members that BB would be visiting all the CCGs to discuss the emerging strategy and the opportunities for clinical input.

MB emphasised the importance of timely and robust reporting from the Primary Care programme Board and the need to align the strategy with the GP Five Year Forward View and other national policies. He noted that a further update would be provided at the next STPJC development session prior to a more detailed report being presented at the public STPJC meeting in April.
The STPJC **DISCUSSED and NOTED** the update on the development of the Primary Care Strategy.

### 9. Mobilisation of an Integrated Urgent Care (IUC) Service in Mid and South Essex

DM presented an update on the mobilisation of the Integrated Urgent Care (IUC) service. DM noted that the CCGs within the STP had previously approved the collaborative redesign and procurement of an IUC service to become a key component of urgent and emergency care provision across STP footprint.

DM advised that the first four stages of the procurement had been completed and the project was now in the ‘mobilisation’ phase. DM reported that the terms of reference of the IUC Programme Board had been reviewed and refreshed to reflect the requirements of the mobilisation phase of the project and these were now being presented to the STPJC for approval.

DM also acknowledged the need for NHS 111 online to be implemented by the national deadline of December 2018 and advised that an STP-wide local solution was planned to be implemented by October 2018.

In response to a question from CD, DM confirmed that there would be Mental Health input at various levels of the Integrated Urgent Care service however there was still an issue about the lack of a crisis service at weekends. DM agreed that this issue needed to be explored further but explained that it was outside the remit of the IUC Programme Board.

AG queried if the Committee was being asked to agree that NHS 111 online services would be delivered by the IUC Programme Board. DM advised that this was not the case however it was important that the two services were compatible and this was the reason why it was being proposed that the NHS 111 Online Project Group should report into the IUC Programme Board.

Responding to a query from AD, DM confirmed that Castle Point & Rochford CCG would hold the IUC contract as the host commissioner for this service.

The STPJC **NOTED** the progress of the IUC mobilisation and **APPROVED** the revised terms of reference for the Programme Board and the inclusion of NHS111 online into the Programme structure.

### 10. Any Other Business

There were no other items of other business from the membership.

### 9. Close of Meeting

The meeting closed at 4.15pm.

### 10 Date and time of Next Joint Committee Meeting in Public:

3:15pm on Friday 6th April 2018 at Thurrock CCG, Civic Offices, New Road, Grays RM17 6SL.
<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Agenda Item</th>
<th>Action</th>
<th>Lead</th>
<th>Deadline for Completion</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/02/2018</td>
<td>6</td>
<td>LA to confirm details of Basildon &amp; Thurrock patients subject to the Transforming Care Programme</td>
<td>LA</td>
<td>02/03/2018</td>
<td>Confirmation received that B&amp;B patient should not have been on TCP list and so formal approval of recommendations now confirmed.</td>
<td>Complete</td>
</tr>
<tr>
<td>02/02/2018</td>
<td>7</td>
<td>CR to forward suggestion to include the Polish community in the EIA to the STP communications team.</td>
<td>CR</td>
<td>02/03/2018</td>
<td>Completed - suggestion forwarded to STP communications team on 14/2/18.</td>
<td>Complete</td>
</tr>
<tr>
<td>Agenda No:</td>
<td>5</td>
<td></td>
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</tr>
<tr>
<td>Report Title:</td>
<td>Mid and South Essex Value Based Commissioning Policies [previously Service Restriction Policy (SRP) Mid and South Essex CCGs]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submitted by:</td>
<td>Karen Wesson, Director of Commissioning and Performance, Joint Commissioning Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Written by:</td>
<td>Karen Wesson, Director of Commissioning and Performance, Joint Commissioning Team, Paula Wilkinson, Chief Pharmacist, Paula Saunders, AD Governance and Patient Involvement, Donald McGeachy, Medical Director, Joint Commissioning Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purpose</td>
<td>To seek approval for the adoption of the Value Based Commissioning Policy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approval Route</td>
<td>The content and principles of the Value Based Commissioning policies have been discussed in advance with each of the Mid and South Essex CCGs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status:</td>
<td>For approval</td>
<td></td>
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</tbody>
</table>
1. Purpose

This paper seeks the Joint Committee approval of the mid and south Essex Clinical Commissioning Groups (CCGs) Value Based Commissioning Policies to standardise the commissioning approach across the five CCGs; reducing disparity of commissioning for the 1.2 million population.

2. Overview

Across mid and south Essex CCGs the commissioning policies for elective procedures vary significantly; this results in disparity in access for many procedures/interventions/devices. Since the formation of the Joint Committee; there is agreement across the 5 CCGs for a more cohesive policy.

Due to the complex nature of the policies within the previously named Service Restriction Policy (SRP); full alignment and standardisation across the 5 CCGs will need to be undertaken in a number of phases.

These are listed below:

- **Phase 1:** Alignment of surgical procedures, devices and treatments where the change made, is to criteria to align the offer to patients and reflect NICE recommendations, help ensure clarity of commissioning policy and/or status of the policy i.e. individual prior approval is required or there is a criteria for the procedure that should be applied prior to undertaking this (group prior approval)
- **Phase 2:** Consultation undertaken on the proposal to align those commissioning policies for those procedures, where the existing policy of one or more CCG is not to fund a procedure, device or treatment

During the development of the policy presented many stakeholders were consulted with these included:

- Clinical leads from the 5 CCGs
- The 3 main acute providers (BTUH, MEHT, SUHFT*)
- Additional acute providers (BHRUT, CUHFT)
- Independent Sector
- Community Providers

All stakeholders who were consulted with provided responses, which have been
taken into consideration in the development of the policy presented to the Committee.

3. Equality/Quality Impact Assessment (EQIA)

An EQIA has been undertaken for the changes to this phase one SRP. This will be included within the policy, has been signed off by the Deputy Chief Nurse for the Joint Committee. The full EQIA is not attached to this report because of its size, however an electronic copy is available on request.

4. Affordability/QIPP Benefits

There is a potential for financial saving for each CCG in adopting the Value based commissioning policies (phase 1). The benefits include consistent approach and decision making, streamlined approach to audit and for some CCGs the introduction of a tighter status for the policy and monitoring process.

All policies reflect either best practice, NICE or have been aligned to reflect Public Health recommendations for commissioning of those procedures identified as of limited clinical effectiveness or value.

5. Project group

The Group developing and leading this work programme included Medical Director for the Joint Commissioning Team, Commissioners from both the Joint Commissioning Team and Clinical Commissioning Groups, Project Management Lead and Prescribing Leads/Chief Pharmacists.

6. Stakeholder engagement

To ensure support and engagement in the development of this Value based commissioning policies for mid and south Essex policy, the Medical Director and Chief Pharmacist have:

- Met twice with each of the five CCGs clinical leads at their respective forums
- Shared electronically the draft SRP with stakeholders (as per list above, section 2)
- Received feedback from stakeholders
- Met with those Trusts/Providers that have expressed that they would like to meet to discuss the proposed changes

The timeline of engagement with stakeholders is attached at Appendix 2.
7. Overview of changes to the policy

A summary of all the STP commissioning policies and the impact of moving to a common set of policies at CCG level is provided in Appendix 3.

The policies where there has been a change in status from group prior approval (previously threshold) to individual prior approval, or where the prime objective of the commissioning policy has not changed even though the wording may have altered slightly are not considered to be a significant change.

Areas of significant change:

**Acupuncture**- where South Essex CCGs have commissioned acupuncture in accordance with NICE CG88. This NICE guidance has been updated and replaced with NG59: Low back pain and sciatica in over 16s: assessment and management - which clearly states: Do not offer acupuncture for managing low back pain with or without sciatica as such the policy has changed to reflect this.

**Platelet Rich Plasma (Autologous Blood) injections for tendinopathy.**
NICE Interventional Procedure Guidance (IPG438) relating to this interventions states: The evidence on autologous blood injection for tendinopathy raises no major safety concerns. The evidence on efficacy remains inadequate, with few studies available that use appropriate comparators. Therefore, this procedure should only be used with special arrangements for clinical governance, consent and audit or research.

The M&SECCG commissioning policy- will reflect this, changing to a policy for mid and south Essex that does not support the use of procedures where there is a requirement for special arrangements, or they are classified as research only or ‘Do Not Use’. Moving to a negative policy for this procedure.

**Spinal injections**
Previous policies across the CCGs have not been sufficiently robust on when spinal injections were funded. The commissioner’s intention was to fund for diagnostic reasons and not for therapeutic reasons. The new policy, based on BBCCG policy, correctly implemented will impact positively on all CCGs by reducing considerably the number of spinal injections being undertaken and ensuring a consistent application across the STP and equity for patients. This is supported by NICE guidance NG59 referred to above.

The commissioning policy being presented to the Committee for approval reflects the changes proposed and consulted on with both CCG and acute hospital clinicians in the specialties where changes were proposed (Appendix 2).
The revised policy has:

- Detailed introduction that details the rationale for the policy, how the policy is applied, the difference in Individual Prior Approval, Group Prior Approval, Not Funded
- The policy (mainly for providers and referrers) explains the Individual Prior Approval expectation, length of its validity
- The policy has been divided into sections to reflect the position of differences across the CCGs
- The policy states the need to refer to individual CCGs for those commissioning policies that will be part of the phase two consultation
- Sections of the SRP:
  - Introduction
  - Guidance on procedures of limited clinical value – aligned for the STP
  - Core commissioning policies – aligned for the STP
  - CCG specific section – contains embedded documents showing CCG specific policies for the seven areas (Appendix 3) - and links to the respective CCG websites.

CCG specific policies:

The individual CCGs have some areas where there has been previous CCG specific public consultation and subsequent decision taken to stop or have tight restrictions, with very limited access to the procedures. It is these areas that will constitute phase two of aligning the SRP for the mid and south Essex population and will involve public consultation.

8. Timelines

<table>
<thead>
<tr>
<th>Event</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>SRP/IFR Policy presented to the Joint Committee of the mid and south Essex CCGs</td>
<td>6 April 2018</td>
</tr>
<tr>
<td>Policies (subject to approval) varied into the providers contracts</td>
<td>9 April to 30 April 2018</td>
</tr>
<tr>
<td>Letters communicating the revision and when the individual prior approvals will be implemented from shared with providers</td>
<td>9 April to 30 April 2018</td>
</tr>
<tr>
<td>CCGs to discuss and align IFR panels to form one panel</td>
<td>9 April to 30 June 2018</td>
</tr>
<tr>
<td>CCGs to undertake and complete consultation with staff to align IFR/exceptional case/MDT panels</td>
<td>9 April to 30 June 2018</td>
</tr>
</tbody>
</table>
Develop documentation for phase 2 of the SRP alignment | June 2018 to 30 September 2018
Commence consultation for phase 2 | 1 October 2018 – 31 December 2018
Develop revised policy reflecting consultation feedback | 1 January 2019 – 31 January 2019
Joint Committee to review and approve policy changes | February 2019
Policy to be added to new contracts | March/April 2019

9. Recommendation

The Joint Committee are asked to approve:

- The Value Based Commissioning Policy for mid and south Essex CCGs – previously known as the Service Restriction Policy (SRP); and
- The Phase 2 consultation and engagement on the proposed changes to align the other 7 CCG specific commissioning policies.

10. Appendices

Appendix 1: Timeline of engagement with Stakeholders
Appendix 2: Summary of all STP commissioning policies and the impact of moving to a common set of policies at a CCG level
Appendix 3: Value Based Commissioning Policies
# Appendix 1

## Timeline of engagement with stakeholders.

<table>
<thead>
<tr>
<th>Development of draft SRP</th>
<th>November 2017 to February 2018</th>
</tr>
</thead>
</table>

### Engagement with CCGs:

<table>
<thead>
<tr>
<th>CCG</th>
<th>Dates and Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thurrock CCG</td>
<td>9&lt;sup&gt;th&lt;/sup&gt; November 2017-TASC, 16&lt;sup&gt;th&lt;/sup&gt; January 2018 Clinical Reference Group, 8&lt;sup&gt;th&lt;/sup&gt; March 2018 – TASC</td>
</tr>
<tr>
<td>Southend CCG</td>
<td>14&lt;sup&gt;th&lt;/sup&gt; December 2017-Clinical Senate, 8&lt;sup&gt;th&lt;/sup&gt; March 2018 – Clinical Senate</td>
</tr>
<tr>
<td>Basildon and Brentwood CCG</td>
<td>14&lt;sup&gt;th&lt;/sup&gt; December 2017-Clinical Senate, 8&lt;sup&gt;th&lt;/sup&gt; February 2018 – Clinical Senate</td>
</tr>
<tr>
<td>Mid Essex CCG</td>
<td>6&lt;sup&gt;th&lt;/sup&gt; February 2018-Livewell Committee</td>
</tr>
<tr>
<td>Castle point and Rochford CCG</td>
<td>9&lt;sup&gt;th&lt;/sup&gt; November 2017- Clinical Executive Group, 8&lt;sup&gt;th&lt;/sup&gt; February 2018 – Clinical Executive Group</td>
</tr>
</tbody>
</table>

### Draft Policy shared with providers:

- BTUH
- SUHFT
- MEHT
- BHRUT
- Ramsey
- Nuffield
- Spire
- Connect

- 13 February 2018 – request for response by 6<sup>th</sup> March 2018

### Feedback from:

- Ramsay: 5<sup>th</sup> & 6<sup>th</sup> March 2018
- MEHT: 6<sup>th</sup> March 2018
- BTUH: 6<sup>th</sup> March 2018
- SUHFT: 6<sup>th</sup> March 2018
- Meeting with BHRUT: 8<sup>th</sup> March 2018
- Meeting with MEHT: 21<sup>st</sup> March 2018
Summary SRP changes for STP document

Service Restriction Policy Review –

A review of all current Service Restriction Policies (SRPs) has taken place from a clinical perspective, taking into account changed NICE guidance or other relevant national guidance.

The commissioning priority of all SRPs is reviewed annually. With the establishment of the Joint Commissioning Committee and single acute contracts it is necessary to move to a single set of SRPs for the Mid and South Essex Sustainability and Transformation Partnership (STP).

This document provides a summary of the STP Commissioning Position and Policies. There are seven current areas of commissioning where until a full review and consultation can take place, each of the five CCGs will retain their previous commissioning policy- these seven areas are:

- Assisted Conception –including IVF/ICS/IUI-specialist fertility services
- Bariatric Surgery
- Breast asymmetry
- Breast reduction
- Female Sterilisation
- Gynaecomastia
- Vasectomies

A list of all the policies are shown below, along with level of impact.
## STP wide-Service Restriction Policies and Changes/Impact

<table>
<thead>
<tr>
<th>Indication</th>
<th>Funding Status</th>
<th>Impact for CCGs of proposed policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominoplasty/Apronectomy</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Acne Vulgaris-Laser/Resurfacing/Surgical treatments</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Aesthetic Facial Surgery</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Allergy Disorder- Unconventional Treatments</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Arthroscopy Hip including Femoro-Aacetubular Impingement (FAI)</td>
<td>Group Prior Approval/Individual Prior Approval</td>
<td>None</td>
</tr>
<tr>
<td>Arthroscopy Knee</td>
<td>Group Prior Approval</td>
<td>None</td>
</tr>
<tr>
<td>Arthroscopy Shoulder</td>
<td>Group Prior Approval</td>
<td>None</td>
</tr>
<tr>
<td>Assisted conception</td>
<td>Retain individual CCG policies</td>
<td>None</td>
</tr>
<tr>
<td>Autologous Cartilage Transplantation</td>
<td>Group Prior Approval</td>
<td>None</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>Retain individual CCG policies</td>
<td>None</td>
</tr>
<tr>
<td>Benign Skin Conditions</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Biologic Mesh</td>
<td>Individual prior approval</td>
<td>Tightening for Mid; removal of access to some mesh but no recent requests for any from MEHT. No impact on South Essex as already in place.</td>
</tr>
<tr>
<td>Blepharoplasty</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Bobath Therapy</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Bone Morphogenic Proteine</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Breast Asymmetry</td>
<td>Retain individual CCG policies</td>
<td>None</td>
</tr>
<tr>
<td>Breast Augmentation</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Breast Implants- Removal</td>
<td>Individual prior approval</td>
<td>Change for BB-to replace NHS funded implants removed for clinical reasons–other CCGs remain the same.</td>
</tr>
<tr>
<td>Breast Lift - Mastopexy</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Breast Reconstruction</td>
<td>Group prior approval</td>
<td>Restriction to one follow up operation-change for S’end, CPR and Thurrock.</td>
</tr>
<tr>
<td>Breast Reduction</td>
<td>Retain individual CCG policies</td>
<td>None</td>
</tr>
<tr>
<td>Bunion (Hallux valgus) Surgery</td>
<td>Individual Prior Approval</td>
<td>None</td>
</tr>
<tr>
<td>Elective Caesarean section</td>
<td>Group Prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Capsule Endoscopy</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Double Balloon Endoscopy</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Indication</td>
<td>Funding Status</td>
<td>Impact for CCGs of proposed policy - this reflects the content of the policy - but in some cases there is a change from group prior approval to individual prior approval so need to review approval process.</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Carpal Tunnel</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Cataracts</td>
<td>Group prior approval/Individual Prior Approval</td>
<td>None</td>
</tr>
<tr>
<td>Chalazion (cyst on or in eye lid)</td>
<td>Group Prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Chronic Fatigue Syndrome</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Circumcision</td>
<td>Group Prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Complementary and Alternative Therapies</td>
<td>Not funded</td>
<td>Principally affects Acupuncture - All but Mid currently fund Acupuncture - but based on out of date NICE guidance - new NICE NG59 states 'Do not offer' - BB and Thurrock most affected based by stopping on current activity/spend.</td>
</tr>
<tr>
<td>Continuous Glucose Monitoring</td>
<td>Individual Prior Approval</td>
<td>None - but need to address Freestyle Libre element.</td>
</tr>
<tr>
<td>Continuous Positive Airway Pressure (CPAP) in Adults</td>
<td>Group prior approval</td>
<td>New policy for South Essex - reflects SIGN guidance</td>
</tr>
<tr>
<td>Dupuytren’s Contracture</td>
<td>Group prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Dynamic Lycra Splinting</td>
<td>Group prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Dysthyroid Eye Disease</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Ear microsuction/ wax removal</td>
<td>Group Prior Approval</td>
<td>Tightened to ensure not used as a substitute for ear irritation.</td>
</tr>
<tr>
<td>Endoscopic laser spinal surgery</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Exogen Bone healing ultrasound system</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Facial surgery (aesthetic- cosmetic)</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Facial surgery (non aesthetic)</td>
<td>Group prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Female Sterilisation</td>
<td>Retain individual CCG policies</td>
<td>None</td>
</tr>
<tr>
<td>Functional Electrical Stimulation</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Gallstones/ cholecystectomy</td>
<td>Group Prior Approval</td>
<td>None</td>
</tr>
<tr>
<td>Ganglion/Mucoid cysts</td>
<td>Group Prior Approval</td>
<td>None</td>
</tr>
<tr>
<td>Grommets</td>
<td>Group Prior Approval/Individual Prior Approval</td>
<td>None for Mid- inclusion of adults for South Essex</td>
</tr>
<tr>
<td>Gynaecomastia</td>
<td>Retain individual CCG policies</td>
<td>None</td>
</tr>
<tr>
<td>Haemorrhoids</td>
<td>Group Prior Approval</td>
<td>None</td>
</tr>
<tr>
<td>Hair Depilation/Hirsutism</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Heavy Menstrual Bleeding (including uterine fibroids)</td>
<td>Group Prior Approval/Not funded</td>
<td>Myomectomy and UAE not funded – out of line with NICE</td>
</tr>
<tr>
<td>Hernia (surgical treatment)</td>
<td>Individual Prior Approval</td>
<td>None</td>
</tr>
<tr>
<td>Indication</td>
<td>Funding Status</td>
<td>Impact for CCGs of proposed policy - this reflects the content of the policy - but in some cases there is a change from group prior approval to individual prior approval so need to review approval process.</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
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<tr>
<td>Hip Injections</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Hip Joint Replacement</td>
<td>Group prior approval</td>
<td>Removal of threshold OHKS 19 for referral in Mid; policy wording changed to reflect greater emphasis on shared decision making</td>
</tr>
<tr>
<td>Hip Resurfacing</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Hyperhidrosis (Botox)</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Hysterectomy/ Dilatation and Curettage (D&amp;C)</td>
<td>Group prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Ingrown Toe Nail Surgery</td>
<td>Group Prior Approval/Individual Prior approval</td>
<td>New policy for S Essex-minimal impact</td>
</tr>
<tr>
<td>Insulin Pump Therapy</td>
<td>Individual Prior Approval</td>
<td>None</td>
</tr>
<tr>
<td>Irritable Bowel Syndrome-diagnostic colonoscopy/flexible sigmoidoscopy-calprotectin</td>
<td>Individual prior approval</td>
<td>None for BB; new for Mid, Send, CPR and Thurrock-NICE guidance but reflects agreed pathway</td>
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<tr>
<td>Knee Joint Replacement</td>
<td>Group prior approval</td>
<td>Removal of threshold OHKS 19 for referral in Mid; policy wording changed to reflect greater emphasis on shared decision making</td>
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<tr>
<td>Labial Reduction/Refashioning/Vaginoplasty/Cliteroplasty</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Lymphoedema Services</td>
<td>Group prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Monodiabetic diabetes testing</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Myopia (laser)</td>
<td>Not routine funded</td>
<td>None</td>
</tr>
<tr>
<td>Nipple Inversion</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Open/Wide-bore MRI</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Orthoses/Orthotics</td>
<td>Group Prior Approval/Individual Prior approval</td>
<td>None for Mid; new policy for South Essex CCGs</td>
</tr>
<tr>
<td>Photodynamic therapy for age related macular degeneration</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Pinnaplasty/Otoplasty</td>
<td>Individual prior approval</td>
<td>Change for BB-</td>
</tr>
<tr>
<td>Positional plagiocephaly</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Platelet rich plasma injections for tendinopathy</td>
<td>Not funded</td>
<td>Change impacting on South Essex CCGs- current significant activity in CRP and Send. NICE IPG- but restricted.</td>
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<tr>
<td>Repair of Ear Lobes-Immediate and Post-Immediate Traum</td>
<td>Group prior approval/Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Reversal of Sterilisation</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Indication</td>
<td>Funding Status</td>
<td>Impact for CCGs of proposed policy - this reflects the content of the policy but in some cases there is a change from group prior approval to individual prior approval so need to review approval process.</td>
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<tr>
<td>----------------------------------------------------------------------------</td>
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<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Rhinophyma</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Riser Recliner Chairs</td>
<td>Individual prior approval</td>
<td>None for Mid Essex - new to S Essex CCGs</td>
</tr>
<tr>
<td>Sacral Nerve Modulation</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Scar revision</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Scotopic Sensitivity Syndrome (Mears-Irlen Syndrome) and Coloured Filters/Tinted Lenses</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Septoplasty</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Skin Contouring/Liposuction/Liposculpture</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Sleep Studies including Diagnostic Investigations and Treatments for Obstructive Sleep Apnoea/Hypopnoea Syndrome (OSAHS) in Adults</td>
<td>Group prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Snoring and Snoring ENT referrals</td>
<td>Not funded/Group Prior Approval</td>
<td>None</td>
</tr>
<tr>
<td>Sperm, Embryo or Oocyte Cryopreservation</td>
<td>Individual prior approval</td>
<td>None - but reduction in years of storage</td>
</tr>
<tr>
<td>Spinal cord stimulation</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Spinal Injections for Low Back Pain and Radicular Leg Pain</td>
<td>Therapeutic-Low Back Pain-Not funded Therapeutic-Radicular-Individual Prior Approval Diagnostic-Individual Prior Approval Radiofrequency denervation-Individual Prior Approval</td>
<td>None from intention of policy - but high current activity in associated injections-Mid and others</td>
</tr>
<tr>
<td>Spinal Surgery for Non-Acute Lumbar Conditions</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Surrogacy</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Synthetic Mesh</td>
<td>Individual prior approval</td>
<td>Tightening for Mid; removal of access to some mesh but no recent requests for any from MEHT. No impact on South Essex as already in place.</td>
</tr>
<tr>
<td>Tattoo Removal</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Temporomandibular Joint Replacement</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Temporomandibular Joint Retainers and Appliances</td>
<td>Not funded (outside specialist services within tariff)</td>
<td>None</td>
</tr>
<tr>
<td>Tinnitus</td>
<td>Group Prior Approval</td>
<td>None</td>
</tr>
<tr>
<td>Tonsillectomy</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Toric Lens Implants- Astigmatism</td>
<td>Not funded</td>
<td>None</td>
</tr>
<tr>
<td>Indication</td>
<td>Funding Status</td>
<td>Impact for CCGs of proposed policy - this reflects the content of the policy - but in some cases there is a change from group prior approval to individual prior approval so need to review approval process.</td>
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<tr>
<td>-------------------------------------------</td>
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</tr>
<tr>
<td>Transcranial magnetic stimulation</td>
<td>Not routine funded</td>
<td>None</td>
</tr>
<tr>
<td>Trigger Finger</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Vaginal/ uterine prolapse</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Varicose Veins</td>
<td>Individual prior approval</td>
<td>None</td>
</tr>
<tr>
<td>Vasectomies</td>
<td>Retain individual CCG policies</td>
<td>None</td>
</tr>
<tr>
<td>Wigs and Hair Pieces/Hair Transplantation</td>
<td>Group Prior Approval/Not funded</td>
<td>None</td>
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</tbody>
</table>

PMW March 2018
# Mid & South Essex STP

## Value Based Commissioning Policies

<table>
<thead>
<tr>
<th>Approved by:</th>
<th>Mid and south Essex Joint Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date approved</td>
<td></td>
</tr>
<tr>
<td>Author</td>
<td>Paula Wilkinson-Chief Pharmacist</td>
</tr>
<tr>
<td>Executive Sponsor/Lead Director</td>
<td>Paula Wilkinson-Chief Pharmacist</td>
</tr>
<tr>
<td>Name/Title of responsible committee/individual:</td>
<td>Mid and south Essex Joint Committee</td>
</tr>
<tr>
<td>Version 1 Date issued:</td>
<td>April 2020</td>
</tr>
<tr>
<td>Target audience</td>
<td>GPs, Optometrists, Dentists, Secondary care consultants, Central Referral Service Triagers, Public and Patients</td>
</tr>
</tbody>
</table>

### Version Control

<table>
<thead>
<tr>
<th>Version</th>
<th>Key Changes</th>
<th>Authorisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version 1</td>
<td>Original compilation of most restrictive SRPs across STP</td>
<td></td>
</tr>
<tr>
<td>Version 2</td>
<td>Checking through for accuracy, changes to status for some items and wording. Changes to layout for MM and NHSE commissioned services</td>
<td></td>
</tr>
<tr>
<td>Version 3</td>
<td>Incorporate wording from SCCG re spinal stimulation</td>
<td></td>
</tr>
<tr>
<td>Version 4</td>
<td>Revision of wording for spinal injections and index updated; change of title to Commissioning policies</td>
<td></td>
</tr>
<tr>
<td>Version 5</td>
<td>Incorporation of lowest cost procedure statement e.g. not using day case when outpatient procedure appropriate.</td>
<td></td>
</tr>
<tr>
<td>Version 6</td>
<td>Consolidation following meeting with Paula Saunders</td>
<td></td>
</tr>
<tr>
<td>Version 8</td>
<td>Addition of list of outpatient procedures and codes</td>
<td></td>
</tr>
<tr>
<td>Version 9</td>
<td>Addition of wording re pathway activity</td>
<td></td>
</tr>
<tr>
<td>Version 10</td>
<td>Amended hip and knee SRPs</td>
<td></td>
</tr>
<tr>
<td>Version 11</td>
<td>Amended to established separate section for policies which will remain as per current individual CCG policies: Access to Specialist Obesity Services- Bariatric Surgery Specialist Fertility Services Female Sterilisation Vasectomies Amendment of breast asymmetry, reduction and gynaecomastia SRPs to commission on restricted basis</td>
<td></td>
</tr>
<tr>
<td>Version 12</td>
<td>Slight amendment to smoking cessation statement-NHSE request</td>
<td></td>
</tr>
<tr>
<td>Version 13</td>
<td>Amended to reflect more clarification re: general section and definition</td>
<td></td>
</tr>
<tr>
<td>Version 14</td>
<td>Changes reviewed, and further changes following initial clinical discussions at BB and CPR.</td>
<td></td>
</tr>
<tr>
<td>Version 15</td>
<td>Amended following engagement visits to all CCG clinical leads committees and feedback from MSB and private providers.</td>
<td></td>
</tr>
<tr>
<td>Version 16</td>
<td>With retained individual policies embedded</td>
<td></td>
</tr>
<tr>
<td>Version 17</td>
<td>Removal of Appendix 1 (outpatient/day case HRGs and amended wording to introduction.</td>
<td></td>
</tr>
<tr>
<td>Version 18</td>
<td>Tonsillectomy- further clarification based on comments. Clarity on post-trauma nasal surgery for blockage.</td>
<td></td>
</tr>
<tr>
<td>Version 19</td>
<td>Southend CCG assisted conception policy updated</td>
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<tr>
<td>Version 20</td>
<td>Index and Hyperlinks updated</td>
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</table>
INTRODUCTION

The over-riding commissioning policy requirement is that all commissioning must be based on value for money, defined as “the best mix of quality and effectiveness for the least outlay”.

Mid & South Essex CCGs’ commissioning position is that treatments/ interventions/device/ procedures* (hereafter known as procedures*) not currently included in commissioned established care pathways (as identified for example in the Schedules to the service agreements with acute care provides) or identified for funding through the commissioning process are not routinely funded. For a number of commissioned procedures M&SECCGs operate a Prior Approvals Scheme setting out criteria for access, based on evidence of effectiveness or relative priority for funding. Those related to procedures* are included within this document; those relating to prescribing can be found on the commissioner Medicines Optimisation website. Providers must not assume that because a procedure* is not included in this document or listed on the Medicines Optimisations website that by default it will be funded.

As a general principle it is expected that patients are managed in a setting which not only meets their clinical needs but is charged at the lowest appropriate tariff charge. For example where a procedure* can be carried out in an outpatient setting at a lower tariff charge than as a day case, this is what is expected. For a few HRGs there is a single price across outpatient procedures and day cases, or a single price across all settings. This approach has been taken where a price that is independent of setting is clinically appropriate. Where following audit it is found that procedures could have been carried out in a lower cost setting, the commissioner will only pay at the lowest appropriate tariff charge.

Commissioning policy development is an on-going process and future commissioning policy on future procedures* as developed or in response to NICE Guidance/Guidelines, health technology assessments etc. will be produced and published periodically on M&SECCGs’ websites - Commissioning Policies.

Each new referral, regardless of advice provided following a previous referral or episode of care, must be assessed against the policy in place on the date the referral is made. The fact that a patient has previously been treated for the referral condition, or a related condition, and previously met the policy in place at the time does not support a referral or treatment outside the current service restriction policy.

This document sets out access to procedures* where compliance with the Prior Approvals process is required.

For these procedures*, the criteria listed apply to both the referring and treating clinicians GPs should not refer patients who do not meet criteria which they can assess. This not only takes up an unnecessary outpatient appointment but results in a poor patient experience. Equally treating clinicians should review referrals and return to the GP those where it is clear from the information provided that the patient does not meet criteria, thus reducing the number of inappropriate outpatient appointments. Providers are contractually obliged to abide with the Prior Approvals scheme, and failure to do so is a breach of that contractual obligation and any unapproved activity will not be funded.

The following sets out the different levels of Prior Approval recognised by M&SECCGs.
**Group Prior Approvals** (previously known as Threshold Approval) – Those procedures* which are commissioned by M&SECCGs on a restricted basis only for patients who meet the defined criteria set out within the relevant commissioning policy but for which individual prior approval is not required e.g. cataract surgery. M&SECCGs notification of compliance or audit will be required according to contractual arrangements. Providers should be aware that payment may be withheld where they cannot demonstrate that patients treated meet the criteria specified.

Group prior approval should be applied in line with the policy in force at the time the patient is listed (where relevant) for the procedure*. This approval will last for 12 months. After 12 months have elapsed the patient should be reviewed against the policy in force at the time and the criteria for the procedure* will apply. Subsequent reviews should be undertaken in line with the policy in force at the time and approval time limits will also be in line with the policy in force at the time.

This process and associated time limits will apply unless an alternative policy is subsequently introduced for a named procedure*

**Individual Prior Approvals** - Those procedures* which are commissioned by M&SECCGs but only for patients who meet the defined criteria set out within the relevant commissioning policy and which require individual funding approval on a patient by patient and, in some circumstances, treatment by treatment basis e.g. botox before the treatment can be provided.

For these procedures*, the criteria listed apply to both the referring and treating clinicians and if a patient is deemed to meet these criteria individual prior approval must be sought. When applicable, GPs should seek individual prior funding approval before a referral is made/outpatient appointment is booked.

Individual prior approval should be sought in line with the policy in force at the time the patient is identified as requiring the procedure* (where relevant) for the procedure*. Once approved the individual prior approval will be valid for 12 months. After 12 months have elapsed the patient should be reviewed against the policy in force at the time and the criteria for the procedure* will apply and, if the procedure* continues to be required, a new individual prior approval application should be made. Subsequent reviews should be undertaken in line with the policy in force at the time and approval time limits will also be in line with the policy in force at the time.

This process and associated time limits will apply unless an alternative policy is subsequently introduced for a named procedure*

**Not Funded** – These procedures* have been assessed as Low Clinical Priority by M&SECCGs and will not be funded unless there are exceptional clinical circumstances. Applications for funding for these procedures* can be made using the Individual Funding Request process but should only be made where the patient demonstrates clinical exceptionality.
Legacy patients
It is acknowledged where funding criteria has changed there will be patients who have received funding for a procedure* under a previous policy which is no longer funded or the criteria for funding has changed. Where for clinical reasons a previously funded procedure* needs repeating / revision / replacement the current policy applies.

Individual Funding Requests (IFR) - M&SECCGs always allows clinicians on behalf of their patients the opportunity to make specific funding requests via the IFR process. Requests may include patients with conditions for which M&SECCGs do not have an agreed commissioning policy, including patients with rare conditions, and patients whose proposed treatment is outside agreed commissioning policies (exceptional clinical circumstances) or service agreements. Such requests should not constitute a request for a service development.

Equality and Diversity - The Equality Act 2010 protects people against unfair treatment (discrimination) on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. The Equality Act defines ‘disability’ as a physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day to day activities. Providers are reminded that under this Act they must make adequate and reasonable adjustment to services, which includes provision for interpreters, carers and for others from whom patients may require assistance, providing information and/or signage in an appropriate range of formats, media and languages. Providers shall ensure that service and customer care is delivered in an inclusive manner which respects the diversity of users. It is therefore unlikely that an application for additional funding for such adjustments will be successful.

Children and Families Act 2014 - All providers are also reminded that they must take into account the requirements of the Children and Families Act 2014. Commissioned service provision for children must be delivered to young people 19-25 years of age if they have an Education, Health and Care Plan in place.

The responsibility for adherence to these policies lies with the treating clinician and failure to adhere to these criteria may result in non-payment of the activity.
Policy statement: Smoking and Weight Management and Surgery

Smoking and Surgery

All patients being referred for non-urgent elective surgery who are smokers should be referred to smoking cessation services by the GP at the time of referral, and strongly encouraged to be non-smokers at the time of surgery.

There is strong evidence of higher risks and worse surgical outcomes when a patient continues to smoke. The risks associated with smoking mean that it is not always safe for surgery to take place when a patient continues to smoke and, as a result, some surgeons will not carry out procedures until a patient is able to abstain from smoking.

For smokers who are unable to quit, the Royal College of Anaesthetists advises that smokers should give up smoking for at least several weeks before surgery and certainly not to smoke on the day of an operation. Smokers are 38% more likely to die after surgery than non-smokers.


Obesity and Surgery

There is strong clinical evidence that obese patients undergoing surgery are at significantly higher risk of getting infections and suffering heart, kidney and lung problems than people who are a healthy weight. They are also likely to have to spend more time in hospital recovering and their risk of dying as a result of surgery is higher compared to patients with a normal weight.

Overweight patients are strongly encouraged to lose weight BEFORE their operation and should consider delaying referral for non-urgent elective surgery; this is particularly applicable to patients who have a BMI over 40 or those with a BMI between 30 and 40 who have metabolic syndrome—a combination of diabetes, high blood pressure and obesity.

Patients should aim to reduce their weight by at least 10% over 9 months or to a BMI of less than 30.
Policy statement: Medicines Management and Optimisation

Medicines Optimisation is the clinical, cost-effective use of medicines to ensure that patients get the maximum benefit from the medicines they need, while at the same time minimising potential harm. The aims of medicines management and optimisation is to increase clinical and cost effective prescribing, reduce variance from expected performance, reduce medicines waste, and improve patient outcomes.

Medicines and Devices Covered by CCG Commissioning Policies

M&SECCGs policy is that medicines not currently included in formulary or prescribing polices or guidelines are not routinely funded. For a number of medicines/devices including High Cost Drugs M&SECCGs have published specific policy statements setting out restrictions on access based on evidence of effectiveness or relative priority for funding. These are available on the relevant CCG website.

For drugs excluded from national tariff, all providers must comply with local and agreed East of England drugs commissioning policies.


Providers commissioned to provide services on behalf of M&SECCGs are required to follow the formulary and prescribing policies/guidance as referenced above and detailed in their contract (Medicines Management Service Specification).

Introduction of New Drugs and Technologies

M&SECCGs will not fund new drugs/technologies on an ad-hoc basis through the mechanism of individual case funding. To do so risks inequity, since the treatment will not be offered openly and equally to all with equal need. There is also the risk that diversion of resources in this way will de-stabilise other areas of health care which have been identified as priorities by the CCGs. The CCGs expects consideration of new drugs/technologies to take place within the established planning frameworks of the NHS. This will enable clear prioritisation against other calls for funding and the development of implementation plans which will allow access for all patients with equal need.

NICE New Technology Appraisals (TAs).

Drugs and technologies that are approved as the result of a NICE Technology Appraisal (TA) need to be implemented within 3 months of the appraisal being published. The CCG will, within resource constraints, seek to ensure implementation of NICE TAs without delay but recognises that the CCG may take the full period of 3 months before a new commissioning policy can be brought into place where significant service change and/or development are required as part of the implementation. NICE also produces other guidelines which are a valuable source of good practice which the CCG will take into account in developing policy but the CCG retains discretion and is not mandated by Directions to implement such Guidance within a fixed time period or at all.
Policy statement: NHS England Commissioning-Specialised Services

| Status                        | Not Commissioned by M&SECCGs |

NHS England is responsible for commissioning specialised services to meet a wide range of health and care needs. These include a range of services from renal dialysis and secure inpatient mental health services, through to treatments for rare cancers and life threatening genetic disorders. The commissioning of specialised services is a prescribed direct commissioning responsibility of NHS England.

A list of all specialised services commissioned by NHS England can be found


M&SECCGs are not the responsible commissioners for the specialised services listed within the Prescribed Services Manual, and any requests for funding must be directed to NHS England. Exceptional funding requests for specialised services must be directed to NHS England and will not be considered by M&SECCGs.

M&SECCGs will not fund any activity (or associated drugs/devices) for these specialised services if undertaken in CCG commissioned providers. Patients must be referred to specialised centres commissioned by NHS England.

The following are commonly requested treatments / procedure that at the time of publication are the responsibility of NHS England. The list is not exhaustive, and providers must check the NHS England website for the current commissioning position.

- Autologous chondrocyte implantation (ACI) of the knee
- Bone Anchored Hearing Aids
- Cochlear Implants
- Dental Procedures (Orthodontics, Wisdom Teeth)
- Gender Dysphoria
- Gastro Electrical Stimulation
- Penile Prosthesis/Implants
- Sacral nerve modulation
Policy statement: Low Clinical Priority Procedures*

Status: Not Funded

A number of procedures* have been assessed as **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances**.

Applications for funding for these procedures can be made through the IFR process but should only be made where the patient demonstrates clinical exceptionality.

In making a case for special consideration in relation to a restricted treatment on grounds of clinical exceptionality, it needs to be demonstrated that:

- The patient is significantly different from the general population of patients with the condition in question
  
  AND
  
- The patient is likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition

Only evidence of clinical need will be considered. Factors such as gender, ethnicity, age, lifestyle or other social factors such as employment or parenthood cannot lawfully be taken into account.

It is not necessary to obtain a psychiatric opinion to support an application. M&SECCGs expect mental health professionals to treat related problems through established services commissioned from the mental health trust(s) and this does not include surgery.

M&SECCGs’ Exceptional Cases Panels consistently takes the view that psycho-social considerations should not be a justification for surgery. In such cases, psychological treatment such as counselling or cognitive behavioural therapy may be considered as an appropriate alternative to surgery. The effect of the problem on essential activities of day-to-day living is a key factor in decision-making.

Where referrers consider that there may be exceptional clinical circumstances they must provide details of these exceptional clinical circumstances bearing in mind the points above.

Where indicated in the policy or where relevant, all individual funding requests should be accompanied by suitable clinical photography that demonstrates the extent of the problem. This, of course, would be subject to patient consent.

**Cosmetic surgery/treatments/interventions** are not funded. Plastic surgery is only funded as detailed in policies or commissioned pathways e.g. as part of surgical management of trauma; serious congenital malformation. Post-surgical reconstruction is commissioned as per service level agreements for surgical services and in line with separate policies where in place.

**Correction of privately funded treatments** M&SECCGs do not routinely fund the correction of privately funded treatments cosmetic or otherwise. Where such treatments give rise to clinical problems, these will be managed through routine commissioned pathways and in line with any relevant commissioning policies.

**Commissioning Policies** This document has been written to be as complete as possible however it is not an exhaustive list, providers **must not assume** that because a device or treatment/intervention/procedure is not included that by default it will be funded. M&SECCGs’ commissioning policy is that devices/treatments/interventions/procedures not currently included in established commissioned pathways (as identified for example in the Schedules to the service agreements with acute care provides) or identified for funding through the commissioning process are not routinely funded.
NICE issues Interventional Procedure Guidance (IPGs) with the aim of protecting the safety of patients and supporting the NHS in the process of introducing new procedures. The IPGs are not covered by the Secretary of State’s directions to NHS organisations to fund the implementation of NICE recommendations within a given timescale because this direction relates only to NICE Technology Appraisal Guidance (TAGs).

Interventional Procedure Guidance makes recommendations on the safety of the procedure and how well it works. The guidance does not recommend whether the NHS should fund a procedure; or not and these decisions are therefore for M&SECCGs.

M&SECCGs recognises that it is not within the remit of the NICE IPG Programme to evaluate the cost-effectiveness of interventional procedures or to advise the NHS whether interventional procedures should be funded. M&SECCGs will not fund and providers must not introduce new interventional procedures where NICE has considered them to be safe but which give rise to additional cost/activity without approval of a business case by the M&SECCGs.

Specific commissioning position with respect to different categories of IPG is laid out below:

**Special Arrangements**

M&SECCGs will not fund health care interventions that are subject to a NICE IPG where the IPG states:

- Current evidence on safety is inadequate.
- Current evidence on efficacy is inadequate.
- Evidence of safety and efficacy is on small numbers of patients and of limited quality.
- No major safety concerns, but efficacy has not been shown.
- Evidence is limited to a small number of patients. Good short term efficacy but little evidence of long term efficacy.
- There is adequate evidence of safety and efficacy but the technical demands are such that it should not be used without special arrangements.
- Evidence for short term efficacy is limited and long term outcomes are uncertain.

**Research Only**

M&SECCGs will not fund health care interventions that the NICE IPG programme has recommended should only be undertaken in the context of research. Clinicians wishing to undertake such procedures should ensure they fulfil the normal requirements for undertaking research.

Where there is a possibility that NHS funded care may be impacted following the cessation of the trial, or a patient’s completion of a trial, clinicians must agree this with M&SECCGs before the trial commences. Do not use:

M&SECCGs will not fund health care interventions where a NICE IPG recommends that the intervention should not be used in the NHS.
### Policy statement: Medical Technologies Guidance (MTG)

The NICE Medical Technologies Evaluation Programme (MTEP) identifies and selects medical devices and diagnostic technologies and routes them to appropriate evaluation programmes at NICE. It also develops guidance and advice on the effective and cost efficient use of these technologies for the NHS and its social care partners, and where appropriate, commissions research on the clinical utility of technologies with an underdeveloped evidence base.

Medtech innovation briefings (MIBs) provide a description of the technology, including its likely place in therapy, the costs of using the technology and a critical review of the strengths and weaknesses of the relevant published evidence. Their purpose is to provide a rapid service that gives objective information on device and diagnostic technologies to aid local decision-making by clinicians, managers and procurement professionals. By making this information available, NICE helps to avoid the need for NHS organisations to produce similar information for local use.

MIBs are not NICE guidance. They differ in format, contain no judgement on the value of the technology and do not constitute a guidance recommendation.

**M&SECCGs will not fund and providers must not introduce new medical devices, diagnostics or digital technology recommended by NICE which give rise to additional cost/activity without approval of a business case by the M&SECCGs.**

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All procedures will be funded for a single stage procedure except where specifically indicated otherwise in a commissioning policy. Individual prior approval is required for a two or more staged procedures and must be reviewed internally by the provider in advance of applications to M&SECCGs for funding. The application must clearly indicate the intended number of stages that the procedure will occur in and the cost associated with the complete pathway of care.
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Across mid and south Essex for the following procedures* individual CCGs will retain an individual commissioned policy and will not be part of the common Mid & South Essex CCGs common set of value based commissioning policies.

Access criteria for procedures* may vary between CCGs and GPs/providers must confirm funding arrangements before referral/treatment.

At the time of publication these include:

- Assisted Conception –including IVF/ICS/IUI-specialist fertility services
- Bariatric Surgery
- Breast asymmetry
- Breast reduction
- Female Sterilisation
- Gynaecomastia
- Vasectomies

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M&SECCGs commission Abdominoplasty/Apronectomy on a restricted basis -

A  For patients where it is required as part of abdominal hernia correction or other abdominal wall surgery

This could include patients with scarring resulting in skin tethering to deep tissues and severe functional problems* or severe pain, but does not include contour irregularities and moderate asymmetry which are predictable following surgery. Any post-surgical cosmetic irregularities (including dog ears or unequal fat distribution) will not be funded by M&SECCGS for revision surgery. Patients who have predictable abdominal changes due to pregnancy will not be funded.

OR

B  Those patients from the following groups who have significant abdominal aprons as a result of weight loss and have severe functional problems*

- Patients with excessive abdominal folds who had an initial BMI >40 and have achieved a reduction in BMI to < 25 and have maintained the BMI < 25 for at least 2 years.
  
  OR

- Patient with excessive abdominal folds who have an initial BMI > 50 and have achieved their maximum weight loss goal (which must be a minimum drop of 25 BMI points) and have maintained at that lowest weight for at least 2 years, without fluctuation up or down.

*Severe functional problems include:

- Chronic and persistent skin condition (for example, intertriginous dermatitis, cellulitis or skin ulcerations) beneath the skin fold that is refractory to at least six months of consistent medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics

- Experiencing severe difficulties with daily living i.e. ambulatory restrictions. These patients will need full assessment by the appropriate professional e.g. OT prior to referral

- Abdominal wall prolapse with proven urinary symptoms

- Problems associated with poorly fitting stoma bags which cannot be resolved by specialist stoma nurses/consultant other than with surgery.

Multi-staged procedures

All funding for abdominoplasty/apronectomy will usually be for a single stage procedure. Applications for a 2 stage abdominoplasty must be reviewed internally by the trust in advance of applications to M&SECCGs for funding. The application must clearly indicate that the procedure will occur in two stages and the cost associated with this pathway of care.

Patients not meeting the above criteria will not be funded unless there are clinically exceptional circumstances.
Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

Value Based Commissioning Policies

Patient Information:
https://www.nhs.uk/conditions/cosmetic-treatments/

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M&SECCGs do not fund laser, resurfacing or other surgical treatments for treatment of acne vulgaris.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances**.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

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M&SECCGs commission adenoidectomy on a restricted basis. This policy should be read in conjunction with commissioning policy **Grommets** and **Tonsillectomy**.

Adenoids are small lumps of tissue at the back of the nose, above the roof of the mouth. Adenoids are part of the immune system, which only children have. They start to grow from birth and are at their largest when a child is around three to five years of age. Adenoids tend to shrink by adulthood and will often have disappeared.

**Adjuvant adenoidectomy** is funded in patients meeting the criteria listed below:

Children 18 years of age or under

**AND**

- with Otitis Media with Effusion (OME) who meet the CCG commissioning criteria for ventilation tubes (grommets) **and** in the presence of persistent and/or frequent upper respiratory tract infections (see Grommets)

**OR**

- Children where obstructive sleep apnoea (OSA) is demonstrated by sleep study or diagnosed clinically in the presence of excessively large tonsils and adenoids with documented evidence of failure to thrive assessed as per NICE guidance- NG 75 (see Tonsillectomy)

**Adenoidectomy as a separate procedure will not be funded.**

Patients not meeting the above criteria will not be funded unless there are **clinically exceptional circumstances**.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

**Value Based Commissioning Policies**

**Ref:** Faltering growth: recognition and management of faltering growth in children (NG 75) September 2017

https://www.nice.org.uk/guidance/ng75/chapter/Recommendations#weight-loss-in-the-early-days-of-life
M&SECCGs do not fund unconventional treatments for allergy disorder.

Only standard treatments with evidence of clinical effectiveness will be funded under the NHS. These include allergen avoidance, drugs and immunotherapy. Unconventional approaches to the management of allergy disorders will not be funded. These include clinical ecology, acupuncture, homeopathy, hypnosis, ionisation and herbal medicine.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGS and will not be funded unless there are **exceptional clinical circumstances**.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

**Value Based Commissioning Policies**

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M&SECCGs commission hip arthroscopy on a restricted basis.

Patients will be funded if they meet the criteria as listed for the following conditions.

**Group Prior Approval**

Arthroscopy of the hip can be carried out for the following:

- **Sepsis of the Hip Joint (Septic arthritis /Infectious arthritis)** – Hip arthroscopy is supported in the washout of an infected hip joint in patients refractory to medical management; patients with underlying disease or patients who are immunosuppressed.

- **Loose Bodies** – Hip arthroscopy is supported for the removal of radiologically proven loose bodies within the hip joint with an associated acute traumatic episode. Arthroscopy is not supported as a diagnostic tool where there is suspicion of loose bodies.

- **Excision/repair of Radiological Proven Labral Tears in the Absence of Osteoarthritis or Femoro-Acetabular Impingement Syndrome (FAI)** – Hip arthroscopy is supported for the excision of radiological proven labral tears associated with an acute traumatic episode in the absence of osteoarthritis or FAI syndrome.

**Individual Prior Approval**

**Femoro-Acetabular Impingement (FAI)**

M&SECCGs will fund open or arthroscopic hip surgery for the treatment of femoro-acetabular impingement (FAI) ONLY when patients fulfil ALL of the following criteria:

- Diagnosis of definite femoro-acetabular impingement defined by appropriate investigations, X-rays, MRI and CT scans.
- An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis. This should include discussion of each case with a specialist musculoskeletal radiologist.
- Severe symptoms typical of FAI with duration of at least six months where diagnosis of FAI has been made as above.
- Failure to respond to all available conservative treatment options including activity modification, pharmacological intervention and specialist physiotherapy.
- Compromised function, which requires urgent treatment within a 6-8 months’ time frame, or where failure to treat early is likely to significantly compromise surgical options at a future date.
- Treatment with more established surgical procedures is not clinically viable.
Exclusions for FAI

M&SECCGs will not fund hip arthroscopy in patients with femoro-acetabular impingement (FAI) where any of the following criteria apply:

- Patients with advanced osteo-arthritis change on preoperative X-ray (Tonnis grade 2 or more) or severe cartilage injury (Outerbridge grade III or IV).
- Patients with a joint space on plain radiograph of the pelvis that is less than 2mm wide anywhere along the sourcil.
- Patients who are a candidate for hip replacement.
- Any patient with severe hip dysplasia or with a Crowe grading classification of 4.
- Patients with generalised joint laxity especially in diseases connected with hypermobility of the joints, such as Marfan syndrome and Ehlers-Danlos syndrome.
- Patients with osteogenesis imperfecta.

Treatment of FAI should be restricted to centres experienced in treating this condition and staffed by surgeons adequately trained in techniques addressing FAI and all governance and audit undertaken in accordance with NICE IPG 403 and 408.

Funding for hip arthroscopy for all other circumstances will only be made available for clinically exceptional cases.

Patients not meeting the above criteria will not be funded unless there are clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

Value Based Commissioning Policies

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Ref:

NICE interventional procedure guidance 408 and 403

https://www.nice.org.uk/guidance/ipg403

https://www.nice.org.uk/guidance/ipg408
M&SECCGs commission knee arthroscopy on a restricted basis. Cases will only be funded if they meet the criteria below:

Arthroscopy of the knee can be undertaken where a competent clinical examination (or MRI scan if there is diagnostic uncertainty or red flag* symptoms/signs/conditions/ reason) has demonstrated clear evidence of an internal joint derangement (meniscal tear, ligament rupture or loose body) and where conservative treatment has failed or where it is clear that conservative treatment will not be effective.

Knee arthroscopy can therefore be carried out for:
- Removal of loose body where there is a clear history of locking and other treatment has failed
- Meniscus resection/meniscectomy or meniscus repair
- Articular cartilage debridement/chondroplasty or microfracture of chondral defect
- Anterior or posterior ligament reconstruction-primary or revision
- Synovectomy / symptomatic plica
- To assist selection of appropriate patients for uni-compartmental knee replacement
- Treatment of osteoarthritis with arthroscopic lavage (washout) and debridement only if the person has knee osteoarthritis with a clear history of mechanical locking (not gelling, ‘giving way’ or X-ray evidence of loose bodies)
- Continuing diagnostic uncertainty following MRI, but only in the following circumstances:
  - When the MRI is of low quality and cannot be interpreted
  - The report shows a significant degree of movement artefact
  - Where the patient has had an Anterior Cruciate Ligament reconstruction and the metal screws are affecting the image quality
  - Patient has a pacemaker

Knee arthroscopy will not be funded for any of the following indications:
- Diagnostic purposes only (noting the above exception)
- Investigation of knee pain (MRI is a less invasive alternative for the investigation of knee pain)
- Treatment of osteoarthritis including arthroscopic lavage (washout) and debridement without a clear history of mechanical locking (not gelling, ‘giving way’ or X-ray evidence of loose bodies).

*Red flag symptoms or signs include recent trauma, constant progressive non- mechanical pain (particularly at night), previous history of cancer, long term oral steroid use, history of drug abuse or HIV, fever, being systematically unwell, recent unexplained weight loss, persistent severe restriction of joint movement, widespread neurological changes, and structural deformity. Red flag conditions include infection, carcinoma, nerve root impingement, bony fracture and avascular necrosis.

Funding for knee arthroscopy outside the defined criteria will only be funded in clinically exceptional circumstances.
Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

**Value Based Commissioning Policies**

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M&SECCGs commission shoulder arthroscopy on a restricted basis.

Shoulder arthroscopy will only be funded for patients with adhesive capsulitis (‘frozen shoulder’) if the following treatments have all been tried and failed:

(a) Activity modification
(b) Physiotherapy and exercise programme
(c) Oral analgesics including NSAIDs (unless contraindicated)
(d) Intra-articular steroid injections

GPs should not refer unless all the above have been tried and failed, and referrals must include objective information to demonstrate this.

For the avoidance of doubt the CCG does not commission shoulder arthroscopy in the following:

- As a diagnostic tool
- For frozen shoulder or adhesive capsulitis except if the above criteria are met.

In the majority of circumstances a clinical examination (history and physical examination) by a competent clinician will give a diagnosis and demonstrate if internal joint degeneration is present. If there is a diagnostic uncertainty despite competent examination or if there are ‘red flag’ symptoms/signs/conditions then an MRI scan (not shoulder arthroscopy) might be indicated.

The CCGs commission shoulder arthroscopy as part of a procedural treatment i.e. as a less invasive surgical treatment which does not require prior approval. However if used to treat adhesive capsulitis will only be funded if the above criteria are met and prior approval obtained.

Red Flag symptoms or signs including:
- Recent trauma,
- Constant progressive non-mechanical pain (particularly at night),
- Previous history of cancer,
- Long term steroid use,
- History of drug abuse,
- History of HIV,
- Fever,
- Being systematically unwell,
- Recent unexplained weight loss,
- Persistent severe restriction of joint movement,
- Widespread neurological changes,
- Structural deformity.

**Red Flag conditions cont’d:**
- Infection, carcinoma,
- Nerve root impingement,
- Bony fracture
- Avascular necrosis.

Providers should be aware that payment may be withheld if they cannot demonstrate that patients meet these criteria.

Patients not meeting the above criteria will not be funded unless there are **clinically exceptional circumstances**.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>OPCS codes</th>
<th>W88.1, W88.8, W88.9 with Secondary code of Z81.4</th>
</tr>
</thead>
</table>
M&SECCGs do not fund Autologous Cartilage Transplantation.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGS and will not be funded unless there are **exceptional clinical circumstances**.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>OPCS codes</th>
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<tr>
<td></td>
<td>W85.3 (knee)</td>
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</table>

Please check website for latest versions of policies as may be subject to change throughout the year:
M&SECCGs do not fund laser/pulse dye laser/intense pulsed light (IPL) treatment of clinically benign skin lesions/conditions.

M&SECCGs do not commission surgical removal or cryotherapy of clinically benign skin lesions/conditions for purely cosmetic reasons. Surgery or treatments to improve appearance alone is not provided for normal changes such as those due to ageing. The fact that a patient wants to have a lesion removed does not constitute a sound reason for doing so at NHS expense.

M&SECCGs commission surgical removal of benign skin lesions on a restricted basis only when criteria as detailed below are met. **Individual prior approval** is required (except A below). GPs should not refer patients who do not meet the criteria detailed below. Providers will not be funded where patients are treated outside the commissioned service.

GPs providing Minor Surgery as an Additional Service (curettage and cautery and, in relation to warts, verrucae and other skin lesions e.g. seborrhoeic keratosis, cryocautery) or Minor Surgery as a Directed Enhanced Service (DES) under GMS/APMS contracts must adhere to the restrictions as detailed within this service restriction policy. Although these services are commissioned by NHS England, GPs should note that removal of benign skin lesions for purely cosmetic reasons will not be funded by NHS England under this DES and as such should apply this policy.

**All suspected malignant lesions are excluded from this policy** – these should be managed via the 2 week wait with the exception of Basal Cell Carcinoma (BCC), where low risk BCC may be removed in the community in line with NICE recommendations and high risk BCC should be referred through the usual pathway.

Once it is established that a skin lesion is not malignant its removal will not normally be funded by the NHS though a clinician may request exceptional funding. Clinicians referring on this basis should make the patient explicitly aware that removal of the lesion may not be funded by the NHS.

**Examples** of lesions covered by this policy include:

- Benign pigmented naevi (moles)
- Comedones
- Corn/Callous
- Dermatofibromas (skin growths)
- Lipomas
- Milia
- Molluscum contagiosum
- Neurofibromata
- Port wine stains
- Rosacea
- Sebaceous cysts (epidermoid and pilar cysts)
- Seborrhoeic keratoses (benign skin growths, basal cell papillomas)
- Skin tags including anal tags
- Spider naevus (telangiectasia)
- Thread veins
- Warts and plantar warts
- Xanthelasma (cholesterol deposits underneath the skin),
Individual prior approval must be obtained before referral in all circumstances other than where a patient meets criteria A below.

A. Group Prior Approval-Eye
If a benign skin lesion of the eye obscures vision or is causing a separate ocular problem then the patient can be referred to an appropriate service for removal.

B. Individual Prior Approval
Requests for surgical removal of benign skin lesions will be considered where at least one of the following criteria is met:

- Lesions with confirmed, evidenced history of recurrent infection (3 or more of the same lesion) requiring regular courses of antibiotics.
  OR
- Lesions causing significant pain (a direct result of the lesion) requiring regular prescribed strong analgesics.
  OR
- Sebaceous cysts where there has been more than one episode of infection requiring treatment with antibiotics;
  OR
- Lesions which cause demonstrable severe functional impairment which prevents the individual from fulfilling activities of daily living.
  OR
- Lesions on the face where the extent, location and size of the lesion can be regarded as considerable disfigurement, and which sets them apart from the cohort of people with similar lesions.
  OR
- Lesions are rapidly growing or abnormally located (e.g. sub-fascial, sub-muscular)
  OR
- Lesions where there is clinical evidence that a commonly benign or non-aggressive lesion may be changing to a malignancy, or there is sufficient doubt over the diagnosis to warrant removal.

Evidence that previous treatment has been pursued before referral has been made will be required. For those requiring prior approval this evidence must be provided with the request for funding.

Funding for patients not meeting the defined criteria will only be funded in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

Value Based Commissioning Policies

References:
Greater Manchester EUR Policy Statement Common Benign Skin Lesion November 2014
ICD10 codes | D17*, D22*, D23* (dermatofibroma and papillomas but may be used for other conditions), L70.0, L57.8 (milia but may be used for other conditions). B08.1, L72.0, L72.1 (sebaceous cyst eyelid, breast, genital organs). H02.8, N60.8, N94.8, N50.8 – may be used for other conditions. L82, (L91.8 Skin tag, may be used for other conditions). I84.6

OPCS codes | I78.1, B07, H02.6, D33.3, D36.1. S03*, S04*, S05*, S06*, S08*, S09*, S10*, S11*
Biologic and Synthetic Mesh are forms of surgical mesh- loosely woven sheet of either biologic or synthetic materials, used as either a permanent or temporary support for organs and other tissues during surgery.

Biological meshes are excluded from National Tariff.

**Synthetic mesh** is not excluded from National Tariff and the cost of synthetic mesh is within tariff and not funded separately.

**Synthetic Equivalents** This wording was included within 2014/15 PbR exclusions and is intended to allow for the possibility that there are synthetic materials in use which may represent a similar disproportionate cost as biological mesh – synthetic equivalents to biologic mesh are therefore also excluded from 2014/15.

M&SECCGs will separately fund use of biological mesh for the following indications whilst it is listed as an exclusion from National Tariff

- **eLAPE reconstructive surgery for low rectal cancer**: when used as part of eLAPE (extra-Levator Abdomino Perineal Excision of the rectum) reconstructive surgical technique for low rectal cancer to achieve wound closure where all the following circumstances are met:
  - Breast reconstruction - when used in patients
    - with cancer of the breast, ductal carcinoma in situ and those patients identified with the high risk BRCA gene
    - for single stage skin sparing mastectomy/reconstruction to avoid the need for a 2 stage operation involving mastectomy and reconstruction.

M&SECCGs will not separately fund as an exclusion from National Tariff

- Biological mesh when used for any indication not listed above.
- Synthetic mesh for any indication
- Synthetic equivalents (as defined above) to biological mesh.

M&SECCGs will not fund use of biologic mesh for complex abdominal wall hernia repair & closure of laparostomy. Given the uncertainties in the literature regarding evidence and circumstances for use, the use of biological mesh in complex abdominal wall hernia repair and closure of laparostomy is not separately funded as tariff exclusion at the current time.

The CCGs fund biological mesh for the above criteria and in accordance with the table below:

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<thead>
<tr>
<th>Size</th>
<th>Upper cost per single dressing (£)</th>
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<tbody>
<tr>
<td>Smaller than 10X10 cm</td>
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<tr>
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<tr>
<td>15-20x20 cm</td>
<td>6000</td>
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<tr>
<td>&gt;20x20 cm</td>
<td>6400</td>
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</table>
Funding for patients not meeting the defined criteria will only be funded in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

**Value Based Commissioning Policies**

Ref: Funding arrangements for the use of biologic and synthetic mesh equivalents-January 2017-Worcestershire CCGs

<table>
<thead>
<tr>
<th>ICD10 codes</th>
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<tr>
<td>OPCS codes</td>
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Mid & South Essex CCGs Value Based Commissioning Policies

Please check website for latest versions of policies as may be subject to change throughout the year:
M&SECCGs commission blepharoplasty on a restricted basis for functional reasons only for patients who meet the criteria below. M&SECCGs do not fund blepharoplasty for cosmetic reasons.

**Group Prior Approval:** The correction of ectropion or entropian affecting the lower lid.

**Individual Prior Approval**

**In all cases photography will be required for the individual prior approval** Photographs must be taken from the front with the camera at eye level and the individual looking straight ahead (primary gaze).

**Upper Lid**

**A**

- Excess eyelid tissue (Dermatochalasis) causing functional visual impairment AND
- Documented complaints of interference with vision or visual field-related activities such as difficulty reading or driving due to upper eyelid skin drooping, looking through the eyelashes or seeing the upper eyelid skin. AND
- Photographic evidence must show redundant skin overhanging the upper eyelid margin and resting on the upper eyelashes when gazing straight ahead.

NOTE: excess tissue below the eye rarely causes functional visual impairment and therefore lower lid blepharoplasty is not funded for this indication.

**B**

- Rehabilitation of eyelids affected by the pathological processes of thyroid eye disease, nerve palsy or blepharochalasis AND
- Causing either functional visual impairment (complaints of interference with vision or visual field-related activities such as difficulty reading or driving due to upper eyelid skin drooping, looking through the eyelashes or seeing the upper eyelid skin) or corneal exposure/irritation.

**C**

- To correct prosthesis difficulties in an ophthalmic socket

Visual field testing is not necessary to determine the presence of excess upper eyelid skin; a patient could cause a visual field defect by lowering their lids during the test. Photographs that document redundant skin overhanging the upper eyelid margin and resting on the upper eyelashes when gazing straight ahead provide a practical indication of the need for surgery. If visual field tests are performed, the tests should show that eyelids impinge on visual fields reducing field to 120° laterally and 40° vertically.
Individual Prior Approval

Lower Lid
This will be funded for

- The removal of lesions of the eyelid skin or lid margin which impair function.

Also see related policy Dysthyroid eye disease.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

Value Based Commissioning Policies

References:


<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>OPCS codes</th>
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<td>C13.1 – C13.9</td>
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<tr>
<td></td>
<td>C151, C152, C154, C155, (correction of deformity of eyelid)</td>
</tr>
<tr>
<td></td>
<td>C18.1 - C18.9 (correction of ptosis of eyelid)</td>
</tr>
</tbody>
</table>
Policy statement: Bobath Therapy
Status: Not Funded

M&SECCGs do not commission Bobath therapy.

Referral for assessment and/or treatment at specific Bobath centres outside commissioned therapy services will not be funded.

This service/procedure has been assessed as a Low Clinical Priority by M&SECCGS and will not be funded unless there are exceptional clinical circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

Value Based Commissioning Policies

<table>
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<tbody>
<tr>
<td>OPCS codes</td>
<td>N/A</td>
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</table>
M&SECCGs commission use of BMP on a restricted basis and only in line with the East of England policy for use of BMP:

**Acute tibial fractures with Grade 111B fractures (i.e. more severe cases)**

Diboterminal alfa is recommended as an adjunct to standard care using open fracture reduction and intramedullary nail fixation in patients in whom there is a substantial risk of non-union. It is restricted to patients treated with undreamed intramedullary nails.

OR

**Non-union of long bones exceeding nine months which have been assessed for bone autograft and found to be unsuitable for such procedure:**

Eptoterminal alfa combined with bovine collagen should only be considered third line

Treatment is restricted by named consultants for use in tibial, ulnar, radial, humoral, femoral and clavicular non-union.

The CCGs do not commission BMP for:

- In skeletal immature individuals defined as those who can reasonably be expected to not have fusion of the long bone epiphyses, in other words they are still growing (variant; normally in girls below 16 years and in boys below 19 years. To be individually confirmed)
- For repeat doses or sequential use of BMPs due to the possible development of antibody production.

Funding for patients not meeting the above criteria will only be granted in **exceptional clinical circumstances**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

Value Based Commissioning Policies

<table>
<thead>
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<th>ICD10 codes</th>
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<tbody>
<tr>
<td>OPCS codes</td>
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</table>
Policy statement: Breast Augmentation
Status: Not Funded

M&SECCGs do not fund surgery or treatments for Breast Augmentation.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances**.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>Exclude cancer related diagnosis codes</th>
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<tbody>
<tr>
<td>OPCS codes</td>
<td>B31.2 B30.1 B30.8 B30.9 (coding overlaps with reconstruction)</td>
</tr>
</tbody>
</table>
Policy statement: Breast Implants  
Status: Individual Prior Approval

M&SECCGs only commission the removal/replacement of breast implants on a restricted basis.

Removal

- The implant(s), whether funded privately or on the NHS, need to be removed for clinical reasons, such as implant rupture, infection or capsular contraction.

- Where implants are privately funded patients will be offered the choice of removing both prostheses in the event that only one has ruptured with the intention of preserving symmetry.

Replacement

- Implants removed for clinical reasons under this policy may be replaced when insertion of the removed implants was funded by the NHS.

- The replacement of privately funded breast implants removed for clinical reasons under this policy will not be funded.

Individual prior approval for funding is required.

Funding for patients not meeting the above criteria will only be granted in exceptional clinical circumstances

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

Value Based Commissioning Policies

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<th>ICD10 codes</th>
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<tbody>
<tr>
<td>OPCS codes</td>
<td>B31.2 B30.1 B30.8 B30.9 (coding overlaps with reconstruction)</td>
</tr>
</tbody>
</table>
M&SECCGs do not commission surgery or treatments for Breast Lift – Mastopexy

This service/procedure has been assessed as a Low Clinical Priority by M&SECCGS and will not be funded unless there are exceptional clinical circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

Value Based Commissioning Policies

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<tbody>
<tr>
<td>OPCS codes</td>
<td>B31.3</td>
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</tbody>
</table>
Policy statement: Breast Reconstruction

Status: Group Prior Approval/Individual Prior Approval

M&SECCGs commissions breast reconstruction surgery on a restricted basis in the following circumstances:

**Group Prior Approval**

- after a mastectomy or lumpectomy causing significant deformity when undertaken as part of treatment or prophylaxis of cancer
- OR
- as part of post-trauma reconstruction surgery

**Individual Prior Approval**

- congenital amastia (complete absence of breast tissue)

Breast surgery to rebuild the normal contour of the affected and the contralateral unaffected breast to produce a more normal appearance, is considered reconstructive, following a mastectomy, lumpectomy, or other breast surgery carried out in circumstances detailed above.

In all cases M&SECCGs only routinely fund two elective operation for an individual patient as part of the episode of care for the purpose of breast reconstruction- the first during or soon after the initial surgery e.g. mastectomy (although this may be delayed for medical reasons) followed by one further operation which is usually carried out as a day case. The second operation may include for example contra-lateral reduction, nipple reconstruction, lipofilling and removal of dog-ears.

All patients must be advised that further requests for surgery to address concerns about appearance, size, position, angle or balance- breast asymmetry- will be considered to be cosmetic and as such will not be routinely funded.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below and opening the relevant document on the page.

**Value Based Commissioning Policies**

<table>
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<tr>
<th>ICD10 codes</th>
<th>Exclude cancer related diagnosis codes</th>
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<tbody>
<tr>
<td>OPCS codes</td>
<td>B29*, B30*</td>
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</tbody>
</table>
Policy statement: Bunion (Hallux valgus) Surgery
Status: Individual Prior Approval

M&SECCGs commission surgery for bunions on a restricted basis.

Funding requests for Bunion surgery will only be considered when either of the following criteria are met:

**Criteria 1**
- the patient experiences persistent severe pain and significant functional impairment that is interfering with the activities of daily living.
- all appropriate conservative* measures have been tried over a 6 month period and failed to relieve symptoms, including up to 12 weeks of evidence based non-surgical treatments, i.e. analgesics/painkillers/bunion pads, footwear modification
- there is radiographic evidence of joint damage (at point of referral).
- the patient understands that they will be out of sedentary work for 2-6 weeks and physical work for 2-3 months and they will be unable to drive for 6-8 weeks, (2 weeks if left side and driving automatic car)

**Criteria 2**
- there is an increased risk of ulceration or other complications, for example, neuropathy, for patients with diabetes. Such patients should be referred for an early assessment.

*Conservative measures* include:
- Avoiding high heel shoes and wearing wide fitting leather shoes
- Non-surgical, self-funded treatments such as bunion pads, splints, insoles or shields or exercise where appropriate

**Significant functional impairment** is defined as:
- The patient complains of severe joint pain not relieved by extended non-surgical management and analgesics AND has severe impact on their ability to undertake activities of daily living.

A patient should not be referred for surgery for prophylactic or cosmetic reasons for asymptomatic bunions. Concerns about cosmetic appearance should be managed by the patient and not referred into secondary care or a Community Podiatric service.

Detailed documentation against the above criteria that are fulfilled is mandatory in the referral letter to secondary care. Clinically inappropriate referrals will be returned to GPs.

Follow up will be capped at one follow up unless there are exceptional circumstances.

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.
Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies

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<tr>
<td>OPCS codes</td>
<td>W79.1, W79.2 with supplementary code W15*, W16* or W59*</td>
</tr>
<tr>
<td>Policy statement:</td>
<td>Caesarean Section (Elective)</td>
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<tr>
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<td>-----------------------------</td>
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<tr>
<td>Status:</td>
<td>Group Prior Approval</td>
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</tbody>
</table>

Elective Caesarean Section will only be funded when **one** of the following criteria is met:

- Breech presentation.
- Multiple pregnancy.
- Preterm birth
- Small for gestational age.
- Placenta praevia.
- Morbidly adherent placenta.
- For cephalopelvic disproportion in labour,
- Mother-to-child transmission of maternal infections
- Mother has a disability or condition which prevents or restricts her ability to proceed with a vaginal delivery.
- Maternal request, including mothers who have had previous C-section(s), following an assessment by a health professional with expertise in perinatal mental health and meeting NICE guidance—see NICE. [https://www.nice.org.uk/Guidance/CG132](https://www.nice.org.uk/Guidance/CG132).


Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below:

Value Based Commissioning Policies

<table>
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<td>R17*, R18*</td>
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<tr>
<td>Admission Method</td>
<td>11,12,13</td>
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</table>
M&SECCGs commission wireless capsule endoscopy and double balloon endoscopy on a restricted basis in the following circumstance

**Diagnostic - Wireless capsule endoscopy (WCE) and double balloon enteroscopy (DBE) in obscure gastrointestinal bleeding**

M&SECCGS will fund wireless capsule endoscopy or double balloon enteroscopy for obscure gastrointestinal bleeding under the following circumstances.

**Capsule endoscopy for investigation**
- Patients with gastrointestinal bleeding who have undergone a gastroscopy and/or endoscopy and results are negative.

**Double balloon enteroscopy for treatment**
- If wireless capsule endoscopy identifies source of bleeding in small bowel and such treatment is appropriate.

If results of wireless capsule endoscopy are normal but there is persistent bleeding then
- Consider second look wireless capsule endoscopy
  OR
- Double balloon enteroscopy for investigation and treatment where appropriate

**Rationale**
- The evidence available shows that WCE and DBE are safe and effective diagnostic procedures for the detection of OGIB. Both have a higher diagnostic yield than conventional methods.
- WCE and DBE have common indications but different features. WCE can cover the whole GI tract, requires no sedation and is better tolerated by patients. Its major limitations are the inability to obtain a biopsy, precisely localise a lesion, or perform therapeutic endoscopy. DBE has the advantage of being controllable and enabling therapeutic treatment to take place simultaneously. The procedure is invasive and not as well tolerated as WCE, requiring additional staff, typically two physicians or an additional specialist nurse.
- Cost-effectiveness modelling suggests that that CE-guided DBE may be associated with better long-term outcomes because of the potential for fewer complications and decreased utilisation of endoscopic resources.
Diagnostic - Wireless capsule endoscopy and double balloon enteroscopy in Crohn's disease
M&SECCGs will fund wireless capsule endoscopy or double balloon enteroscopy for Crohn’s disease in the following circumstances

Following inconclusive ileocolonoscopy and/or small bowel radiology clinical suspicion of Crohn’s disease remains then:

- Wireless capsule endoscopy for diagnosis-If pain is not a significant feature or where pain is a significant feature and there is no evidence of strictures on small bowel radiography.
- Double balloon enteroscopy to obtain histology-If pain is significant feature and there is evidence of strictures on small bowel radiography or wireless capsule endoscopy results are inconclusive.

Rationale
- The evidence available shows that WCE is a safe and effective diagnostic procedure for the detection of Crohn’s disease. WCE has a higher diagnostic yield than push enteroscopy and other conventional methods. The results suggest that it is superior to conventional radiological procedures in the detection of lesions in patients with Crohn's disease. However, the high number of patients with strictures limits its use as a first line diagnostic test in patients previously diagnosed.
- Capsule retention remains a risk in patients with Crohn’s disease with significant strictures. The risk is greater in patients with established Crohn’s disease compared to patients suspected to have Crohn’s disease.

Evidence

NICE produced interventional procedure guidance on WCE in 2004 Guidelines produced by British Society of Gastroenterologists in 2008, state DBE should be used complementary to WCE, particularly in the context of therapeutic intervention beyond the reach of push enteroscopy.

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies

References:

<table>
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<tr>
<td></td>
<td>G802</td>
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</table>
Policy statement: Carpal Tunnel

Status: Individual Prior Approval

M&SECCGs commission surgery for carpal tunnel syndrome on a restricted basis.

Patients with wasting of the hand muscles should be urgently referred to the acute hospital (outside the scope of this policy).

**Nerve conduction studies** (EMG) are not indicated in the diagnosis of classical carpal tunnel syndrome and will not generally be funded. These may be done where there is doubt about the diagnosis, which is uncommon.

M&SECCGs will only fund surgery in patients diagnosed with Carpal Tunnel Syndrome meeting one of following criteria:

- The patient has **severe** neurological symptoms at presentation, for example altered sensation, muscle wasting or weakness of thenar abduction (wasting or weakness of abductor pollicis brevis).
- The patient has **severe** symptoms (fewer than 5% of patients) uncontrolled by conservative measures, significantly interfering with activities of daily living.
- The patient has **moderate** symptoms as defined below AND has not responded to a **minimum of 6 months of conservative** management before referral for surgery is made.

*Community based conservative treatment before referral must include the following:

- Splinting with a cock-up splint (night time only or constant) for at least 12 weeks AND
- Steroid injections—unless contra-indicated—which should be administered at least twice prior to referral for consideration of surgery

All GPs should seek access to carpal tunnel steroid injections prior to referral for surgery if they are not able to provide these themselves.

Where applicable, referral letter must detail conservative methods tried and the length of time that each of these was carried out, along with confirmation that the referrer and the patient have discussed treatment options for carpal tunnel syndrome using the Shared Decision tool.

**Classification for Severity of Carpal Tunnel Syndrome:**

- **Mild:** Intermittent paraesthesia with or without pain that may be nocturnal, or occurs with a certain hand position.

- **Moderate:** Paraesthesia that interferes with activities of daily living or causes constant night waking and/or reversible numbness and/or pain (perhaps by clenching and unclenching of fist or hand shaking).
Severe: Constant numbness or disabling pain with wasting of thenar muscles and/or weakness of thumb muscles (Abductor Pollicis Brevis and Opponens Pollicis).

Rationale:
Conservative treatment offers short-term benefit (1-3 months) similar to surgery and many patients’ symptoms may resolve for at least a year after conservative treatment. After corticosteroid injection, up to 50% of patients may report minor or no symptoms at one year. The benefits of conservative therapy are seen early after treatment and then decrease while the benefits of surgery take longer to be fully realised.

Corticosteroid injections and nocturnal splinting are effective conservative therapies. Therefore patients would not normally be referred for carpal tunnel syndrome unless they have had one local steroid injection into the carpal tunnel together with the provision of night splints.

Electro-diagnostic tests are not indicated in the diagnosis of classical carpal tunnel syndrome. These may be done where there is doubt about the diagnosis, which is uncommon.

In the longer term (3-18 months), surgery is better than conservative therapy with up to 90% of patients reporting complete or much improvement at 18 months.

A trial of conservative therapy offers the opportunity to avoid surgery for some patients.

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>G560</th>
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<tr>
<td>OPCS codes</td>
<td>A65.1 A65.8, A65.9, W021, W022, W023, W024, W028, W029,</td>
</tr>
</tbody>
</table>
Policy statement: Cataracts/Lens Extraction
Status: Group Prior Approval/Individual Prior Approval

M&SECCGs commission surgery for cataracts/lens extraction on a restricted basis.

Referrals should not be based simply on the presence of a cataract.

**Group Prior Approval**

M&SECCGs commission surgery for cataracts/lens extraction where the patient
- is willing to have eye surgery. The referring optometrist or GP must discuss this with the patient before referring. The Shared Decision Making leaflet - Deciding what to do about cataracts- must form the basis for this discussion.

deciding-what-to-do-about-cataracts.pdf

- AND with best corrected visual acuity 6/12 or worse in the worst eye assessed by the clinician as being due to a rectifiable lenticular opacity,
- AND where the reduced visual acuity significantly interferes with activities of daily living,

**Individual Prior Approval**

Patients with best corrected visual acuity of better than 6/12 in the worst eye will not normally be offered surgery unless there is evidence of very significant impact on activities of daily living. A description of this impact must accompany the referral information (as detailed below), and including confirmation that the patient is willing to have eye surgery. The referring optometrist or GP should discuss this with the patient before referring. The Shared Decision Making leaflet - Deciding what to do about cataracts- will form the basis for this discussion. Individual prior approval will be required.

All referrals must be accompanied by a completed proforma and provide the following information. Incomplete proformas will be returned to the referrer for completion, and will delay the referral.
- Details of the optical prescription
- Corrected distance visual acuity
- Corrected near visual acuity
- Co-existing other eye conditions, management and current status
- Other co-existing medical conditions affecting vision or the eyes; management and status e.g.
  - Diabetes
  - Glaucoma
  - Any other medical condition impacting on vision.
- Confirmation that the patient is willing to have eye surgery.
- Using the patient’s own words, the reasons why the patient’s vision and lifestyle are adversely affected by the cataract, and the likely benefit from surgery must be included in the referral.
Second eye - Patients will be offered second eye surgery provided they fulfil the referral criteria (see above).

Second eye surgery should be deemed urgent when there is resultant symptomatic anisometropia i.e. a large refractive difference between the two eyes resulting in poor binocular vision (this should be clearly recorded in the patient’s notes).

M&SECCGs do not commission cataract surgery/lens extraction solely for the purpose of correcting longstanding pre-existing myopia (short sighted or near sighted) or hypermetropia (long sighted).

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies

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<th>ICD10 codes</th>
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<tr>
<td>OPCS codes</td>
<td>C71.1 – C72.9, C74.1 – C75.9</td>
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</table>
Policy statement: Chalazion (cyst on or in eye lid)

Status: Group Prior Approval

M&SECCGs commission surgery for chalazia on a restrictive basis.

Chalazia are benign, granulomatous lesions caused by blockage of the Meibomian gland duct, which will normally resolve within 6 months with conservative management in primary care. They can be unsightly and, if large enough, obscure vision. In rare cases, they can lead to conjunctivitis or cellulitis. Conservative treatment is the regular i.e. three or four times a day application of hot compression to the cyst (e.g. hot wet flannel) to encourage it to spontaneously drain.

When chalazia are treated with conservative treatment for one month, rates of resolution are around 50%. Further conservative treatment may increase rates of resolution but, where conservative treatment fails, patients may be treated with surgery or steroid injections, which give high rates of resolution (80-90%).

Excision of Chalazion will be funded for those patients with TWO or more of the following criteria:

- Present for more than six months
- Present on the upper eyelid
- Source of regular infection (at least twice within the last six month) requiring medical treatment.
- Interferes with vision
- Conservative management with heat and compression has been tried for at least six months & failed and there is no appropriate alternative to surgical intervention.
- The site of the lesion or lashes renders the condition as requiring specialist intervention.

Patients meeting the above criteria may be treated in community (Tier2) services where commissioned.

Patients meeting the following criteria should be referred to secondary care:

- All children should be referred.
- Any recurrent chalazion should be referred.
- Any atypical features i.e. lash loss, bleeding should be referred.
- Any patient with previous history of Basal cell carcinoma (BCC) or Squamous cell carcinoma (SCC) or where malignancy is suspected should be referred.

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.
Value Based Commissioning Policies

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<tr>
<td>C19</td>
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<tr>
<td>C191</td>
<td>Drainage of lesion of eyelid</td>
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<tr>
<td>C198</td>
<td>Other specified incision of eyelid</td>
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<tr>
<td>C199</td>
<td>Unspecified incision of eyelid</td>
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<tr>
<td>C22</td>
<td>Other operations on eyelid</td>
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<tr>
<td>C224</td>
<td>Injection into eyelid</td>
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<td>C225</td>
<td>Exploration of eyelid</td>
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<tr>
<td>C228</td>
<td>Other specified other operations on eyelid</td>
</tr>
<tr>
<td>C229</td>
<td>Unspecified other operations on eyelid</td>
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</table>
M&SECCGs commission specialist treatment for chronic fatigue syndrome / myalgic encephalomyelitis (CFS/MS) on a restricted basis.

All specialist treatment for chronic fatigue syndrome / myalgic encephalomyelitis (CFS/MS) is accessed through a referral from the patient’s clinician to the Essex CFS/ME Service.

Patients should be managed by GPs as recommended by NICE clinical guideline number 53 – Chronic Fatigue syndrome/ myalgic encephalomyelitis (or encephalopathy) – Diagnosis and management of CFS/ME in adults and children.

Patients can be referred for unexplained fatigue lasting at least 4 months once the following alternative diagnosis have been considered and excluded:

- Obesity (BMI >40kg/m2).
- Organ failure.
- Chronic infections.
- Chronic inflammatory diseases.
- Major neurological diseases.
- Systemic treatment for neoplasms.
- Untreated endocrine diseases.
- Primary sleep disorders.
- Alcohol/Substance abuse.
- Reversible causes of fatigue (medications, infections or recent major surgery).
- Psychiatric conditions.

The clinical guideline also states the following:

- Do not use the following drugs for the treatment of CFS/ME: monoamine oxidase inhibitors, glucocorticoids (such as hydrocortisone), mineralocorticoids (such as fludrocortisone), dexamphetamine, methylphenidate, levothyroxine or antiviral agents.
- There is insufficient evidence for the use of supplements – such as vitamin B12, vitamin C, co-enzyme Q10, magnesium, NADH (nicotinamide adenine dinucleotide) or multivitamins and minerals – for people with CFS/ME, and therefore they should not be prescribed for treating the symptoms of the condition. Some people with CFS/ME have reported finding these helpful as a part of a self-management strategy for their symptoms, and in which case should purchase such products.
- People with CFS/ME who are using supplements should be advised not to exceed the safe levels recommended by the Food Standards Agency.

M&SECCGs do not provide funding for NHS prescribing of these medicines/supplements and therefore GPs must not prescribe these medicines/supplements on FP10s for this condition.

M&SECCGs do not fund referral to secondary care specialists in CFS/ME care for assessment or treatment on either an in-patient or outpatient basis outside this commissioned service.
Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

**Value Based Commissioning Policies**

| ICD10 codes | G93.3 |
Policy statement: Circumcision
Status: Group Prior Approval

Male circumcision is defined as the surgical removal of all or part of the foreskin of the penis.

M&SECCGs commission circumcision on a restricted basis and this procedure will only be funded for therapeutic reasons if the patient meets one of the following criteria:

- Suspicion or evidence of malignancy (use 2ww cancer referral pathway), dermatological disease (such as lichen planus or eczema) which is unresponsive to other treatment, where biopsy is required, and occasionally for selected patients with urinary tract infections (normally referred by a paediatrician)
- Traumatic foreskin injury where it cannot be salvaged.
- Phimosis (inability to retract the foreskin due to a narrow prepucial ring) in children when associated with recurrent infection. This does NOT include normal non-retractile foreskin of childhood.
- Adult phimosis, usually caused by recurrent balanitis or Balanitis Xerotica Obliterans (BXO)(chronic inflammation leading to a rigid fibrous foreskin).
- Paraphimosis (inability to pull forward a retracted foreskin).
- Balanoposthesis (recurrent bacterial infection of the prepuce).

There are several alternatives to treating retraction difficulties (e.g. steroid creams) before circumcision is carried out.

It is important that all those performing circumcision should follow the General Medical Council (GMC) guidelines.

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

Value Based Commissioning Policies

References:

Patient Information:
https://www.nhs.uk/conditions/circumcision-in-men/

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Mid & South Essex CCGs Value Based Commissioning Policies

Please check website for latest versions of policies as may be subject to change throughout the year:
M&SECCGs do not fund standalone treatments using complementary or alternative therapies. This restriction applies equally to primary and secondary care provision, and GPs must not prescribe such products e.g. homeopathic remedies-supplements/desensitising injections on FP10s. This list is not exhaustive but provides examples.

### Acupuncture

### Osteopathy
- Children with spastic cerebral palsy
- Paediatric dysfunctional voiding
- Adults with Lumbor or Cervical pain not warranting surgical referral.
- Adults with large joint pain as part of a care pathway that may lead to joint replacement.

### Biofeedback for:
- Chronic constipation (biofeedback is the primary treatment option for patients with dyssynergic defecation).
- Irritable bowel syndrome.
- Levator ani syndrome.
- Migraine and tension headaches (muscle, thermal or skin biofeedback).
- Neuromuscular rehabilitation of stroke and traumatic brain injury (TBI) (policy does not cover neuromuscular electrical stimulators).
- Raynaud's disease.
- Refractory severe subjective tinnitus – See Tinnitus.
- Temporomandibular joint (TMJ) syndrome – See TMJ.
- Urinary incontinence.

### Electrical stimulation
As an adjunct or as an alternative to the use of drugs either in the treatment of acute postoperative pain in the first 30 days after surgery, or for certain types of chronic, intractable pain not adequately responsive to other methods of treatment including, as appropriate, physical therapy and pharmacotherapy. A physician evaluated trial lasting between 1 and 2 months should determine if treatment is to continue.

### Selected use in palliative care
- Mistletoe in cervical cancer.
- Meditation and Tai Chi in selected elderly patients with optimally treated heart failure – evidence of reduction in sympathetic activity (SIGN 95).

### Hypnotherapy
- Severe chronic insomnia.
- IBS.

### Manipulation and Stretching
- Selected cases of osteoarthritis of the hip as an adjunct to core treatment.
- Sub-acute and chronic low back pain of more than six weeks duration.
- Acute low back pain of less than six weeks.
- Mobilisation of the neck.

### Complementary and Alternative Therapies
The CCGs will NOT fund the following therapies because of lack of sufficient evidence of effectiveness* (not an exhaustive list):
- Homeopathy
- Aromatherapy
- Herbal remedies
- Clinical ecology
- Active release technique
- Acupressure
- Alexander technique
- AMMA therapy
- Antineoplastons -- see CPB 240 - Antineoplastic Therapy and Sodium--
- Apitherapy
- Applied kinesiology

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*Please check website for latest versions of policies as may be subject to change throughout the year.
• Art therapy
• Autogenous lymphocytic factor
• Auto urine therapy
• Bioenergetic therapy
• Biofield Cancell (Entelev) cancer therapy
• Bioidentical hormones
• Brain integration therapy
• Carbon dioxide therapy
• Cellular therapy
• Chelation therapy for Atherosclerosis --
• Chiropractic services
• Chung Moo Doe therapy
• Coley's toxin
• Colonic irrigation
• Clinical ecology
• Conceptual mind-body techniques
• Craniosacral therapy
• Cupping
• Dance/Movement therapy
• Digital myography
• Ear Candling
• Egoscue method
• Electrodiagnosis according to Voll (EAV)
• Equestrian therapy --
• Essential Metabolics Analysis (EMA)
• Essiac
• Feldenkrais method of exercise therapy (also known as awareness through movement)
• Flower essence
• Fresh cell therapy
• Functional intracellular analysis (also known as essential metabolic analysis, intracellular micronutrient analysis, leukocyte nutrient analysis, as well as micronutrient testing).
• Gemstone therapy
• Gerson therapy
• Glyconutrients
• Graston technique
• Greek cancer cure
• Guided imagery
• Hair analysis –
• Hako-Med machine (electromedical horizontal therapy)
• Hellerwork
• Hoxsey method
• Human placental tissue
• Hydrolysate injections
• Humor therapy
• Hydrazine sulfate
• Hypnosis
• Hyperoxygen therapy
• Immunoaugmentive therapy
• Infratronic Qi-Gong machine
• Insulin potentiation therapy
• Inversion therapy
• Iridology
• Iscador
• Juvent platform for dynamic motion therapy
• Kelley/Gonzales therapy
• Laetrile
• Live blood cell analysis
• Macrobiotic diet
• Magnet therapy
• MEDEK therapy

Please check website for latest versions of policies as may be subject to change throughout the year:
- Meditation/transcendental meditation
- Megavitamin therapy (also known as orthomolecular medicine)
- Meridian therapy
- Mesotherapy
- Moxibustion (except for fetal breech presentation)
- MTH-68 vaccine
- Music therapy
- Myotherapy
- Neural therapy
- Ozone therapy
- Pfirrmer deep muscle therapy
- Polarity therapy
- (Poon's) Chinese blood cleaning
- Primal therapy
- Psychodrama
- Purging
- Qigong longevity exercises
- Ream's testing
- Reflexology (zone therapy)
- Reflex Therapy
- Reiki
- Remedial massage
- Revici's guided chemotherapy
- Rife therapy/Rife machine
- Rolfing (structural integration)
- Rubenfeld synergy method (RSM)
- 714-X (for cancer)
- Sarapin injections
- Shark cartilage products
- Telomere testing
- Therapeutic Eurythmy-movement therapy
- Therapeutic touch
- Thought field therapy (TFT) (Callahan Techniques Training)
- Trager approach
- Visceral manipulation therapy
- Whitcomb technique
- Wurn technique/clear passage therapy
- Yoga

These services/procedures have been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances**.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

**Value Based Commissioning Policies**
Complimentary therapies are seen by an increasing number of people (with increasing requests for treatment) as a more holistic and 'natural' approach to dealing with a variety of complaints. Attractions include the comparably longer interaction time with the practitioner and the belief that such therapies will work, affecting a complex mix of factors impacting on health. However there is much uncertainty about benefit/effectiveness, evidence of complications for some therapies and considerable grounds to suspect other adverse effects may occur. Since conventional medicine also aspires to a holistic approach, this means that some alternative therapies should be considered where evidence exists.

The types of complimentary therapies covered under this policy include Homoeopathy, Acupuncture, Osteopathy, Biofeedback, Hypnotherapy, Chiropractic Therapy, Massage, Reflexology, Clinical Ecology, Aromatherapy, Herbal Remedies, Chinese medicines, Psychotherapy and Meditation. This list is not exhaustive and other treatments not listed here but that are considered ‘alternative’ or ‘complimentary’ therapies will be considered in the same way. Some procedures may be available through services in hospices and hospitals as part of a palliative care package; these are usually through charitable services and not part of commissioned services.

Some patients may also be treated as part of an integrated conventional and complimentary service for a specific condition where these are commissioned, although exceptionality would need to be demonstrated.

**Evidence Base**

The House of Commons Science and Technology Committee enquiry into the provision of homeopathic services within the NHS in 2009 recommended that homeopathic treatments should not be routinely available within the NHS. The committee report included a robust review of the evidence base for a variety of homeopathic treatments but found no evidence of effectiveness for any condition from published RCTs and systematic reviews. A previous report commissioned by the Association of Directors of Public Health in 2007 and more recent reviews by AETNA are all consistent in confirming the lack of sufficient evidence of effectiveness of homeopathic treatments despite many years of research and hundreds of studies.

There is some evidence of clinical benefit for some complimentary therapies such as acupuncture, osteopathy, biofeedback and hypnotherapy for certain conditions. For example, NICE recommends Acupuncture for up to ten sessions for the treatment of sub-acute and chronic low back pain of more than six weeks duration. NICE also suggests that manipulation and stretching should be considered as an adjunct to core treatment for osteoarthritis of the hip, sub-acute and chronic low back pain of more than six weeks duration, acute low back pain of less than six weeks duration and mobilisation of the neck.

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<td>A70.6 – Acupuncture</td>
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Policy statement: Continuous Glucose Monitoring
Status: Individual Prior Approval

M&SECCGs fund continuous glucose monitoring in adults, children or young people with Type 1 Diabetes on a restricted basis.

Funding for real-time continuous glucose monitoring (CGM) with alarms for children or young people with type 1 diabetes will be considered on a case by case basis only when despite optimised management the patient has:
- frequent severe hypoglycaemia or
- impaired awareness of hypoglycaemia associated with adverse consequences (for example seizures) or
- inability to recognize or communicate about symptoms of hypoglycaemia (for example, because of cognitive or neurological disabilities).

Requests for funding CGM in adults with Type 1 diabetes will be considered on a case by case basis only when despite optimised management the patient has
- complete loss of awareness of hypoglycaemia or
- frequent (more than 2 episodes a week) asymptomatic hypoglycaemia that is causing problems with activities of daily living.

Individual prior approval is required in all cases.

M&SECCGs commission the provision of continuous subcutaneous insulin infusions (via insulin pumps) in line with NICE Technology Appraisal 151. In accordance with NICE principles and the ethos of NICE clinical guideline Type 1 diabetes in adults: diagnosis and management (nice.org.uk/guidance/ng17) M&SECCGS supports funding of the insulin pump with the lowest acquisition cost that meets the clinical needs of the patient, and without consideration of a patient’s desire to self-fund CGM. Co-funding, which involves both private and NHS funding for a single episode of care, is not permitted for NHS care. The choice of pump in very young children should take into account the ability to deliver a very low basal rate,

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

Value Based Commissioning Policies
**Policy statement:** Continuous Positive Airway Pressure (CPAP) in Adults

**Status:** Group Prior Approval

M&SECCGs commissions Continuous Positive Airway Pressure (CPAP) on a restrictive basis for patients with moderate or severe Obstructive Sleep Apnoea/Hypopnoea Syndrome (OSAHS) in Adults (≥15 hypopnoea events/hour per night)

CPAP is the first choice therapy for patients with moderate or severe OSAHS that is sufficiently symptomatic to require intervention.

Persistent low CPAP use (less than two hours per night) over six months, following efforts to improve patient comfort, should lead to a review of treatment.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

**Value Based Commissioning Policies**

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<td>OPCS codes</td>
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Dupuytren’s Contracture

Status: Individual Prior Approval

Dupuytren’s Contracture is nodular or cord-like thickening of the palmar fascia causing a tethering of the digits and a loss of range of extension.

Surgical treatment for Dupuytren’s contracture is commissioned by M&SECCGs on a restricted basis. Cases will only be funded if they meet the criteria below:

- Metacarpophalangeal joint (MCPJ) joint contracture of 30° or more and/or proximal IP joint contracture of 10° or more (inability to place hand flat on table)
  
  AND

- Where such condition (either MCPJ or PIPJ) is severely impacting on activity of daily living.

  OR

- Young patients with early onset disease (25-40) +/- family history, who may benefit from early assessment.

The use of Collagenase clostridium histolyticum (Xiapex®) is only supported in line with NICE TA459

- People who meet the inclusion criteria for the ongoing clinical trial (HTA-15/102/04), comparing collagenase clostridium histolyticum (CCH) with limited fasciectomy, are encouraged to participate in the study.

- For people not taking part in the ongoing clinical trial, CCH is recommended as an option for treating Dupuytren’s contracture with a palpable cord in adults only if all of the following apply:
  
  - There is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° or first web contracture) plus up to 2 affected joints.
  
  - Limited fasciectomy is considered appropriate by the treating hand surgeon.
  
  - The choice of treatment (CCH or limited fasciectomy) is made on an individual basis after discussion between the responsible hand surgeon and the patient about the risks and benefits of the treatments available.
  
  - One injection is given per treatment session by a hand surgeon in an outpatient setting. ME&SCCGs will not fund any activity/treatments costs associated with administration of CCH in any other circumstances. **Individual funding approval is required for each injection (High Cost Drug proforma).**

For audit purposes the referral letter must detail loss of extension and functional impairment.
The following surgery/treatments are considered to be a low clinical priority and are not routinely funded.

- Needle aponeurotomy (also known as percutaneous needle fasciotomy)
- Radiation therapy for early Dupuytren’s contracture
- Simple nodules in the palm

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies

References:
https://www.nice.org.uk/Guidance/IPG43
https://www.nice.org.uk/guidance/IPG368
https://www.nice.org.uk/guidance/indevelopment/gid-tag364

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Policy statement: Dynamic Lycra Splinting
Status: Not Funded

Dynamic Lycra Splinting is provided for a small cohort of people with cerebral palsy as part of some commissioned community health care services, but is not funded separately.

**Background**
Lycra splints are made-to-measure and consist of sections of lycra stitched together using specific tension, direction of pull, type of material (e.g. water absorbent for under the arms) and thickness. Boning can be included to give extra support. Splints range from hand splints to full body garments. The closeness and tightness of the splint fitting increases proprioception and helps to increase spatial awareness. In turn, this aids the reduction of any excessive tone and relaxes the patient with possible improvements in posture and gait.

Dynamic lycra splinting is not suitable for patients who have fixed deformities of a bony nature which are not amenable to change.

Compliance has a significant role to play in determining outcome, as it does for all therapy and medical interventions. Problems with comfort, toileting issues, level of support needed to put on and take off the garments and carer / patient’s willingness to comply with treatment have been reported. The patient and family or carers, who may be assisting them to apply the splints, must be made fully aware of the commitment required to ensure success.

**Evidence of effectiveness**
There has been very little research into the effectiveness of dynamic splinting. A Technology Scoping Report from Healthcare Improvement Scotland published in May 2013 concluded that

- There is limited clinical and cost-effectiveness evidence available
- Splinting may improve functional ability in some children with cerebral palsy
- There is no evidence relating to adults

Expert opinion suggests that younger children with athetoid disorders, those with quadriplegic palsy and those with neuromuscular disorders benefit the most.

Funding for patients outside commissioned services will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

Reference:
http://www.pencru.org/media/universityofexeter/general/training/pdftdocuments/Lycra orthoses_April_2013.pdf

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<td>X491 with ICD code above</td>
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Policy statement: Dysthyroid Eye Disease (Proptosis)

Status: Individual Prior Approval

Surgery for proptosis is commissioned on a restricted basis.

Funding will be provided to treat proptosis, arising from thyroid disease, as a result of enlargement of muscles in the socket and increased fatty tissue or abnormality of position of eyelid which causes extra exposure to the eye surface.

Surgery will only be offered for abnormality of the eyelid position after artificial tears have been tried for at least 6 months and failed

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies

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M&SECCGs commission ear micro suction on a restricted basis for patients who meet one of the following criteria:

a. Patients with contraindications to syringing (tympanic perforation, previous ear surgery, history of otitis externa following syringing, young children uncooperative to ear irrigation)

b. Acute or chronic otitis externa with excessive debris or swollen external meatus not settling after initial topical treatment or who require regular microsuction to prevent recurrent episodes

c. The patient has a cleft palate (repaired or not).

d. Wax unresponsive to ear irrigation. Ear irrigation must have been attempted and documented as failed on at least two occasions before referral for ear micro-suction on each occasion.

e. Ear foreign body extraction

f. Regular mastoid cavity de-waxing

Routine repeated ear micro-suctioning to prevent ear wax build up will not be funded.

Patients not meeting the above criteria will only be funded on exceptional clinical circumstances.

For more information http://www.nhs.uk/conditions/earwax/pages/introduction.aspx

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies

<table>
<thead>
<tr>
<th>ICD10 codes</th>
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</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td>D07.2</td>
</tr>
</tbody>
</table>
### Policy statement: Endoscopic Laser Spinal Surgery

| Status: | Not Funded |

M&SECCGs do not fund endoscopic laser spinal surgery for chronic back pain.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances**.

This restriction applies to the following procedures:
- Laser lumbar disectomy considered when there is nerve compression or persistent symptoms that are unresponsive to conservative treatment. Laser disectomy can be performed when the prolapse is contained. It is one of several minimally invasive surgical techniques which are alternatives to open repair procedures such as open lumbar disectomy or laminectomy. (IPG027)
- Endoscopic laser surgery for aminoplasty for chronic back and leg pain from a variety of causes. (IPG031)
- Percutaneous endoscopic laser thoracic disectomy is used to treat symptomatic thoracic disc hemiation. (IPG061)
- Endoscopic division of epidural adhesions for lower back pain, particularly when radiculopathy (a disorder of the spinal nerve roots) is present. (IPG088)
- Percutaneous intradiscal electrothermal therapy for discogenic back pain. (IPG081)

### Rationale:

Endoscopic laser spinal surgery for chronic back pain is of unproven benefit. Referral and treatment should only be considered under exceptional circumstances, in settings which meet the requirements of NICE guidance (IPG027, IPG031, IPG061 and IPG088).

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

### Value Based Commissioning Policies

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>V33.8 with V55*, Y76.3 and Y08.3</th>
</tr>
</thead>
</table>
Policy statement: Exogen® Bone healing ultrasound system

Status: Individual Prior Approval

M&SECCGs commission EXOGEN® ultrasound bone healing system for non-union in long bone (defined as humerus, ulna, radius, femur, tibia and fibula) fracture on a restricted basis.

The case for adopting the EXOGEN® ultrasound bone healing system to treat long bone fractures with non-union- i.e. failure to heal after 9 months is supported by the clinical evidence, which shows high rates of fracture healing.

On this basis M&SECCGs only fund EXOGEN® in patients meeting ALL the following criteria:

- Patients with non-union fractures in long bones which have failed to heal after 9 months.
- Patient age ≥18 years
- Patient does not have fractures related to or secondary to malignancy
- The bones are well aligned and the inter-fragment gap is < 10mm.
- The patient has been screened and referred by a Consultant Radiologist/Consultant Orthopaedic Surgeon following review on at least two occasions at least 90 days apart to allow examination of serial x-rays.
- The patient has received a further assessment in a non-union clinic by surgeon with expertise of dealing with non-union of long bones AND appropriateness of EXOGEN® has been determined through agreement of two specialist non-union Consultants.
- The patient has been counselled and has the ability to comply with usage protocol and criteria in line with the EXOGEN International* Performance Program which includes a 90% minimum adherence to the treatment regimen.

Only patients registered on the EXOGEN® International Performance Program meeting the above criteria and who successfully heal will be funded. **It is the provider’s responsibility to confirm that the patient is eligible for the ‘money-back guarantee’**

Providers must fund this treatment themselves initially and may only claim reimbursement from M&SECCGS when healing has occurred, and on the basis that individual prior approval was obtained before treatment commences and evidence is provided to M&SECCGS to support the application. For treatment failures, it is the provider’s responsibility to claim reimbursement in accordance with the manufacturers “money back guarantee” arrangement; M&SECCGs do not fund these patients.

M&SECCGs do not commission the use of EXOGEN® in patients with delayed healing fractures that have no radiological evidence of healing between 3 and 9 months.

M&SECCGs do not commission the use of EXOGEN® for any other indications

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

| OPCS codes | Not classified |
Policy statement: Facial Surgery- Aesthetic (Cosmetic)

Status: Not Funded

M&SECCGs do not fund aesthetic (cosmetic) facial surgical procedures including (but not limited to) face lifts (rhytidectomy), brow lifts, neck lifts, nose reshaping (rhinoplasty), split earlobe correction, eye bag reduction and upper eye lid surgery.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGS and will not be funded unless there are **exceptional clinical circumstances**.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
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<tbody>
<tr>
<td>S01.1 – S01.9 (Face / Brow Lift)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>OPCS codes</th>
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</thead>
<tbody>
<tr>
<td>E02.1 – E02.9 (Rhinoplasty)</td>
</tr>
<tr>
<td>Eye bags, Eyelids – see Blepharoplasty,</td>
</tr>
<tr>
<td>D03.1, D03.2, D03.4, D03.8, D03.9 (Ear tear)</td>
</tr>
<tr>
<td>Rhytidectomy</td>
</tr>
</tbody>
</table>
M&SECCGs commission non-aesthetic facial surgery on a restricted basis for the treatment of:

- Congenital craniofacial abnormalities
- Facial palsy (congenital or acquired paralysis)
- As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis
- To correct the consequences of trauma

All patients must be advised that requests for surgery to address concerns about appearance or to treat the natural ageing process are considered to be cosmetic and as such will not be funded.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>OPCS codes</th>
<th>S01.1 – S01.9 (see face/brow lift)</th>
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</thead>
<tbody>
<tr>
<td>Policy statement:</td>
<td>Flash Glucose Monitoring</td>
<td></td>
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<tr>
<td>------------------</td>
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<td></td>
</tr>
<tr>
<td>Status:</td>
<td>Not Funded</td>
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</tbody>
</table>

Flash Glucose Monitoring is not funded by M&SECCGs.

Flash Glucose Monitoring systems monitor blood glucose levels using interstitial fluid levels rather than capillary blood glucose from finger prick testing. It consists of a handheld reader and a sensor, which is sited in the back of the arm. When the reader unit is passed over the sensor, the reader shows a reading based on interstitial fluid glucose levels. The sensor lasts for up to 14 days and then needs to be replaced. The reader can show a trace for the last 8 hours and displays an arrow showing the direction the glucose reading is heading.

Flash Glucose Monitoring is not the same as continuous glucose monitoring (CGM).

The use of Flash Glucose Monitoring Systems e.g. Freestyle Libre® for patients with type 1 and type 2 diabetes is not supported due to limitations in the current evidence base that this method improves the control of glucose levels, poor accuracy in time of rapidly changing glucose levels, and cost-effectiveness.

This service/procedure has been assessed as a Low Clinical Priority by M&SECCGS and will not be funded unless there are exceptional clinical circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
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</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td>N/A</td>
</tr>
</tbody>
</table>
M&SECCGs do not fund Functional Electrical Stimulation (FES) for the treatment of dropped foot / foot drop in patients with neurological conditions.

Providers of services for patients who were funded by the NHS prior to the introduction of this policy, who require on-going funding for maintenance and support, must seek Individual approval on an annual basis and the following criteria apply:

- The patient will have objectively demonstrated (using validated tools) that the use of FES is still clinically appropriate, e.g. by
  - foot drop which impedes gait and evidence that this is not satisfactorily controlled using ankle–foot orthoses
  - gait improvement from its use

This service/procedure has been assessed as a Low Clinical Priority by M&SECCGS and will not be funded unless there are exceptional clinical circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

Value Based Commissioning Policies

<table>
<thead>
<tr>
<th>ICD10 codes</th>
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<tr>
<td>OPCS codes</td>
<td>A70.1, A70.7</td>
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</table>
M&SECCGs commission cholecystectomy on a restricted basis.

Cholecystectomy is routinely commissioned for **symptomatic gallstones** as a day-case laparoscopic cholecystectomy for people having it as an elective planned procedure, unless their circumstances or clinical condition make an inpatient stay necessary.

M&SECCGs **do not routinely fund cholecystectomy** for **asymptomatic** gallstones because the risks of surgery outweigh the benefits.

Asymptomatic gallstones are defined as the presence of gallstones detected incidentally in patients who do not have any abdominal symptoms, or have symptoms that are not thought to be due to gallstones.

The following tables indicate appropriateness of indication versus risk due to patient co-morbidity.

### Indications for cholecystectomy:

<table>
<thead>
<tr>
<th>Indication</th>
<th>Investigative Findings</th>
<th>Comorbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vague Symptoms</td>
<td>Stone in CBD</td>
<td>No+low</td>
</tr>
<tr>
<td>Single attack of biliary colic</td>
<td>Stone(s) in GB or CBD or non-functioning GB</td>
<td>No+low</td>
</tr>
<tr>
<td>Multiple attacks of biliary colic</td>
<td>Stone(s) in GB or CBD or non-functioning GB</td>
<td>No+low</td>
</tr>
<tr>
<td>Confirmed acute cholecystitis</td>
<td>Stone(s) in GB or CBD or non-functioning GB</td>
<td>No+low</td>
</tr>
<tr>
<td>Suspected acute cholecystitis</td>
<td>Stone(s) in GB or CBD</td>
<td>No+low</td>
</tr>
<tr>
<td>Porcelain gall bladder</td>
<td>Stone(s) in GB or CBD</td>
<td>No</td>
</tr>
<tr>
<td>Silent onset of jaundice</td>
<td>Stone in CBD or dilated CBD</td>
<td>No+low</td>
</tr>
<tr>
<td>Acute pancreatitis with and without appreciable alcohol intake</td>
<td>Stone(s) in GB or CBD</td>
<td>No+low</td>
</tr>
<tr>
<td>Acute recurrent pancreatitis – no significant alcohol intake</td>
<td>Stone(s) in GB or CBD</td>
<td>No, low +med</td>
</tr>
<tr>
<td>Acute recurrent pancreatitis – appreciable alcohol intake</td>
<td>Stone in CBD</td>
<td>No + low</td>
</tr>
<tr>
<td>Incidental cholecystectomy + compatible symptoms</td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>
Inappropriate Indications for cholecystectomy:

<table>
<thead>
<tr>
<th>Indication</th>
<th>Investigative Findings</th>
<th>Comorbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vague Symptoms</td>
<td>Stone in GB or chronic cholecystitis Any</td>
<td>Med+high</td>
</tr>
<tr>
<td>Single attack of biliary colic</td>
<td>Stone(s) in GB or non-functioning GB</td>
<td>High</td>
</tr>
<tr>
<td>Suspected acute cholecystitis</td>
<td>No Stones Stones but no complications</td>
<td>High</td>
</tr>
<tr>
<td>Porcelain gall bladder</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Silent onset of jaundice</td>
<td>No Stones Stones in GB only</td>
<td>All</td>
</tr>
<tr>
<td>Acute pancreatitis with and without appreciable alcohol intake</td>
<td>No Stones Stones in GB only</td>
<td>All</td>
</tr>
<tr>
<td>Acute recurrent pancreatitis – no significant alcohol intake</td>
<td>No Stones</td>
<td>Med+high</td>
</tr>
<tr>
<td>Acute recurrent pancreatitis – appreciable alcohol intake</td>
<td>No Stones Stones in GB only</td>
<td>All</td>
</tr>
<tr>
<td>Incidental cholecystectomy + Asymptomatic</td>
<td>Med + high</td>
<td></td>
</tr>
<tr>
<td>Long term TPN</td>
<td>Symptoms only Stones only Symptoms + stones Incidental findings</td>
<td>Med + high</td>
</tr>
<tr>
<td>Asymptomatic cholecystentereric fistula</td>
<td>Med+high</td>
<td></td>
</tr>
</tbody>
</table>

Exceptions to this policy could include patients with asymptomatic gallstones and
- Sickle cell disease.
- Calcified 'porcelain' gallbladder or a family history of gallbladder carcinoma immunosuppression, as they would be at higher risk if they develop an infective complication i.e. cholecystitis or cholangitis.

https://www.nice.org.uk/guidance/CG188

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies
<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>K802</th>
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</thead>
<tbody>
<tr>
<td>OPCS Codes</td>
<td>J18*, J21.1</td>
</tr>
</tbody>
</table>
Policy statement: Ganglion/Mucoid cysts
Status: Group Prior Approval

M&SECCGs commission surgical removal of ganglion/mucoid cysts on a restricted basis.

Ganglia are caused by cystic degeneration of a joint capsule or tendon sheath. Lesions at the base of the digits are often small but very tender (seed ganglion). Mucoid cysts arise at the distal interphalangeal joint and may disturb nail growth. Ganglia arising at the level of the wrist are rarely painful and most will resolve spontaneously within 5 years.

Ganglia arising at the level of the wrist are rarely painful or functionally impairing and about 50% will resolve spontaneously within 5 years. In the longer term approximately 60% of ganglia remain resolved following aspiration and about 70% following surgery. When other complications of surgery such as scar sensitivity, joint stiffness or distal numbness are taken into account operating is usually an unattractive option. Appropriately counselled patients will often not request surgical referral.

Patients with asymptomatic ganglia should not be referred to secondary care. They can be reassured in primary care and asked to seek assistance if the ganglion becomes symptomatic.

There is no indication for the routine excision of simple or asymptomatic ganglia; these should not be referred.

Surgical removal of ganglion will only be funded when they meet the criteria specified below:

- Painful seed ganglia requiring regular analgesia
  OR
- Mucoid cysts that are disturbing nail growth or have a tendency to discharge (risk of septic arthritis in distal inter-phalangeal joint)
  OR
- Surgery for ganglion of the wrist where:
  - there are symptoms associated with the ganglia such as pain, loss of sensation in certain parts of the hand, neurological loss or weakness of the wrist with the ganglion, and where the ganglion has resulted in functional impairment which prevents the individual from fulfilling activities of daily living, but has not responded to all appropriate conservative\(^1\) treatments over a minimum period of 3 months
  AND
  - the patient is aware that most ganglia resolve spontaneously over time AND
  - the patient is aware of the complications of excision such as scar tenderness, stiffness or numbness, and likelihood of recurrence.

\(^1\)Conservative treatments include:

- Reassurance-35-45% of wrist ganglia resolve with no treatment at all.
- Aspiration – There is a significant recurrence rate after a single aspiration (using wide bore needle) but after 3 serial aspirations the recurrence rate is only 12-15% which is comparable with surgery.
For audit purposes, the referral letter and hospital records should include detail on:

- Precise location of ganglion e.g. flexor tendon
- Size in cm/inches (length and width)
- How function of the area is impaired? i.e. what is the patient unable to do as a result of the ganglion?
- Degree of pain
- How long it has existed plus dates of 3 serial aspirations

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

<table>
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<tr>
<th>ICD10 codes</th>
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<tbody>
<tr>
<td>OPCS codes</td>
<td>T59*, T60*</td>
</tr>
</tbody>
</table>
M&SECCGs commission grommet insertion on a restricted basis.

**Group Prior Approval**

**Children**

Children will be funded for grommet (ventilation tube) insertion if they meet the following criteria:

- Children with severe hearing loss—i.e. persistent bilateral otitis media with effusion (OME) documented over a period of 3 months with a hearing level in the better ear of 25–30 dBHL or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available)

**OR**

- Children who have had at least 5 occurrences* of acute otitis media in the last year with additional complications such as perforations, persistent discharge, febrile convulsions, sensor neural deafness or cochlear implantation.

The persistence of bilateral OME and hearing loss needs to be confirmed over a period of **3 months before** surgical intervention will be considered. The child’s hearing should be retested at the end of this time. During this active observation period of 3 months, advice on educational and behavioural strategies to minimise the effects of the hearing loss should be offered.

*GPs should provide details of infection occurrences at the time of referral.

**Individual prior approval**

Children will be **considered** for funding if they meet one of the following criteria and individual prior approval for funding must be obtained:

- A child with persistent bilateral OME with a hearing level better than 25–30 dBHL where the impact of the hearing loss on a child’s developmental, social or educational status is judged to be significant by a specialist with expertise in child development.

- Children with Down’s Syndrome as an alternative to hearing aids for treating persistent bilateral OME with hearing loss and/or significant impact on child’s developmental, social or educational status as judged by a specialist with expertise in child development.

For children with Down’s syndrome, the following factors need to be considered before the intervention is offered:

- the severity of hearing loss
- the age of the child
- the practicality of ventilation tube insertion
- the risks associated with ventilation tubes
- the likelihood of early extrusion of ventilation tubes
Funding for children on the Cleft Lip/Palate Clinical care management pathway is through NHS England- Specialised Commissioning and therefore is not funded by the CCG.

**Individual Prior Approval**

**Adjuvant adenoidectomy** will only be funded in children with Otitis Media with Effusion (OME) who meet the above criteria for ventilation tubes (grommets) **and** in the presence of persistent and/or frequent upper respiratory tract infections.

**Adenoidectomy as a separate procedure will not be funded.**

**Group Prior Approval**

**Adults**

Grommet insertion is only funded for adults with disabling conductive hearing loss due to middle ear effusions who have not responded to non-surgical intervention over a period of 3 months, who meet the following criteria:

- Treatment for Meniere’s disease where other treatments have not resolved the problem

**OR**

- Severe retraction of the tympanic membrane, if the clinician feels this may be reversible and reversing may help avoid erosion of the ossicular chain or the development of cholesteatoma

**OR**

- Persistent bilateral Otitis Media with effusion (OME) documented over a period of 3 months **WITH**
  - A hearing level in the better ear of 25-30 dBHL or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available) **AND**
  - The persistence of bilateral OME causing conductive hearing loss has been confirmed at 3 months through audiologist assessment **AND**
  - Investigation and treatment of underlying causes has been completed without improvement in hearing

**OR**

- Unilateral hearing loss which needs to be referred for review of post lateral space

Myringotomy with or without grommet insertion is commissioned where middle ear ventilation is an essential feature of **specialist investigation** for management of:

- Underlying malignancy
- acute or chronic otitis media with complications: facial palsy or intracranial infection e.g. meningitis
- eustachian tube dysfunction that prevents the commencement or completion of hyperbaric oxygen treatment as commissioned by NHS England


The CCGs **do not commission:**

- a) Balloon dilatation of the Eustachian tube as per NICE IPG 409
b) Myringotomy with or without grommet insertion for treatment of hearing loss or other symptoms of otitis media in adults as there is insufficient research evidence of long term benefits compared with conservative management

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies

**Patient Information Leaflet:**
https://www.nhs.uk/conditions/glue-ear/

**References:**
2. NICE Clinical Guidance 60, Surgical Management Of OME, by the Collaborating Centre for Women's and Children's Health

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>H65*, H66*</th>
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</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td>D15.1</td>
</tr>
</tbody>
</table>
Policy statement: Haemorrhoids
Status: Group Prior Approval

This policy does not apply to referrals for suspected cancer and acute, profuse rectal bleeding.

Haemorrhoidectomy will be funded for patients with first or second degree haemorrhoids who do not respond to:
- Conservative treatment (e.g. lifestyle changes and pharmacological treatment)
- Other techniques (e.g. rubber band ligation, sclerotherapy, or infra-red photocoagulation).

Haemorrhoidectomy will be funded for patients with third or fourth-degree haemorrhoids that are either too large for other measures or have not responded to them.

- Grade 1 are small swellings on the inside lining of the anal canal. They cannot be seen or felt from outside the opening of the back passage (anus). Grade 1 piles are common. In some people they enlarge further to grade 2 or more.
- Grade 2 are larger. They may be partly pushed out from the anus when you go to the toilet, but quickly spring back inside again.
- Grade 3 hang out from the anus when you go to the toilet. You may feel one or more as small, soft lumps that hang from the anus. However, you can push them back inside the anus with a finger.
- Grade 4 permanently hang down from within the anus, and you cannot push them back inside. They sometimes become quite large.

Ref: https://patient.info/health/rectal-bleeding-blood-in-faeces/piles-haemorrhoids

Funding will not be made available outside the above criteria unless there are clinical exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

Value Based Commissioning Policies

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>H51*, H52*, H53*, H558, H559, H568, H569</th>
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<tbody>
<tr>
<td>OPCS codes</td>
<td>H51*, H52*, H53*, H558, H559, H568, H569</td>
</tr>
</tbody>
</table>
Policy statement: Hair Depilation/Hirsutism
Status: Not Funded

M&SECCGs do not fund hair depilation procedures or medication (e.g. Vaniqa®) or laser treatment for Hirsutism.

This service/procedure/treatment has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances**.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
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<tbody>
<tr>
<td>OPCS codes</td>
<td>S60.6, S60.7,</td>
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</tbody>
</table>
Policy statement: **Heavy Menstrual Bleeding (including uterine fibroids)**  
**Hysterectomy/Myomectomy/Uterine Artery Embolisation**

**Status:**  
**Group Prior Approval-Hysterectomy/Endometrial Ablation**

**Status:**  
**Not funded-Myomectomy/Uterine Artery Embolisation**

Hysterectomy for heavy menstrual bleeding will only be funded by M&SECCGs when the following criteria are met:

Heavy Menstrual Bleeding (HMB) is defined as excessive menstrual blood loss which interferes with the woman’s physical, emotional, social and material quality of life, and which can occur alone or in combination with other symptoms. **The policy does not apply to post-menopausal, inter-menstrual or post-coital bleeding.**

Hysterectomy for heavy menstrual bleeding will only be funded when:

- There has been a trial with a levonorgestrel-releasing intrauterine system LNG-IUS, e.g. Mirena®, unless contraindicated, for at least 12 months and this has not successfully relieved symptoms or has produced unacceptable side effects. Contraindications to the levonorgestrel intrauterine system are:
  - Distorted or small uterine cavity (with proven ultrasound measurements; uterocervical canal length < 5cm)
  - Genital malignancy
  - Active trophoblastic disease
  - Active pelvic inflammatory disease
  - Large cavity over 10cm length
- **AND**
- At least **two** of the following drug treatments *(for at least 3 months each)* have failed to relieve symptoms (unless contraindicated or inappropriate):
  - Alternative hormonal treatment in keeping with NICE guidance e.g. combined or progestogen only oral contraceptives, injected progesterone, Gn-RH analogues
  - NSAIDs
  - Tranexamic Acid

For those who for ethical reasons cannot accept the use of Mirena®, they should have tried at least two of the alternative treatments.

- **AND**
- where ultrasound shows small fibroids <3cms; uterus <12 wks gestation **AND** severe impact on quality of life and
  - Endometrial Ablation or Resection has been unsuccessful (unless contraindicated or inappropriate) as first line surgical treatment for women with heavy menstrual bleeding who do not wish to conceive in the future.

Women offered hysterectomy should have a full discussion of the implication of the surgery before a decision is made. The discussion should include: sexual feelings, fertility impact, bladder function, need for further treatment, treatment complications, the woman’s expectations, alternative surgery and psychological impact.

Women offered hysterectomy should be informed of the increased risk of serious complications (such as intraoperative haemorrhage or damage to other abdominal organs) associated with hysterectomy when uterine fibroids are present.
Women should be informed of the risk of possible loss of ovarian function and its consequences, even if their ovaries are retained during hysterectomy.

Taking into account the need for individual assessment, the route of hysterectomy should be considered in the following order: first line vaginal; second line abdominal or laproscopic.

NICE guidelines state that removal of healthy ovaries at the time of hysterectomy should not be undertaken; however prophylactic removal of fallopian tubes may be considered to reduce the risk of ovarian cancer. Ovary removal should be discussed with the patient on an individual basis and the age of the patient should also be taken into account. Ovary removal should only be undertaken with the expressed wish and consent of the woman.

**Interventions not funded by M&SECCGS**

Myomectomy and Uterine Artery Embolisation (UAE) are not funded by M&SECCGS.

NICE published update guidance in 2010 for UAE NICE interventional procedure guidance [IPG367] stating that ‘Current evidence on uterine artery embolisation (UAE) for fibroids shows that the procedure is efficacious for symptom relief in the short and medium term for a substantial proportion of patients’. However re-intervention rates are significantly higher after UAE than after surgery with up to 32% re-intervention rates for either symptom recurrence or complication by 5 years (4% for surgery). Myomectomy has a higher re-intervention rate than UAE.

The evidence for fertility and pregnancy outcomes after myomectomy and after UAE is poor. Currently it is not possible to make an evidence based recommendation about treatment (myomectomy or UAE) for women with fibroids who wish to maintain their fertility. Surgical treatments for fibroids in women of childbearing age who wish, or might wish to become pregnant in the future should be offered only after fully informed discussion.

There is limited evidence on the role of other interventions such as uterine artery ligation, Magnetic Resonance guided Focussed Ultrasound (MRgFUS) and myolysis. NICE assessment of MRgFUS indicates that although the procedure appears effective in the short term, there is a lack of evidence for its longer term effectiveness. These procedures are not funded.

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**
References:

NICE Heavy Menstrual Bleeding –Clinical Guideline March 18
https://www.nice.org.uk/guidance/ng88/resources

Clinical recommendations on UAE in management of fibroids

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>N92.0, N92.1, N92.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td>Q07.1 – Q08.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>D25*</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td>L71.3, Y53*, Z96.6</td>
</tr>
</tbody>
</table>
This policy does not include situations where emergency treatment is required e.g. strangulation is suspected-refer direct to secondary care

Femoral: All suspected femoral hernias should be referred to secondary care due to the increased risk of incarceration/strangulation

M&SECCGs commission surgical treatment of hernias on a restrictive basis for patients meeting the defined criteria below. This policy covers the management of inguinal, umbilical, ventral and incisional hernias, with criteria for referrals/treatment.

Inguinal:
For asymptomatic or minimally symptomatic hernias, a watchful waiting approach is advocated with informed consent.

Surgical treatment should only be offered when one of the following criteria is met:
- Symptomatic i.e. symptoms are such that they interfere with work or activities of daily living OR
- The hernia is difficult or impossible to reduce, OR
- Inguino-scrotal hernia, OR
- The hernia increases in size month on month OR
- The patient is currently asymptomatic but works in a heavy manual occupation (for e.g. in removal firms lifting heavy weights) and there is an increased risk of strangulation and future complications.

Umbilical:
Surgical treatment should only be offered when one of the following criteria is met:
- Pain/discomfort severely impacting on activity of daily living with a demonstrable significant detrimental impact on daily activities with functional limitation OR
- increase in size month on month OR
- to avoid incarceration or strangulation of bowel OR
- The patient is currently asymptomatic but works in a heavy manual occupation (for e.g. in removal firms lifting heavy weights) and there is an increased risk of strangulation and future complications.

Incisional/Ventral:
Surgical treatment should only be offered when BOTH of the following criteria are met:
- Pain/discomfort severely impacting on activity of daily living with a demonstrable significant detrimental impact on daily activities with functional limitation.
  AND
- Appropriate conservative management has been tried first e.g. weight reduction where appropriate OR
- The patient is currently asymptomatic but works in a heavy manual occupation (for e.g. in removal firms lifting heavy weights) and there is a risk of strangulation and future complications.
**Diastases/Divarication of recti** is a separation between the left and right side of the rectus abdominis muscle, and causes a protrusion in the midline, but is not a "hernia and does not carry the risk of bowel becoming trapped within it and thus does not require repair.

Evidence suggests that divarication does not carry the same risks as that of actual herniation.

**M&SECCGs consider repair of diastasis/divarication of recti to be a cosmetic procedure and a low clinical priority and as such do not fund.**

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>K40*, K41*, K42*</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td>T19.1 – T21.9, T24.9 – T26.9</td>
</tr>
</tbody>
</table>
Policy statement: Hip Joint Injections
Status: Individual Prior Approval

M&SECCGs commission hip joint injections under imaging guidance on a restricted basis.

Current evidence on the safety and efficacy does not appear adequate to routinely recommend hip joint injections.

M&SECCGs only fund hip injections in the following circumstances:

- Diagnostic aid
- To introduce contrast medium to the joint as part of hip arthrogram
- Investigation of infection in biological and replaced hips.
- Adults with inflammatory arthropathy

**Individual prior approval approval is required.**

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>OPCS codes</td>
</tr>
</tbody>
</table>

**References:**

Intraarticular Hip Injection and Early Revision Surgery Following Total Hip Arthroplasty: A Retrospective Cohort Study 23 September 2014. [https://doi.org/10.1002/art.38886](https://doi.org/10.1002/art.38886)

Policy statement: Hip Joint Replacement
Status: Group Prior Approval

M&SECCGs commission surgery for hip joint replacement on a restricted basis as defined overleaf.

Referral to secondary care for consideration of elective hip joint replacement should only be made when there is clinically significant functional limitation resulting in significant diminished quality of life and management of other pre-existing medical conditions has been optimised, and, except for patients with severe functional limitation (as defined in table below), an extended course (at least 6 months) of non-surgical management to manage moderate to severe persistent pain has been exhausted and failed. This will include weight reduction and changing activity -which NICE considers core treatments, use of NSAIDs and other analgesics, and introducing a walking aid. There must be radiological features of joint damage and a narrowing of the joint space on radiograph.

The Oxford Hip Score must be completed in Primary Care prior to referral for consideration of surgical hip joint replacement. The completed tool in full (not just the score) should be attached to the referral. The tool can be found at http://www.orthopaedicscore.com/scorepages/oxford_hip_score.html

The Oxford Hip Score tool should be used in conjunction with other information to help a patient make an informed decision as whether to proceed to surgery or not. This, together with the Shared Decision Making leaflet - Deciding what to do about osteoarthritis of the hip-, should form the basis for this discussion between GP / triage referral service and patient.

The patient must be willing to have surgery and, if relevant, had any risks associated with smoking or obesity explained to them. This must be discussed this with the patient before referring for surgical opinion for surgery.

Grading for the Oxford Hip Score

0 -19 May indicate severe hip arthritis. It is likely that some form of surgical intervention is required. Offer referral to a consultant orthopaedic surgeon for consideration of surgery.

20 - 29 May indicate moderate to severe hip arthritis. Consider seeking advice and guidance from consultant orthopaedic surgeon.

30 - 39 May indicate mild to moderate hip arthritis. Patients may benefit from non-surgical treatment, such as exercise, weight loss, and /or anti-inflammatory medication.

40 – 48 May indicate satisfactory joint function. May not require any formal treatment
M&SECCGs will only fund hip joint replacement surgery if:

- The patient complains of severe joint pain* AND has radiological features of severe disease including a narrowing of the joint space on radiograph AND has severe functional limitation* irrespective of whether non-surgical treatments* have been trialled, OR

- The patient complains of severe joint pain* AND has radiological features of severe disease including a narrowing of the joint space on radiograph AND has moderate functional limitation*, despite the use of non-surgical treatments* such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.

OR

- The patient complains of moderate joint pain* AND has radiological features of severe disease including a narrowing of the joint space on radiograph AND has severe functional limitation*, despite the use of non-surgical treatments* such as adequate doses of NSAID analgesia, weight control treatments and physical therapies AND is assessed to be at low surgical risk. Surgical risk divided into; Low (ASA 1 to 3); High (ASA 4)

*Please refer to the tables defining appropriate non-surgical treatments and the classification of pain levels and functional limitations to comply with policy.

In all cases:-

- Shared decision making must take place with respect to all management. This includes presenting the patient with information on all treatment options, and a clear description of the risks and benefits of each treatment, including surgery where indicated. Emphasis should be on dialogue enabling patients’ to realise they have a choice, understand the options available to them, and make a decision as to which option to choose.

- Evidence that the patient has been fully involved in the decision to have joint surgery, and including evidence of shared decision making i.e. a full record of the discussion with the patient in their notes, and including risk/benefits of all treatment options offered.

- There must be documented supporting clinical diagnostics and other assessments to support the decision to perform joint surgery.

Prostheses for total hip replacement are recommended as a treatment option for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years.

Evidence suggests that the following patients would be INAPPROPRIATE candidates for hip joint replacement surgery and will therefore not be funded:

- Where the patient complains of mild joint pain AND has minor or moderate functional limitation
- Where the patient complains of moderate to severe joint pain AND has minor functional limitation AND has not previously had an adequate trial of conservative management as described above

Patients who are inappropriate for hip joint replacement surgery must not be listed for surgery and will not be funded.
## Hip Replacement - Classification of Pain Levels and Functional Limitations

<table>
<thead>
<tr>
<th>Variable</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pain Level</strong></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>Pain interferes minimally on an intermittent basis with normal activities of daily living. Not related to rest or sleep. Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin/paracetamol at regular doses.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Pain occurs daily with movement and interferes with normal activities of daily living. Vigorous activities cannot be performed. Not related to rest or sleep. Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin/paracetamol at regular doses.</td>
</tr>
<tr>
<td>Severe</td>
<td>Pain is constant and interferes with most normal activities of daily living. Pain at rest or interferes with sleep. Pain not controlled, even by narcotic analgesics.</td>
</tr>
</tbody>
</table>

### Previous non-surgical treatments

| Correctly Done | NSAIDs, paracetamol, aspirin or narcotic analgesics at regular doses over a period of at least 6 months without achieving management of pain; provision of weight management advice and support if overweight with patient engagement, physical therapies done. |
| Incorrectly Done: | NSAIDs, paracetamol, aspirin or narcotic analgesics at regular doses over a period of less than 6 months without achieving management of pain; no provision of weight management advice and support if overweight with or without patient engagement, no physical therapies done. |

### Functional Limitations

<table>
<thead>
<tr>
<th>Minor</th>
<th>Functional capacity adequate to conduct normal activities of daily living and self-care. Walking capacity of more than one hour. No aids needed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>Functional capacity adequate to perform only a few or none of the normal activities of daily living and self-care. Walking capacity of about one half hour. Aids such as a cane are needed.</td>
</tr>
<tr>
<td>Severe</td>
<td>Largely or wholly incapacitated. The quality of life is significantly compromised. Walking capacity of less than half hour or unable to walk or bedridden. Aids such as a cane, a walker or a wheelchair are required.</td>
</tr>
</tbody>
</table>

M&SECCGs commission Primary Hip Replacements based on good clinical practice pathways as identified by the British Orthopaedic Association and Monitor\(^1\).

The CCGs commission Hip replacement in line with the British Orthopaedic Association good practice pathway:

Defined as

- a first outpatient appointment,
- a follow-up outpatient appointment,
- an inpatient admission and
- two outpatient follow-up appointments maximum only.
Further long term routine ongoing follow up is considered to be a **low clinical priority** and not funded.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>OPCS4 codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total prosthetic replacement of the hip, with or without cement, bilateral</td>
<td>All above codes with Z941 as in primary hip replacement with code Z941 for bilateral operations</td>
</tr>
<tr>
<td>Complex primary total hip replacement (including bone grafting or femoral osteotomy)</td>
<td>W3713</td>
</tr>
</tbody>
</table>

OPCS codes | WF01A, WF02A. Treatment function code 330.

References:

NICE CG177 Osteoarthritis: care and management  [https://www.nice.org.uk/guidance/cg177](https://www.nice.org.uk/guidance/cg177)

Policy statement: Hip Resurfacing
Status: Individual Prior Approval

M&SECCGs commissions hip resurfacing on the following restricted basis.

M&SECCGs will only fund those patients who would qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements as restricted by NICE Guidance Hip disease - metal on metal hip resurfacing (TA44).

Hip resurfacing is not generally considered the best option for women over the age of 65. Clinicians applying for funding approval should provide full clinical rationale for choice.

Prostheses for resurfacing arthroplasty are recommended as a treatment option for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years.

Issued: February 2014

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies

| ICD10 codes | OPCS codes | W58.1 and Z84.3 |
Policy statement: Hyperhidrosis (Botox)
Status: Individual Prior Approval


Patients with generalised hyperhidrosis should not be referred to secondary care but managed in accordance with the above pathway.

Patients with localised hyperhidrosis should not be referred to specialist without having tried:
- self-funded topical strong antiperspirants AND
- self-funded iontophoresis with tap water for at least six months.

Tap-water iontophoresis is non-invasive and is appropriate for axillary, palmar, plantar and craniofacial hyperhidrosis.

Iontophoresis with glycopyrronium bromide is not funded as the level of evidence for adding glycopyrronium bromide solution is weak and costs in primary care is prohibitive


M&SECCGs do not commission Endoscopic Thoracic Sympathectomy (ETS) due to weak evidence and significant risk of morbidity

**Individual prior approval** for funding for use of botulinium toxin is required. Treatments must not be repeated more frequently than once every 6 months.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**
Policy statement: Hysteroscopy/ Dilatation and Curettage (D&C)

Status: Group Prior Approval

M&SECCGs commissions Dilatation and Curettage/Hysteroscopy on a restricted basis.

M&SECCGS only funds D&C and hysteroscopy when used in line with NICE guidance (NG88)

Hysteroscopy will only be funded for the investigation and management of heavy menstrual bleeding when it is carried out:

- as an investigation for structural and histological abnormalities where suspected submucosal fibroids, polyps or endometrial pathology
  OR
- immediately prior to the ablative procedure to ensure correct placement of the device where endometrial ablation is required.

The CCGs will not fund D&C:

- as a diagnostic tool for heavy menstrual bleeding; or
- as a therapeutic treatment for heavy menstrual bleeding.

Postmenopausal women who have had a pelvic scan and endometrial biopsy and who present with further bleeding 6 months later should be offered hysteroscopy to be sure no small cancer has been missed without a mandatory preliminary scan.

Hysteroscopy for the majority of women should be performed as an outpatient procedure.

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies

References:
Heavy menstrual bleeding: assessment and management
NICE guideline [NG88] Published date: March 2018
https://www.nice.org.uk/guidance/ng88/resources

ICD10 codes | N92.0, N92.1, N92.4
OPCS codes | Q10.1 – Q10.9, Q18.1 – Q18.9
M&SECCGs commission surgery for ingrown toe nails on a restricted basis.

**Group Prior Approval**

Nail surgery for ingrowing toenails will only be funded for patients with moderate to severe symptoms when primary care management has failed and when delivered by a commissioned community provider.

Moderate-Severe Symptoms include:
- Increased pain and inflammation of the toe
- Purulent drainage
- Bleeding
- Recurrent Infection
- Severe and disabling pain
- Substantial erythema and inflammation
- Severe infection
- Chronic inflammation and granulation
- Nail fold hypertrophy

**Individual Prior Approval**

Surgery for ingrown toe nails is not routinely commissioned in a secondary care setting unless future orthopaedic surgery would be compromised- for example a recurrent infected ingrown toenail requiring treatment prior to joint replacement surgery. Individual prior approval must be sought.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>L600</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td>S64.1, S64.2, S68.1, S68.2, S68.3, S70.1, with Z90.6, Z90.7 or Z50.6</td>
</tr>
</tbody>
</table>
Policy statement: Insulin Pump Therapy- continuous subcutaneous insulin infusion

Status: Individual Prior Approval

M&SECCGs commission the use of continuous subcutaneous insulin infusion (CSII) or 'insulin pump' therapy as a treatment for adults and children 12 years and over with type 1 diabetes mellitus where:

- attempts to reach target haemoglobin A1c (HbA1c) levels with multiple daily injections result in the person having 'disabling hypoglycaemia', OR
- HbA1c levels have remained high (8.5% or above) with multiple daily injections (including using long-acting insulin analogues if appropriate) despite the person and/or their carer carefully trying to manage their diabetes AND
- The person has attended and completed a CCG approved diabetes educational course for example DAFNE.

CSII therapy is commissioned as a treatment option for children younger than 12 years with type 1 diabetes mellitus provided that:

- Multiple Daily Injection (MDI) therapy is considered to be impractical or inappropriate, and
- Children on insulin pumps would be expected to undergo a trial of therapy between the ages of 12 and 18 years.

Insulin pump therapy should only be started by a trained specialist team. This team should include a doctor who specialises in insulin pump therapy, a diabetes nurse and a dietitian (someone who can give specialist advice on diet). This team should provide structured education programmes and advice on diet, lifestyle and exercise that is suitable for people using insulin pumps.

Following initiation in adults and children 12 years and older, CSII therapy should only be continued if it results in a sustained improvement in glycaemic control, evidenced by a fall in HbA1c levels, or a sustained decrease in the rate of hypoglycaemic episodes. Appropriate targets for such improvements should be set by the responsible physician, in discussion with the person receiving the treatment or their carer, and notified to the commissioner. Patients must be reviewed against these targets at least annually. Continuation of funding will be dependent upon demonstrating sustained improvement and management in glycaemic control as above.

Insulin pump therapy is not routinely funded for people with type 2 diabetes mellitus.

In accordance with NICE principles and the ethos of NICE clinical guideline Type 1 diabetes in adults: diagnosis and management (nice.org.uk/guidance/ng17), M&SECCGs support funding of the insulin pump with the lowest acquisition cost that meets the clinical needs of the patient, and without consideration of a patient’s desire to self-fund CGM. Co-funding, which involves both private and NHS funding for a single episode of care, is not permitted for NHS care. The choice of pump in very young children should take into account the ability to deliver a very low basal rate.
Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

Ref:
(NICE Technology Appraisal 151: [https://www.nice.org.uk/Guidance/TA151](https://www.nice.org.uk/Guidance/TA151)).
M&SECCGs commission colonoscopy/flexible sigmoidoscopy for the diagnosis of Irritable Bowel Syndrome on a restricted basis.

Calprotectin is a protein biomarker which is used in the differentiation of inflammatory bowel disease (IBD) from irritable bowel syndrome (IBS). This test supports the differentiation of those with IBS, who can be managed in primary care, and facilitates appropriate referral to secondary care of patients with IBD.

This policy does not cover those patients with the following red flag symptoms, who should be referred via a 2 week wait referral:
- Unintentional weight loss
- Family history of bowel or ovarian cancer
- Age >60 and a change in bowel habits lasting >6 weeks
- Symptoms suggestive of ovarian pathology

Requests for endoscopy to diagnose IBS will not be funded unless the below process has been followed and evidenced in the Individual Prior Approval application and referral.

Patients presenting with the following symptoms should be offered a calprotectin test:
- Abdominal pain relieved by defecation
- Altered bowel frequency or consistency
- Symptoms for at least 6 months.
- No red flag symptoms
- Normal examination and blood tests

Patients with calprotectin levels <30ug/g should be managed as IBS patients in primary care.

Patients with calprotectin levels between 30-75ug/g should have a repeat test in 4 weeks. If the repeat test shows a calprotectin level of <30ug/g, the patient should be managed, as an IBS patient, in the primary care setting.

If the first test shows calprotectin level >75ug/g, or if the repeat test shows levels >30ug/g the patient should be referred to secondary care for inflammatory bowel disease.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below:
Value Based Commissioning Policies
https://www.nice.org.uk/Guidance/DG11
M&SECCGs commission surgery for knee joint replacement on a restricted basis.

Referral for consideration of elective knee joint replacement surgery should only be made when the patient has intense or severe joint symptoms (pain, stiffness and reduced function) that have a substantial impact on their quality of life AND are refractory to non-surgical treatment* for at least 6 months AND has radiological features of severe disease. Plain radiographs, with standing AP (or long-leg) and a lateral view may be taken for initial diagnosis but are not essential in patients over 45. Skyline and Rosenberg views may also be requested. Note that standard radiographs are required on all patients prior to referral to secondary care.

Non-Surgical Treatment*-Prior to referral patients must have received and engaged in all core non-operative treatments AND at least one additional non-operative therapy for at least 6 months.

- Core treatments for all patients:
  - Accurate verbal and written information to enhance understanding of the condition and its management and to counter misconceptions, such as that it inevitably progresses and cannot be treated. Ensure that information sharing is an ongoing, integral part of the management plan rather than a single event at time of presentation
  - Exercise irrespective of age, comorbidity, pain severity or disability. Exercise should include local muscle strengthening and general aerobic fitness.
  - Interventions to achieve weight loss if the patient is overweight. Weight maintenance also has a role in managing symptoms.
  - Advice on appropriate footwear (including shock-absorbing properties)
  - Individualised self-management strategies with the person with osteoarthritis. Ensure that positive behavioural changes, such as exercise, weight loss, use of suitable footwear and pacing, are appropriately targeted

- Additional non-operative therapies include: manual therapy (e.g. physiotherapy), supports and braces, local heat and cold therapy, non-steroidal anti-inflammatory medication (topical or oral) or COX-2 inhibitors with a proton pump inhibitor, opioid medication, and intra-articular corticosteroid knee injections.

The Oxford Knee Score should be completed in Primary Care prior to referral for consideration of surgical knee joint replacement. The completed tool in full (not just the score) should be attached to the referral. The tool can be found at http://www.orthopaedicscore.com/scorepages/oxford_knee_score.html

The Oxford Knee Score tool should be used in conjunction with other information to help a patient make a sensible decision as whether to proceed to surgery or not. This, together with the Shared Decision Making leaflet - Deciding what to do about osteoarthritis of the knee-, should form the basis for this discussion between GP/triage referral service and patient.
Grading for the Oxford Knee Score

0 - 19 May indicate severe knee arthritis. It is likely that some form of surgical intervention is required- Offer referral to a consultant orthopaedic surgeon for consideration of knee surgery.

20 - 29 May indicate moderate to severe knee arthritis. Consider seeking advice and guidance (eRS) from consultant orthopaedic surgeon.

30 - 39 May indicate mild to moderate knee arthritis. Patients may benefit from non-surgical treatment, such as exercise, weight loss, and/or anti-inflammatory medication.

40 – 48 May indicate satisfactory joint function. May not require any formal treatment

M&SECCGs will only fund knee joint replacements if:

- The patient complains of intense or severe symptomatology AND has radiological features of severe disease AND has demonstrated disease within all three compartments of the knee (tri-compartmental) or localised to one compartment plus patello-femoral disease (bi-compartmental).

OR

- The patient complains of intense or severe symptomatology AND has radiological features of moderate disease AND limited mobility or stability of the knee joint is severely impacting on activities of daily living. Information demonstrating the severity of the impact on activities of daily living must be included in the referral letter.

*Please refer to the table overleaf for classification of pain levels and functional limitations to comply with policy.

In all cases:-

- Shared decision making must take place with respect to all management. This includes presenting the patient with information on all treatment options, and a clear description of the risks and benefits of each treatment, including surgery where indicated. Emphasis should be on dialogue enabling patients’ to realise they have a choice, understand the options available to them, and make a decision as to which option to choose.

- Evidence that the patient has been fully involved in the decision to have joint surgery, and including evidence of shared decision making i.e. a full record of the discussion with the patient in their hospital notes, and including risk/benefits of all treatment options offered.

- There must be documented supporting clinical diagnostics and other assessments to support the decision to perform joint surgery.
## Knee Joint Replacement - Classification of Pain Levels and Functional Limitations

<table>
<thead>
<tr>
<th>Variable</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mobility and Stability</strong></td>
<td></td>
</tr>
<tr>
<td>Preserved mobility and stable joint</td>
<td>Preserved mobility is equivalent to minimum range of movement from 0° to 90°. Stable or not lax is equivalent to an absence of slackness of more than 5mm in the extended joint.</td>
</tr>
<tr>
<td>Limited mobility and/or stable joint</td>
<td>Limited mobility is equivalent to a range of movement less than 0° to 90° unstable or lax is equivalent to the presence of slackness of more than 5mm in the extended joint.</td>
</tr>
<tr>
<td><strong>Symptomatology</strong></td>
<td></td>
</tr>
<tr>
<td>Slight</td>
<td>Sporadic pain. Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Occasional pain. Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities. Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.</td>
</tr>
<tr>
<td>Intense</td>
<td>Pain of almost continuous nature. Pain when walking short distances on level surfaces or standing for less than half an hour. Daily activities significantly limited. Continuous use of NSAIDs for treatment to take effect. Requires the sporadic use of support systems walking stick, crutches).</td>
</tr>
<tr>
<td>Severe</td>
<td>Continuous pain. Pain when resting. Daily activities significantly limited constantly. Continuous use of analgesics - narcotics/NSAIDs with adverse effects or no response. Requires more constant use of support systems (walking stick, crutches).</td>
</tr>
<tr>
<td><strong>Radiology</strong></td>
<td></td>
</tr>
<tr>
<td>Slight</td>
<td>Ahlback grade I.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Ahlback grade II and III.</td>
</tr>
<tr>
<td>Severe</td>
<td>Ahlback grade IV and V.</td>
</tr>
<tr>
<td><strong>Localisation</strong></td>
<td></td>
</tr>
<tr>
<td>Unicompartmental</td>
<td>Excluded patello-femoral isolated.</td>
</tr>
<tr>
<td>Bicompartmental</td>
<td>Unicompartmental plus patello-femoral.</td>
</tr>
<tr>
<td>Tricompartmental</td>
<td>Disease affecting all three compartments of the knee.</td>
</tr>
</tbody>
</table>
M&SECCGs commission Primary Knee Replacements based on good clinical practice pathways as identified by the British Orthopaedic Association and Monitor\(^1\).

The CCGs commission knee replacement in line with the British Orthopaedic Association good practice pathway:

Defined as

- a first outpatient appointment,
- a follow-up outpatient appointment,
- an inpatient admission and
- two outpatient follow-up appointments maximum only.

Further long term routine ongoing follow up is considered to be a **low clinical priority** and not routinely funded.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>OP CS codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Knee Replacement</strong></td>
<td>W40.1, W40.8, W40.9, W41.1, W41.8, W41.9, W42.1, W42.8, W42.9</td>
</tr>
<tr>
<td><strong>Partial Knee replacement</strong></td>
<td>W52.1, W52.8, W52.9, W53.1, W53.8, W53.9, W54.1, W54.8, W54.9</td>
</tr>
<tr>
<td><strong>Knee Osteotomy</strong></td>
<td>W1660, W16X, W12X</td>
</tr>
</tbody>
</table>

| OP CS codes | WF01A, WF02A. Treatment function code 330. |

Reference:

- NICE CG177 Osteoarthritis: care and management  [https://www.nice.org.uk/guidance/cg177](https://www.nice.org.uk/guidance/cg177)
Policy statement: Labial Reduction/Refashioning/Vaginoplasty/Cliteroplasty

Status: Individual Prior Approval

This policy does not apply to genital reconstruction for gender dysphoria as CCGs are not the responsible commissioners. NHS England is responsible for commissioning gender identity disorder services from Specialist Gender Identity Disorder Clinic Centres.

M&SECCGs do not fund elective vaginal labia reduction/refashioning or hymenorrhaphy or vaginoplasty or cliteroplasty as these are considered to be cosmetic procedures.

M&SECCGs fund in the following circumstances:

- vaginoplasty for congenital absence, significant developmental/endocrine abnormalities of the vaginal canal or post-traumatic vaginal stenosis
- reconstructive surgery for patients who have undergone female genital mutilation or cutting

**Labia repair-trauma**

Repair of labia at the time of trauma will be routinely funded.

Post immediate trauma applications will not be funded unless there are exceptional clinical circumstances.

In all circumstances medical photography is required with the funding request submission.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>P05.5 – P05.7, P21.3 – P21.5, P32.4 – P32.7</th>
</tr>
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<tbody>
<tr>
<td>OPCS codes</td>
<td>P05.5 – P05.7, P21.3 – P21.5, P32.4 – P32.7</td>
</tr>
</tbody>
</table>

N.B.
Policy statement: Lymphoedema Services

Status: Group Prior Approval

M&SECCGs commission lymphoedema services on a restricted basis.

M&SECCGs do not fund intensive acute hospital inpatient therapy or treatment in specialist units outside local CCG community commissioned pathways.

Treatment of lymphoedema by specialist units will only be funded in exceptional clinical circumstances.

Definition:

Lymphoedema is swelling due to excess accumulation of fluid in the tissues caused by inadequate lymphatic drainage. It can affect any part of the body, but most commonly affects the arms and legs. There is no agreement on the quantitative definition of Lymphedema.

Lymphoedema can be classified as primary or secondary. Primary lymphoedema is due to abnormality intrinsic to the lymphatic system. Secondary Lymphoedema is due to damage/obstruction of the lymphatic system. This can be caused by cancer or cancer treatment, but there are a variety of other, non-cancer causes. Historically, lymphoedema services have often developed in relation to cancer services and have extended their scope to treat other types of lymphoedema.

Lymphoedema is essentially incurable as it represents end-stage failure of lymph drainage and will invariably progress unless controlled. Skin infections occur which can necessitate hospital admissions and there is increasing lack of mobility if patients are untreated.

Symptoms include the weight and discomfort of the affected limb, recurrent inflammation and infection, and the psychological distress caused by the appearance on the limb.

Once correct diagnosis has been established, the patient should be referred on to a local CCG commissioned lymphedema service.

Criteria for referral:

As lymphoedema is only one cause of oedema, the GP should ensure
- the correct diagnosis -remembering that most causes of peripheral oedema are cardiac, renal, hepatic or venous in origin, rather than lymphoedema.
- the oedema is persistent or greater than 3 months duration; or
- Patient is at known risk of lymphoedema.
- Patient must have tried and failed all available conservative management options before referral to a community based lymphoedema service.

GPs must include evidence of meeting these requirements and confirm before referral to a community based lymphoedema service.

Where children or younger adults present with limb swelling, the GP may wish to refer to the appropriate specialist to exclude diagnosis such as malignant or vascular causes, dependant on the exact clinical picture. If lymphoedema is diagnosed following investigation, these patients should be regarded as high priority by local lymphoedema services, to prevent avoidable deterioration.
Patients who are restricted from having treatment for an unrelated condition that is usually available on the NHS, and has the effect of increasing life-expectancy or quality life years as a direct result of the lymphoedema will be offered treatment for their lymphoedema.

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

Value Based Commissioning Policies

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>I89.0 (Primary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td></td>
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</table>
Policy statement: Monogenetic Diabetes Testing (MODY)

Status: Individual Prior Approval

Monogenetic Diabetes (Maturity Onset Diabetes of the Young) results from the inheritance of a mutation in a single gene, and accounts for 1-2% of the population in the UK with diabetes. Around 90% of cases are misdiagnosed as T1D or T2D.

When to suspect a diagnosis of Type 1 may not be correct
- A diagnosis of diabetes before 6 months
- Family history of diabetes with a parent affected
- Evidence of endogenous insulin production outside the ‘honeymoon’ phase with detectable C peptide
- When pancreatic islet autoantibodies are absent, especially if measured at diagnosis

When to suspect a diagnosis of Type 2 may not be correct
- Not markedly obese or diabetic family members who are normal weight
- Acanthosis nigricans not detected
- Ethnic background from a low prevalence Type 2 diabetes race e.g. European Caucasian
- No evidence of insulin resistance with fasting C peptide within the normal range

M&SECCGs commission monogenetic diabetes testing for those patients where the outcome of the test is going to change clinical management.

Funding will be made available for patients where the GP has:
- Identified the test being requested
- Provides a report documenting the outcome of the genetic nurse assessment/discussion with Monogenetic diabetes team in Exeter as to whether patient would benefit from testing and test recommended
- Name of monogenetic nurse with whom the discussion took place with (in case of further contact required)
- Assessment for the patient using the link/calculator and documentation of the outcome: http://diabetesgenes.org/content/mody-probability-calculator

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies

<table>
<thead>
<tr>
<th>OPCS/ICD10 codes</th>
<th>N/A</th>
</tr>
</thead>
</table>
M&SECCGs do not commission laser eye surgery for the correction of Myopia.

This service/procedure has been assessed as a Low Clinical Priority by M&SECCGS and will not be funded unless there are exceptional clinical circumstances.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>H44.2, H52.1 (incl Secondary codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td>C44.2, C44.4, C44.5, C46.1</td>
</tr>
</tbody>
</table>
M&SECCGs do not commission surgery to correct nipple inversion.

Nipple inversion may occur as a result of underlying breast malignancy. If the inversion is newly developed, it requires 2 week wait/urgent referral and assessment.

In all other circumstances; this service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances**.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>OPCS codes</th>
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<tr>
<td></td>
<td>B35.6</td>
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</table>
M&SECCGs commission open/wide bore MRIs on a restricted basis.

Funding will only be made available if the patient meets at least one of the criteria below:

- Morbidly obese patients unable to access local MRI services because of their size
- Patients with co-morbidities which mean that the patient will be at significant increased clinical risk if they were to have a standard MRI.

Patients with claustrophobia **are not eligible** for open/wide-bore MRI scans unless either of the above criteria also applies.

It is the responsibility of the referring clinician to provide evidence to support the application. Decisions on funding are made based solely on the information provided.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Policy statement: Orthoses/Orthotics
Status: Group Prior Approval/Individual Prior Approval

M&SECCGs commission assessment and supply of orthoses on a restricted basis.

Referrals for assessment for orthoses will only be accepted in the following circumstances:

1. Neurodisability
2. Talipes equinovarus
3. Adolescent tendinopathy at risk of developmental compromise
4. Post operative patients
5. Congenital skeletal abnormality
6. Burns

M&SECCGs do not fund ‘off-the-shelf’ orthoses / ‘in-shoe’ appliances. Patients who have been funded for ‘off-the-shelf’ / ‘in-shoe’ orthoses by M&SECCGs in the past will no longer be funded on this basis alone.

M&SECCGs only fund customised orthoses for patients with circumstances as listed above and where the clinical needs of a patient cannot be met using an ‘off-the-shelf’ orthoses.

Patients with structural/flexible flat foot requiring arch supports/pronation control orthoses should not be referred but advised to purchase ‘off-the-shelf’ / ‘in-shoe’ orthoses if required.

Cervical Soft Collars
M&SECCGS does not routinely fund cervical soft collars.

Lumbar Supports
M&SECCGs do not routinely fund lumbar support orthoses other than custom moulded back braces when prescribed following consultation with NHS commissioned spinal specialist surgeons for which individual prior approval is required.

Funding outside these criteria will only be provided in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below:

Value Based Commissioning Policies

| ICD10 codes | M21.47
| OPCS codes |  |
M&SECCGs do not fund Photodynamic therapy for age related macular degeneration.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances**.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below:

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>H35.3*</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td>C88.2 or Y13.6</td>
</tr>
</tbody>
</table>
M&SECCGs commission Pinnaplasty/Otoplasty surgery on a restricted basis.

Patients will be considered for surgery on a case by case basis where both the following criteria are met:

- Patient is aged between 10 and 16 years of age and has expressed concern about their appearance
- There is very significant ear deformity or asymmetry.

**All applications for funding must be accompanied by photographs.**

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>OPCS codes</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>D03.3</td>
</tr>
</tbody>
</table>
Craniosynostosis, which results from the premature closure of one of more of the cranial sutures, carries a significant risk of raised intracranial pressure, therefore requiring interventional surgery. **Interventions of craniosynostosis are commissioned by NHS England.**

Nonsynostotic or positional plagiocephaly has not been shown to be associated with any long term developmental problems and treatment has been described as entirely cosmetic.

M&SECCGs do not fund treatments for non-synostotic or positional plagiocephaly

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGS and will not be funded unless there are **exceptional clinical circumstances**.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>Q67.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td>?</td>
</tr>
</tbody>
</table>
**Policy statement:** Platelet Rich Plasma Injections for Tendinopathy  
**Status:** Not Funded

M&SECCGs do not fund Platelet Rich Plasma (autologous blood) Injections for Tendinopathy

The evidence on autologous blood injection for tendinopathy raises no major safety concerns. However the evidence on efficacy remains inadequate, with few studies available that use appropriate comparators.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances**.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

https://www.nice.org.uk/guidance/ipg438/

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>M75.2?</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td>X33.3?</td>
</tr>
</tbody>
</table>
Policy statement: Repair of Ear Lobes
Status: Group Prior Approval-Immediate
Status: Not Funded- Post immediate trauma applications

M&SECCGs commission surgical repair of ear lobes on a restricted basis.

This is only funded when primary suture post trauma occurs immediately after the time of trauma i.e. the patient is automatically eligible for emergency treatment when he/she presents for repair at A&E at the time of trauma.

**Post immediate trauma applications are not funded.**

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>OPCS codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D06.2</td>
</tr>
</tbody>
</table>
**Policy statement** | **Reversal of Sterilisation**  
--- | ---  
**Status:** | Not funded  

M&SECCGs do not fund reversal of sterilisation in men or women.

Sterilisation procedures are undertaken on the understanding that it is an irreversible procedure. Patients are informed and written consent is sought before the operation is carried out. Provider clinical governance systems should continue to embrace good practice guidelines from the Royal Colleges regarding the giving of information and informed consent prior to sterilisation.

Sterilisation is a procedure by which a person is rendered permanently unable to produce children. This is called a vasectomy in men and operative occlusion of the fallopian tubes in women. Reversal of sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes in women and vas deferens in men.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are *exceptional clinical circumstances*.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>N18.1, Q29.1 – Q29.9, Q37.1 – Q37.9</td>
</tr>
<tr>
<td>OPCS codes</td>
</tr>
<tr>
<td>N18.1, Q29.1 – Q29.9, Q37.1 – Q37.9</td>
</tr>
</tbody>
</table>
M&SECCGs do not fund laser or surgical treatments for Rhinophyma.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances**.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below:

**Value Based Commissioning Policies**

| ICD10 codes | L71.1 |
| OPCS codes  |       |
M&SECCGs provide funding for riser recliner chairs on a restricted basis.

In the majority of cases specialist adaptations can be made to fit the existing seating in a patient’s home to achieve correct postural management or pressure relief. It is recognised that not all standard domestic chairs are suitable for adaptations—e.g., pressure relieving overlays may render a chair too high for transfers and that some patients will need to buy suitable standard furniture. Riser recliner chairs are considered to be furniture and are available to purchase from high street stores.

NHS funding for a riser recliner will not usually be made available when there is a profiling bed in-situ or provision planned, or only because a patient has unsuitable furniture, and will not be funded for personal comfort alone. Specialist height adjustments, use of a footstool, posture management or pressure relieving solutions can be added to existing furniture to meet specific needs. Patients with oedematous legs or specific pressure care needs will not automatically be eligible.

M&SECCGs will only fund a riser recliner chair where no other solution can safely meet a genuine healthcare need, so that the patient can sit out for periods of two hours or more and is required to support mobilisation and maintain a level of independence.

It is the responsibility of the applying clinician to provide full information to support the application for funding, demonstrating that the patient:

- has a genuine healthcare need for a riser recliner which cannot be safely met by any other solution, **AND**
- can sit out for periods of two hours or more **AND**
- the riser recliner is required to support mobilisation and maintain a level of independence; **AND**
- the patient agrees to use the chair regularly to optimise their health outcomes.

Applications for funding will be considered on a case by case basis upon receipt of a fully completed proforma.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>OPCS/ICD10 codes</th>
<th>L71.1</th>
</tr>
</thead>
</table>

Please check website for latest versions of policies as may be subject to change throughout the year.
M&SECCGs do not fund sacral nerve modulation for any condition.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances**.

N.B. NHS England is the responsible commissioner for sacral nerve stimulation for urinary and faecal incontinence.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**
<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Scar revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Individual Prior Approval / Not Funded</td>
</tr>
</tbody>
</table>

M&SECCGs commission scar revision surgery on a restricted basis only in patients where ALL of the following criteria apply:

- The scarring is a consequence of previous surgery, burns or trauma; **AND**
- The scarring is causing adverse clinical consequences (due to contraction, tethering or recurrent breakdown); significant functional impairment (for example obstruction of orifice or vision); bleeding or suspicion of malignancy; **AND**
- Where clinically appropriate, proactive conservative/‘over the counter’ therapies (e.g. almond oil, steroid injections, silicone therapy, pressure garments, medication or massage) aimed at arresting the development of adverse, keloid or hypertrophic scarring have been tried but have not been effective; **AND**
- At least 2 years of the natural healing process has passed

GPs should not refer unless the above criteria apply and referrals must include objective information to demonstrate this.

M&SECCGs do not commission scar therapy e.g. laser or surgery, including skin resurfacing, for any of the categories listed below:

- Hypertrophic or keloid scars that are not causing adverse consequences or functional impairments (e.g., keloid scarring after ear piercing)
- Scarring / ulceration from chronic tattoo breakdowns
- Post-acne scarring
- Scars resulting from self-harm
- Scar treatment for skin rejuvenation or other cosmetic purposes

Photographs will be required to support any application for funding

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

**References:**

1. Information for Commissioners of Plastic Surgery Services - Referrals and Guidelines in Plastic Surgery (NHS Modernisation Agency) London


https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2922716/pdf/jcad_3_5_20.pdf

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>L91.0, L90.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td>S06.5, S06.9 with Y06.4, S23.1 – S23.9</td>
</tr>
</tbody>
</table>
**Policy statement:** Scotopic Sensitivity Syndrome (Mears-Irlen Syndrome) and Coloured Filters/Tinted Lenses

**Status:** Not Funded

M&SECCGs do not fund provision of colorimetry and coloured filters/tinted lenses for specific reading difficulty (SRD), dyslexia, Scotopic Sensitivity Syndrome (SSS), visual stress or Mears Irlen Syndrome. There is insufficient evidence of efficacy on this treatment.

Scotopic Sensitivity Syndrome (SSS) is said to cause visual discomfort in a subgroup of people with dyslexia. It consisted of six major categories of symptoms:

- Photophobia: sensitivity to light.
- Background distortion.
- Visual resolution: the inability to see print clearly and free from distortions.
- Scope of focus: the inability to perceive groups of letters, notes, numerals, or words at the same time.
- Sustained focus: the inability to maintain focus except with the employment of inordinate energy and effort.
- Depth perception/gross motor activities: the inability to judge distance accurately.

Sufferers from SSS are diagnosed by a set of questions constituting the Irlen Differential Perceptual Schedule (IDPS) test and treated with coloured lenses specific to each individual.

An update from the Royal College of Ophthalmologists issued in Autumn 2002 stated that “no scientific evidence to support the existence of such a syndrome has been found. The symptoms elicited by the IDPS are vague and medically would have very little diagnostic significance. Although SSS may not exist, interest in coloured filters or overlays as a treatment for dyslexia has persisted. Much of the literature is uncontrolled or poorly planned, but some good studies have supported it”.

There are no proven documented risks to health for the use of individually prescribed coloured overlays or tinted lenses. Pending further high quality research, provision of coloured filters/tinted lenses for specific reading difficulty (SRD) is considered low priority.

Coloured filters for reading disability: A systematic review WMHTAC 2008

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances**.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

<table>
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<tr>
<th>OPCS/ICD10 codes</th>
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</table>
The nose is partitioned in the middle by the nasal septum, dividing it into two nostrils. The nasal septum is made of cartilage and bone. Sometimes, due to injury or simply because it has grown that way, the septum may be bent, buckled or deviated to one (or both) sides, causing blockage by reducing the area available for air to flow through. The operation of Septoplasty is used to correct this abnormality in order to allow air to pass through either nostril more easily.

Rhinoplasty aims to improve the cosmetic appearance of the nose. When rhinoplasty is performed in combination with septoplasty it is called septrhinoplasty. Nasal surgery to improve cosmetic appearance of the nose, including Rhinoplasty and Septorhinoplasty, is not routinely funded by M&SECCGs—see Aesthetic Facial Surgery.

Primary care must obtain prior approval before referring patients to secondary care providers and secondary care providers must satisfy themselves that the patient has funding secured prior to seeing the patient. This is to ensure inappropriate out-patient appointments are avoided and patient expectations are properly managed.

NB: This policy does not apply to:

- Immediate post trauma nasal manipulation which normally occurs two to three weeks after the trauma and not restricted.
- To facilitate sinus surgery access.

M&SECCGs commissions septoplasty on a restricted basis for which individual prior approval is required.

Requests for septoplasty will be considered where the patient has:

- A deviated septum causing significant and persistent nasal blockage. This includes post-traumatic nasal injury associated with septal/bony deviation of the nose which is causing significant and persistent nasal blockage. **OR**
- Nasal deformity secondary to a congenital craniofacial deformity causing significant functional impairment— **OR**
- Part of reconstructive head and neck surgery.

Septorhinoplasty will only be funded when a septoplasty alone will not improve functional impairment.

Note: Cleft lip/palate patients are funded through NHS England commissioned Cleft Lip/Palate clinical management pathway and not funded by M&SECCGs.

M&SECCGs will not approve funding for patients who are unhappy with the outcome of previous surgeries including immediate post-trauma corrections (whether provided by the NHS or private providers) or for snoring unless they meet the criteria above.
Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>Z411 (Secondary code)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td>E03*</td>
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</tbody>
</table>
Policy statement: Skin contouring/Body contouring/Liposuction/Tumescent Liposuction/Liposculpture
Status: Not Funded

M&SECCGs do not fund liposuction/tumescent liposuction/liposculpture/skin contouring surgical procedures except apronectomy/abdominoplasty in defined circumstances- see separate policy.

Body contouring is any procedure that alters the shape of different areas of the body to reduce excess skin or remove fat.

Liposuction, which is sometimes known as liposculpture, is the removal of unwanted body fat using a surgical vacuum and is a form of cosmetic surgery.

Skin excision for contouring including the lifting of buttock, arm and/or thigh is regarded as a cosmetic procedure and as such is not funded.

This service/procedure has been assessed as a Low Clinical Priority by M&SECCGs and will not be funded unless there are exceptional clinical circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

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<tr>
<th>ICD10 codes</th>
<th>OPCS codes</th>
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<tbody>
<tr>
<td>S03.3, S03.8, S03.9</td>
<td></td>
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</tbody>
</table>
M&SECCGs commission sleep studies for adults (over 18 years of age) with suspected sleep apnoea, complex sleep disorders or where necessary to confirm a diagnosis of narcolepsy.

NHS England commissions sleep studies for children and young people from Specialist Paediatric Respiratory Centres.

**Oral Appliances/Mandibular Advancement Devices**

Oral appliances have been shown to improve OSAHS and, in comparison with continuous positive airway pressure (CPAP), no conclusive difference in daytime sleepiness was shown. There is large cost, convenience, and adherence implications for the use of CPAP and, for some patients, oral appliances may be of benefit. Therefore, oral applications (self-funded) should be promoted in primary care to avoid where possible the need for CPAP.

**Driving**

It is the responsibility of people who are sleepy during the day (regardless of the cause) to cease driving until their symptoms resolve. If the symptoms are severe enough to affect driving performance and are due or very likely due to a medical condition (including OSAHS) the driver must inform the DVLA. Although clinicians are not required to inform the DVLA about the patient’s symptoms, they are responsible for advising the patient appropriately.

Vocational drivers of Heavy Goods Vehicles (HGVs) or Public Service Vehicles (PSVs) meeting the referral criteria of this policy may be referred for investigation with oximetry/polysomnography without attempted lifestyle modification and, if diagnosed with OSAHS at any level of severity may be offered oral devices or CPAP as initial options. For vocational drivers, if a diagnosis of OSAHS has been made or is strongly suspected adequate symptom control should be confirmed by a specialist before driving resumes and annual licensing review is required.

**Limited Sleep Studies**

M&SECCGs commission limited sleep studies (pulse oximetry) for patients with suspected sleep apnoea where other causes of daytime sleepiness have been excluded e.g. insufficient sleep, psychological conditions and sedating drugs.

If obstructive sleep apnoea is suspected the patient should have attempted lifestyle modification i.e. weight loss, stop smoking, reduce alcohol consumption- as appropriate before referral.
The following criteria must be met prior to referral for limited sleep studies:

- Patient ≥ 18
- Patient snores
- Daytime sleepiness (rather than tiredness) assessed by Epworth scale with score ≥11

**AND** one or more of the following

- Witnessed regular or frequent nocturnal apnoeic episodes of stopping breathing
- Waking with sensations of choking/obstruction
- Neck circumference ≥17ins in a man or > 15ins in a woman
- Significant retrognathia
- Small oedematous pharynx on visual inspection

**Polysomnography**

Patient has ≥5 <15 hyponea events/hour per night measured by pulse oximetry

**OR**

Patients who have typical symptoms of excessive daytime somnolence but no objective evidence of obstructive sleep apnoea on limited sleep study.

**OR**

Patient has suspected narcolepsy and confirmation of diagnosis is required.

M&SECCGs do not commission surgical procedures for OSAHS.

M&SECCGs do not commission sleep studies for parasomnia, periodic limb movement disorder, chronic insomnia or snoring.

M&SECCGs do not commission procedures for snoring where this is the sole problem- see **Snoring**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

**Value Based Commissioning Policies**

<table>
<thead>
<tr>
<th>ICD10 Codes</th>
<th>G473, R06.8 Snoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td>(A847 – Sleep studies)</td>
</tr>
</tbody>
</table>
Policy statement: Snoring and Snoring ENT referrals
Status: Not Funded/Group Prior Approval

Snoring
M&SECCGs do not fund procedures for simple snoring where this is the sole problem.

Surgical interventions and related treatments for simple snoring will not be funded: Such interventions include, but may not be limited to, the following:

Uvulopalatopharyngoplasty (UP3 or UPPP)
Laser assisted uvulopalatoplasty (LAUP)
Radiofrequency ablation (RFA)
Soft palate implants

If associated with sleep apnoea - see Sleep Studies

This service/procedure has been assessed as a Low Clinical Priority by M&SECCGs and will not be funded unless there are exceptional clinical circumstances.

Snoring ENT referrals

In circumstances where a cancer is suspected, the 2 week wait referral process should be used.

A referral for an assessment to exclude other sinister pathology will be funded when all the following conservative measures have been tried prior to referral.

- Weight reduction if BMI is over 35.
- Use of therapies such as nasal sprays or strips.
- Use of ear plugs whilst asleep.
- Reduction of evening alcohol if relevant.
- Stop smoking.
- Self-training to alter their sleep position to avoid lying on their back. Please indicate in any referral, how the patient has altered sleep position.
- Use of a mandibular device (not funded by the NHS).

See also Septoplasty, Facial Aesthetic-Rhinoplasty and Snoring Value Based Commissioning Policies.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies

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<tr>
<th>ICD10 codes</th>
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<tr>
<td>OPCS codes</td>
<td>F32.5, F32.6</td>
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</table>
Policy statement: Sperm, Embryo or Oocyte Cryopreservation

Status: Individual Prior Approval

M&SECCGs commission Sperm, Embryo or Oocyte cryopreservation on a restricted basis.

Funding for fertility preservation will be offered to patients who have a disease or a condition requiring medical or surgical treatment that has a significant likelihood of making them infertile.

The following fertility preservation methods will be considered for funding:
- Sperm retrieval and cryostorage
- Ovarian stimulation, egg collection and either egg or embryo cryostorage

Patients must meet the following criteria:
- Commenced puberty and be aged up to 41 years old for women or up to 55 years old for men.
- Women need to be well enough to undergo ovarian stimulation and egg collection but this should not worsen their condition and sufficient time is available prior to starting treatment.

Embryo or oocyte cryostorage will not be available where a woman:
- chooses to undergo medical or surgical treatment whose primary purpose is that it will render her infertile, such as sterilisation
- requests cryostorage for personal lifestyle reasons, such as wishing to delay trying to conceive.

M&SECCGs will fund storage of embryo, eggs and sperm:
- until the age of 25 if harvested before 20th birthday
- for 5 years if harvested between her 20th and 38th birthday
- until 43rd birthday if harvested after the age of 38

Patients can choose to fund storage themselves beyond the NHS funded period.

If the patient dies whilst their embryos, eggs and sperm are in storage the CCGs will only fund storage 3 months from the date of the person dying. Extended storage beyond this time may be funded privately if applicable.

If the person is already deceased the 3 months commences on (date of new policy)

NHS Funding for use of stored material for assisted conception in line with patient’s CCG policy. Any further costs e.g. use of sperm/oocytes in private fertility treatment or transport to another clinic etc would need to be met by the patient.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

It should be noted that M&SECCGs are not the responsible commissioner for Pre-implantation Genetic Diagnosis and associated IVF/ICSI. This service is commissioned by NHS England.
Specialist fertility services for members of the Armed Forces are commissioned separately by NHS England

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below and opening the relevant document on the page.

Value Based Commissioning Policies

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<th>OPCS/ICD10 codes</th>
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Mid & South Essex CCGs Value Based Commissioning Policies

Please check website for latest versions of policies as may be subject to change throughout the year:
M&SECCGs do not fund spinal cord stimulators.

Patients requiring spinal cord stimulators, including previously managed patients requiring e.g. battery changes should be referred to an NHS England commissioned specialised pain centre.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below and opening the relevant document on the page.

Value Based Commissioning Policies

Ref: Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin
NICE technology appraisal guidance [TA159] Published date: October 2008
https://www.nice.org.uk/guidance/ta159

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<tr>
<th>ICD10 codes</th>
<th>A48.3, A48.7</th>
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<tbody>
<tr>
<td>OPCS codes</td>
<td>A48.3, A48.7</td>
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</table>
M&SECCGs commission spinal injections on a restricted basis.

**Not Funded**

Therapeutic spinal injections are **not funded** for the treatment of non-specific low back pain.

Spinal injections include:

- Facet joint injections
- Medial branch blocks
- Intradiscal therapy
- Prolotherapy
- Trigger Point Injections

Medial branch blocks for diagnostic purposes prior to radiofrequency denervation will be funded only once for one particular level or side (see below).

**Epidural, sacro-iliac and nerve root injections**

**Not Funded**

Epidural, sacro-iliac and nerve root injections are not funded for the treatment of non-specific low back pain.

**Individual Prior Approval**

Epidural, sacro-iliac and nerve root injections for radicular leg pain (caudal epidural, lumbar epidural, transforaminal epidural or nerve root injections) will only be funded in accordance with the criteria specified below. Nerve root injections should only be performed under imaging.

- The patient has radicular leg pain (below the knee for lower lumbar herniation, into the anterior thigh for upper lumbar herniation) consistent with the level of spinal involvement

**OR**

- There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30° and 70° or positive femoral tension sign)

**AND**

- Moderate to severe and persistent radicular leg pain despite participation in comprehensive back pain programme (e.g. analgesia, physical therapy, modified activity, etc.).

Under these circumstances, a total of **up to two injections** will be funded per episode. The interval between two injections must be at least 6 months. Individual prior approval is required for each injection.
Epidural injections are not recommended or funded for neurogenic claudication caused by central spinal canal stenosis.

Individual Prior Approval
Diagnostic assessment

Medial branch blocks are only commissioned for diagnostic assessment when one procedure will be funded for one particular level or side in each patient being assessed for radiofrequency denervation/surgical management of chronic spinal pain e.g. neck pain; low back pain; leg pain. Patients must have had the pain for more than one year and other conventional options have failed to resolve the pain (oral analgesics and physiotherapy).

Progression to Medial Branch Block Radiofrequency Denervation will only be commissioned (funded) where there is evidence of pain relief of ≥80% at time of the medial branch block injection and the pain starts to recur within 72 hours.

Individual Prior Approval
Radiofrequency denervation (rhizolysis) -
The procedure called ‘radiofrequency denervation’ involves sealing off some of the nerves to the joints of the spine to stop the nerves transmitting pain signals. It aims to achieve longer-term pain relief and allow rehabilitation in people with spinal pain who experience significant but short-term relief after a diagnostic block by injection of local anaesthetic.

Radiofrequency denervation for chronic non-specific low back pain will only be funded in accordance with the criteria below:

- Comprehensive non-surgical treatment including community pain pathway has not been successful
- The main source of pain is thought to come from structures supplied by the medial branch nerve
- Moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral
- Positive response to a diagnostic medial branch block.
- The interval to the last radiofrequency denervation (in the same location) must be at least 12 months

Funding for patients not meeting the condition and relevant criteria set out above will not be granted unless there are clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below

Value Based Commissioning Policies
Do not offer spinal injections for managing low back pain.
Do not offer ultrasound for managing low back pain with or without sciatica.
Do not offer PENS for managing low back pain with or without sciatica.
Do not offer TENS for managing low back pain with or without sciatica.
Do not offer interferential therapy for managing low back pain with or without sciatica.
Do not offer traction for managing low back pain with or without sciatica.
Do not offer belts or corsets for managing low back pain with or without sciatica.
Do not offer foot orthotics for managing low back pain with or without sciatica.
Do not offer rocker sole shoes for managing low back pain with or without sciatica.
Do not offer disc replacement in people with low back pain.
Do not offer spinal fusion for people with low back pain unless as part of a randomised controlled trial.

National Back Pain and Radicular Pain Pathway
https://docs.wixstatic.com/ugd/dd7c8a_caf17c305a5f4321a6fca249dea75ebe.pdf

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<th>ICD10 codes</th>
<th>OPCS codes</th>
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<td></td>
<td>V54.4 - diagnostic</td>
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</table>
Policy statement: Spinal Surgery for Non-Acute Lumbar Conditions

Status: Individual Prior Approval

M&SECCGs commission spinal surgery for non-acute lumbar conditions on a restricted basis.

Funding will only be available under the following circumstance:

- Surgical discectomy (standard or microdiscectomy) in selected patients with sciatica secondary to disc prolapse where conservative management for at least 4-6 weeks has failed.

or

- Lumbar decompression for sciatica with nerve root compression or severe central spinal stenosis with claudication symptoms in one of both legs.

M&SECCGs do not accept requests to fund spinal surgery for low back pain.

NICE Guidance- Low back pain and sciatica in over 16s: assessment and management (2016)

M&SECCGs will not fund and therefore advises that clinicians:

Do not offer spinal injections for managing low back pain.
Do not offer ultrasound for managing low back pain with or without sciatica.
Do not offer PENS for managing low back pain with or without sciatica.
Do not offer TENS for managing low back pain with or without sciatica.
Do not offer interferential therapy for managing low back pain with or without sciatica.
Do not offer traction for managing low back pain with or without sciatica.
Do not offer belts or corsets for managing low back pain with or without sciatica.
Do not offer foot orthotics for managing low back pain with or without sciatica.
Do not offer rocker sole shoes for managing low back pain with or without sciatica.
Do not offer disc replacement in people with low back pain.
Do not offer spinal fusion for people with low back pain unless as part of a randomised controlled trial.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Value Based Commissioning Policies

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<tr>
<th>ICD10 codes</th>
<th>OPCS codes</th>
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</table>
M&SECCGs do not fund surrogacy.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances**.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

**Value Based Commissioning Policies**

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<tr>
<th>ICD10 codes</th>
<th>OPCScodes</th>
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<tbody>
<tr>
<td></td>
<td>Y966 (subsidiary code)</td>
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</table>
Policy statement:  Tattoo Removal
Status:  Not Funded

M&SECCGs do not fund procedures* for the removal of tattoos.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGS and will not be funded unless there are **exceptional clinical circumstances**.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

**Value Based Commissioning Policies**

| OPCS/ICD10 codes | S60.1, S60.2 |
Policy statement: Temporomandibular Joint Replacement
Status: Not Funded

M&SECCGs do not fund temporomandibular joint replacement.

This service/procedure has been assessed as a Low Clinical Priority by M&SECCGS and will not be funded unless there are exceptional clinical circumstances.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Value Based Commissioning Policies

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<th>ICD codes</th>
<th>OPCS codes</th>
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<tr>
<td></td>
<td>V20.1 – V20.9</td>
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</table>
Policy statement: Temporomandibular Joint (TMJ) Retainers and Appliances

Status: Group Prior Approval

M&SECCGs fund TMJ retainers and appliances on a restricted basis only when used within specialist services e.g. management of patients with head and neck cancers and funded as part of national tariff. e.g. Therabite.

These appliances will not be separately funded. GPs should not accept requests to prescribe such appliances on FP10s. Supplies to patients will be made by specialist services.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Value Based Commissioning Policies

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<th>ICD10 codes</th>
<th>OPCS codes</th>
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<td>N/A</td>
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</table>
M&SECCGs provide funding for investigation of tinnitus on a restricted basis.

Investigation is funded if the patient has:

- unilateral tinnitus or pulsatile bilateral tinnitus for over 2 months,
- bilateral or central tinnitus with hearing loss for over 2 months
- intrusive bilateral or central tinnitus without hearing loss for over 6 months

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

### Value Based Commissioning Policies

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<th>ICD10 codes</th>
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<tbody>
<tr>
<td>H93.1</td>
<td>163</td>
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</table>
Policy statement: Tonsillectomy/Adenoidectomy
Status: Individual Prior Approval

Suspected or confirmed malignancy – should be referred via a two week pathway. Tonsillectomies required as part of treatment for malignancy do not need prior funding approval. No prior approval required for patients with tonsillar asymmetry or diagnostic tonsillectomy for suspicion of cancer.

M&SECCGs commission tonsillectomies on a restrictive basis for those patients who meet criteria as outlined in SIGN Guidance 117 (April 2010) or one of the conditions listed below:

**Individual prior approval for funding is required in all cases.** GPs should not refer unless the criteria below have been met, and referrals must include objective information to demonstrate this.

**A period of 6 months watchful waiting by the GP** is recommended prior to tonsillectomy to establish firmly the pattern of symptoms and allow the patient to consider fully the implications of operation. For recurrent tonsillitis in children <16 years old, before referral to secondary care, the GP should discuss with patient/parents or carers the benefits and risks of tonsillectomy vs. active monitoring. Sign post patients to relevant information and reassurance given if no further treatment or referral for tonsillectomy is deemed necessary at this stage. The Right Care Shared Decision Aid for recurrent sore throats should be used ([http://sdm.rightcare.nhs.uk/pda/](http://sdm.rightcare.nhs.uk/pda/)). This discussion should be documented.

**Patients must meet the following criteria:** (the answers to 1 and 2 must be ‘Yes’ and then the answer to any one criteria 3-6 must be ‘Yes’):

1. Sore throats that are due to acute tonsillitis
   **AND**
2. Episodes of sore throat that are disabling and prevent normal functioning
   **AND**
3. Seven or more well documented clinically significant, adequately treated sore throats in the preceding year.
   **OR**
4. Five or more such episodes in each of the preceding two years.
   **OR**
5. Three or more such episodes in each of the preceding three years.
   **OR**
6. Failure to thrive in paediatric patients where recurrent tonsillitis is considered a contributory factor.
   **OR**
   the patient should have one of the following conditions:
   - intractable cough with a high level of streptococcal antibody for longer than one year-test results to be included with referral;
- severe halitosis which has been demonstrated to be due to tonsil crypt debris for longer than one year (diagnosed by an ENT surgeon).
- peritonsillar abscess not responding to antibiotics and incisional drainage.

ME&SCCGs commission tonsillectomy with or without concurrent adenoidectomy for Obstructive sleep apnoea (OSA) in
- adults who has been diagnosed by sleep study/overnight polysomnography, in the presence of large tonsils-see also Sleep Studies policy
- children where OSA is demonstrated by sleep study or diagnosed clinically in the presence of excessively large tonsils and adenoids with documented evidence of failure to thrive as assessed using NICE guidance NG75.

**Adenoidectomy as a separate procedure will not be funded.** See also Grommets.

Once a decision is made for tonsillectomy, this should be performed as soon as possible, to maximise the period of benefit before natural resolution of symptoms might occur (without tonsillectomy).

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding for these procedures can be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below and opening the relevant document on the page.

**Value Based Commissioning Policies**

**Rationale**
This policy has been developed using the criteria within the Royal College of Surgeons commissioning guide for tonsillectomy. Evidence for the benefits of tonsillectomy is poor. In children surgery may be beneficial in selected cases. In adults, limited evidence suggests that tonsillectomy may benefit people with recurrent infection. (NICE evidence summaries).

The potential benefits of tonsillectomy in reducing recurrent or chronic throat infection need to be weighed against complications and operative risks and the possibility that the throat infections may resolve without intervention (watchful waiting). A period of watchful waiting is more appropriate for children with mild sore throats (SIGN 2010).

The Royal College of Surgeons advise that before referral to secondary care a discussion should take place of the benefits and risks of tonsillectomy vs. watchful waiting for both recurrent tonsillitis and sleep disordered breathing. Information to be provided and reassurance given if no further treatment or referral for tonsillectomy is deemed necessary at this stage. This discussion should be documented (Royal College of Surgeons 2013).

For recurrent tonsillitis in children <16 years old the Right Care Shared Decision Aid for recurrent sore throats should be used before referral into secondary care (http://sdm.rightcare.nhs.uk/pda/).
Information to be provided and reassurance given if no further treatment or referral for tonsillectomy is deemed necessary at this stage. This discussion should be documented (Royal College of Surgeons 2013).

The impact of recurrent tonsillitis on a patient’s quality of life and activities of daily living should be taken into consideration. A fixed number of episodes, as described above, may not be appropriate for adults with severe or uncontrolled symptoms, or if complications (e.g. quinsy) have developed (Royal College of Surgeons 2013).

There is a lack of published evidence demonstrating the benefit of performing tonsillectomy for the treatment of tonsilloliths (evidence review April 2015) and therefore this has not been included as an indication for tonsillectomy.

Ref:

SIGN guidance

Commissioning guide: Tonsillectomy
https://www.entuk.org/sites/default/files/files/ENT%20UK%20Tonsillectomy%20revised%20commissioning%20guide%202016%20PUBLISHED.pdf

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<tr>
<td>OPCS codes</td>
<td>F34.1 – F34.9, F36.1</td>
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<tr>
<td>Policy statement:</td>
<td>Toric Lens Implants- Astigmatism</td>
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<tr>
<td>Status:</td>
<td>Not Funded</td>
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M&SECCGs do not fund toric intraocular lens implants as there is insufficient evidence to demonstrate safety, clinical and cost effectiveness. Toric IOLs refer to astigmatism correctintraocular lenses used at the time of cataract surgery to decrease post-operative astigmatism. The Toric IOLs are the so called ‘premium lens’ however these come at a greater cost than the standard.

The standard IOLs design used for cataract surgery in the NHS is the monofocal IOLs. Intraocular lens implants for cataracts will continue to be commissioned in accordance with the Cataracts SRP.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances**.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

**Value Based Commissioning Policies**

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<th>OPCS/ICD10 codes</th>
<th>N/A</th>
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Policy statement: Transcranial Magnetic Stimulation
Status: Not Funded

M&SECCGs do not fund Transcranial Magnetic Stimulation for any indication.

This service/procedure has been assessed as a Low Clinical Priority by M&SECCGs and will not be funded unless there are exceptional clinical circumstances.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Value Based Commissioning Policies

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<td>A09.8</td>
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Surgery for trigger finger is commissioned by M&SECCGs on a restricted basis. Cases will only be funded if they meet the criteria below:

- Patients who fail to respond to all appropriate conservative\(^1\) treatments for a minimum of 6 months.

**OR**

- Patients who have a fixed flexion deformity that cannot be corrected and that is severely impacting on activity of daily living

**OR**

- Patients who have recurrent triggering after 2 injections

Conservative\(^1\) treatments include:

- Reassurance – up to 83% have been found to resolve spontaneously after a few months.
- Steroid injections – 50-80% will resolve after a single injection and a second injection should be carried out after 6 weeks if no response to first injection. Patients should not be referred until they have tried two steroid injections unless contra-indicated.

For audit purposes, the referral letter and hospital records must include evidence that the patient meets the criteria, including the dates of the corticosteroid injections and any other conservative management.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

**Value Based Commissioning Policies**

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<tr>
<td>OPCS codes</td>
<td>M65.3</td>
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Policy statement: Vaginal/Uterine Prolapse
Status: Individual Prior Approval

M&SECCGs will only fund surgical interventions for Uterovaginal Prolapse in the following circumstances:

- In cases of mild to moderate symptomatic cystoceles where trial of a pessary has failed.
- In cases of mild to moderate symptomatic rectoceles.
- In severe cases of prolapse or precedentia

Initially, patients should be assessed and managed conservatively in primary care. Also refer to sections below on vaginal pessaries and surgery.

1. **Watchful waiting**, with observation for the development of new symptoms or complications is appropriate if the prolapse is minimal (Stage I), or asymptomatic

2. **Conservative treatment options**

   2.1 **Lifestyle modification**
   - Treatment of conditions that increase intra-abdominal pressure: constipation, chronic cough, overweight/obesity; reduction of heavy lifting (while POP has been associated with these factors, the role of lifestyle modification in prevention/treatment has not been investigated)

   2.2. **Pelvic floor muscle exercises**
   - Role in managing prolapse unclear; probably not useful if the prolapse ex ends to or beyond the vaginal introitus.
   - Cochrane review 2006: concluded evidence was insufficient (from 3 randomised trials) to judge the value of conservative management of POP, & that further trials were needed
   - The pilot study for the Pelvic Organ Prolapse Physiotherapy (POPPY) multi-centre trial suggested that pelvic floor muscle training delivered by a physiotherapist to symptomatic Stage I or II POP women in an outpatient setting may reduce the severity of prolapse

   Local (vaginal) oestrogen creams and oral treatments-For information on criteria for funding, please see the Medicines Optimisation section of M&SECCGs websites.

3. **Vaginal pessary insertion** – those participating in active vaginal intercourse should be offered surgery once occult urodynamic stress incontinence has been explored.

   - Cochrane review 2004: no RCTs of pessary use in women with prolapse; there is no consensus on the use of different types of device, the indications, nor the patterns of replacement & follow-up care; evidence or pessary selection and management is incomplete so trial and error, expert opinion, and experience remain the best guides for use and management of the pessary
   - Although not supported by definitive evidence, current opinion is that pessaries are effective1 & should be considered before surgery in women who have
symptomatic prolapse; they can be attempted in all POP cases irrespective of stage

- For short-term relief before surgery, or in the long-term if surgery is not wanted or recommended
- To predict surgical outcomes or unmask occult urodynamic stress incontinence before surgery, as part of the investigation of continent women with POP (so that the decision to perform a concomitant continence procedure along with pelvic reconstruction can then be individually tailored)

- Risk factors for unsuccessful fitting include: short vaginal length <6 cm and wide introitus fingerbreadths; local oestrogens may play a role in successful fitting
- Failure to retain the pessary has been associated with increasing parity and previous hysterectomy; and discontinuation with history of hysterectomy or prolapse surgery, and stress incontinence;
- Follow-up: no clear consensus on how often to follow up; after 3 months & then every 6 months, if there are no complications, has been suggested;
- Complications tend to occur in women who are not regularly followed up; self-care of pessary is also important to minimise adverse events; however, many patients find insertion & removal of most pessary types challenging

4. Surgery - those participating in active vaginal intercourse should be offered use of pessaries prior to surgical intervention for those women who have symptomatic prolapse. Or to unmask occult urodynamic stress incontinence before surgery Refer to section on use of vaginal pessaries above

- Assessed as effective, but with a close risk/benefit in mild cases; a combination of procedures may be required and reoperation is required in 29% of cases
- Types of repair surgery vary depending on type of POP & associated symptoms, whether the woman is sexually active & her fitness for surgery

4.1. Reconstructive surgery (abdominal or vaginal approach)

- 2010 Cochrane review of surgical management of POP: found 40 RCTs with a variety of types of POP
  - There was not enough evidence on most types of common prolapse surgery nor about the use of mesh or grafts in vaginal prolapse surgery
  - Impact of POP surgery on bowel, bladder and sexual function can be unpredictable and may make symptoms worse or result in new symptoms such as leakage of urine (unmask occult SI) or problems with intercourse
  - Uterine/vaginal vault prolapse: abdominal sacral colpopexy may be better than vaginal sacrospinous colpopexy – it was associated with a lower rate or recurrent vault prolapse and dyspareunia; these benefits must be balanced against a longer operating time, longer time to return to activities of daily living and increased cost of the abdominal approach
  - Posterior vaginal wall prolapse/rectocele: posterior vaginal wall repair may be better than transanal repair in terms of recurrence of prolapse (limited evidence)
• Value of the addition of a continence procedure to a prolapse repair operation in women who are dry before operation remains to be assessed

• Use of mesh/graft inlays (synthetic):
  o 2010 Cochrane review: use of mesh or grafts at the time of anterior vaginal wall repair reduces the risk of recurrent anterior wall prolapse on examination; however, evidence of benefit to the woman, including symptoms and quality of life improvement, is lacking for the use of grafts over native tissue repairs
  o 2008 NICE guidance: surgical repair of vaginal wall prolapse using mesh

4.2 Obliterative Surgery

  o Corrects POP by moving the pelvic viscera back into the pelvis & closing of the vaginal canal; vaginal intercourse is no longer possible

<table>
<thead>
<tr>
<th>Clinical scenarios where surgery will not be routinely funded</th>
<th>Clinical scenarios where referral for specialist assessment is necessary to determine suitability for surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic pelvic organ prolapse</td>
<td>Failure of pessary</td>
</tr>
<tr>
<td>Mild pelvic organ prolapse (unless combined with urinary/faecal incontinence)</td>
<td>Women with symptomatic prolapse (including those combined with urethral sphincter incompetence or faecal incontinence)</td>
</tr>
<tr>
<td>Prolapse combined with urethral sphincter incompetence/ urinary incontinence or faecal incontinence</td>
<td>Women with moderate to severe prolapse who want definitive treatment</td>
</tr>
</tbody>
</table>

Recommendations

• Initially, patients should be assessed and managed conservatively in primary care
• All patients should have a trial of ring pessary, including suitable candidates for surgery, as part of the investigation of continent women with prolapse; the decision to perform a concomitant continence procedure along with pelvic reconstruction can then be individually tailored

Patient information:
http://www.nhs.uk/conditions/Prolapse-of-the-uterus/Pages/Introduction.aspx

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Value Based Commissioning Policies

Mid & South Essex CCGs Value Based Commissioning Policies

Please check website for latest versions of policies as may be subject to change throughout the year:
<table>
<thead>
<tr>
<th>ICD10 Code</th>
<th>N81*</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPCS codes</td>
<td>P23*, P24*</td>
</tr>
</tbody>
</table>
Policy statement: Varicose Veins
Status: Individual Prior Approval

Conservative management is the first line of treatment and applications will not normally be accepted without evidence that conservative management of asymptomatic and symptomatic varicose veins has been tried, and failed, for a period of at least six months.

Prior to consideration for intervention patients should be given information regarding
- Weight loss if they have a raised BMI
- Light to moderate physical activity
- Avoiding factors which are known to make their symptoms worse, if possible
- Use of compression stockings for a 6 month duration, where this is considered appropriate
- When and where to seek further medical help

M&SECCGS commissions treatment or surgery for varicose veins on a restrictive basis.
Funding for treatment or surgery will only be made available for Grade III and above Varicose Veins.

Grade III: Varicose veins with complications, including bleeding, recurrent phlebitis or eczema.
- Patients who have had bleeding associated with varicose veins should be referred urgently.
- Patients with recurrent thrombophlebitis and persistent varicose veins may be referred, especially if phlebitis has affected veins above the knee.
- Patients with eczema near the ankle or associated with varicose veins below the knee should be referred for specialist advice.

Interventional treatment should be in line with NICE guidance which identifies endothermal ablation as the first line intervention where suitable.
Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.
Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

**Value Based Commissioning Policies**

*In drafting this policy it was noted that NICE CG 168 recommends that all symptomatic varicose veins should be referred for investigation and, where appropriate, treatment. Current resources cannot meet the demand that this would generate either in commissioning costs or in the capacity to undertake Doppler examinations etc. This policy is intended as a holding position until resources are available and the required pathway and contracting changes have been made to enable full adoption of NICE CG 168.*

http://www.nice.org.uk/guidance/CG168/chapter/introduction

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>OPCS codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>L83.1 – L88.9</td>
<td>L83.1 – L88.9</td>
</tr>
</tbody>
</table>
M&SECGGs do not fund provision of vision therapy, behavioural optometry or vision training, including for the following conditions.

- exotropia (eye deviates outward)
- nystagmus (involuntary movement of the eyeballs)
- dyslexia and other learning and reading disabilities
- learning disability or language disorder including developmental delay

If the cause of the condition is orthoptic e.g amblyopia (lazy eye), patients should be assessed and treated with orthoptic treatment by Orthoptists as part of commissioned services within the CCGs.

Vision therapy may also be referred to as eye exercise therapy, visual therapy, visual training, vision training, or optometric vision therapy. Vision therapy may include elements of a wide range of optometric treatment modalities, with the therapeutic goal of correcting or improving specific dysfunctions of the vision system. This may include the use of special lenses, prisms, filters, and other appropriate materials, methods, equipment, and procedures, including eye exercises and behavioural modalities that are used for eye movement and fixation training to eliminate or improve conditions.

Vision therapy has been assessed as a Low Clinical Priority by the CCGs and will not be funded unless there are **exceptional clinical circumstances**.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

**Value Based Commissioning Policies**
Policy statement: Wigs and Hair Pieces/Hair Systems/Transplantation

Status: Wigs and Hair Pieces-as per National Regulations

Status: Hair Systems/Transplantation-Not Funded

Wigs are available on the NHS, but patients will be charged for them unless they qualify for help with charges. 
http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Wigsandfabricsupports.aspx

Hair pieces and wigs for patients experiencing total or severe hair loss as a result of alopecia totalis, cancer treatment, previous surgery or trauma, are available from local NHS Trusts within tariff through commissioned pathways.

Patients requiring reconstruction of the eyebrow following cancer or trauma will be treated within existing contracts.

M&SECCGs do not fund treatments for the correction of male or female pattern baldness as it is a normal process of ageing.

M&SECCGs do not fund hair transplantation or the use of the ‘Interlace’ or other hair systems, regardless of gender. Patients who were initially funded by the NHS will not be funded for ongoing maintenance and support.

These services/procedures have been assessed as a Low Clinical Priority by M&SECCGs and will not be funded unless there are exceptional clinical circumstances.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Value Based Commissioning Policies

<table>
<thead>
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<td>S21.1, S331, S332, S333</td>
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</tr>
<tr>
<td>Agenda No</td>
<td>6</td>
</tr>
<tr>
<td>-----------</td>
<td>---</td>
</tr>
<tr>
<td>Report Title</td>
<td>Individual Funding Request Policy: Mid and South Essex CCGs</td>
</tr>
<tr>
<td>Submitted by</td>
<td>Karen Wesson, Director of Commissioning, Joint Commissioning Team</td>
</tr>
<tr>
<td>Written by</td>
<td>Karen Wesson, Director of Commissioning, Joint Commissioning Team</td>
</tr>
<tr>
<td>Purpose</td>
<td>To seek approval for the adoption of the revised STP Individual Funding Request Policy</td>
</tr>
<tr>
<td>Approval Route</td>
<td></td>
</tr>
<tr>
<td>Status:</td>
<td>For approval</td>
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</table>
1. Purpose

This paper seeks the Joint Committee approval of the mid and south Essex Clinical Commissioning Groups (CCGs) Individual Funding Request (IFR) Policy to align the commissioning policies across the five CCGs’ footprint; reducing disparity of commissioning for the 1.2 million population.

2. Individual Funding Request (IFR) definition

On an individual basis, there may be situations where a clinician believes that their patient’s clinical situation is so different to other patients with the same condition that they should have their treatment funded when other patients would not. In such cases, NHS clinicians can ask the NHS commissioner, a CCG or NHS England, on behalf of a patient, to fund a treatment, device, procedure, or piece of equipment which would not usually be provided for that patient. This request is called an Individual Funding Request (IFR).

Funding for these treatment, device, procedure, or piece of equipment outside the SRP prioritisation process can only be done by reducing the funding that is available in other areas. There is not an allocated separate budget to meet the costs of providing treatments agreed through the IFR process. It is because of this that very careful consideration is required before the decision is taken to fund a treatment for an individual that is not usually available.

3. Overview and proposal

Across mid and south Essex CCGs there are two funding request policies and panels in place. Whilst the two policies are similar, there is a need to align and ensure consistent, standardised application of the policy for the population of mid and south Essex.

With the proposed alignment and changes to the SRP standardising the commissioning offer to our population, as commissioners we should ensure that those applications for IFR are also considered and applied in a consistent way.

This will be supported by one exceptional case/multi-disciplinary case review panel for the 5 CCGs to support a consistent approach to decision making, reduce risks of disparity in commissioning decisions and precedents for the population.

4. Equality/Quality Impact Assessment (EQIA)

An EQIA has been undertaken for the changes to the IFR Policy. This will be included within the policy, has been signed off by the Chief Nurse for the Joint Committee and is summarised below.
A copy of the full EQIA is available upon request.

5. Staff engagement

Following approval of the policy and decision to support alignment of the panels, the CCGs will undertake a consultation with staff as to the model and structure for the aligned approach to IFR panel and supporting panels.

6. Overview of changes to the IFR Policy

The revised IFR Policy has:

- Included reference to all mid and south Essex CCGs.
- Included a clarified definition and example of the exceptionality test especially in regard to equipment requests.

The full IFR Policy is attached at Appendix 1.

7. Timelines

<table>
<thead>
<tr>
<th>Area of Quality</th>
<th>Impact question</th>
<th>P/N</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Score</th>
<th>Full Assessment required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty of Quality</td>
<td>Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution (see appendix 3), partnerships, safeguarding children or adults?</td>
<td>N</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>Could the proposal impact positively or negatively on any of the protected characteristics under the Equality Act 2010 (see appendix 2)</td>
<td>N</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>No</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised &amp; compassionate care?</td>
<td>N</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Carers experience</td>
<td>Could the proposal impact positively or negatively on informal carers? (if negatively, is there an identified resource to meet the need, or does the need require flagging to the CCG carers lead)?</td>
<td>N</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?</td>
<td>N</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>No</td>
</tr>
<tr>
<td>Clinical Effectiveness</td>
<td>Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?</td>
<td>N</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>No</td>
</tr>
<tr>
<td>Prevention</td>
<td>Could the proposal impact positively or negatively on promotion of self-care and health inequality?</td>
<td>N</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Productivity and Innovation</td>
<td>Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?</td>
<td>P</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>No</td>
</tr>
</tbody>
</table>

SRP/IFR Policy presented to the Joint Committee of the mid and south Essex CCGs 6 April 2018

Policies (subject to approval) varied into the providers contracts 9 April to 30 April 2018

Letters communicating the SRP revision and when the individual prior approvals will be implemented from shared with providers 9 April to 30 April 2018
<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCGs to discuss, consult and align IFR panels to form one panel</td>
<td>9 April to 30 June 2018</td>
</tr>
<tr>
<td>CCGs to undertake and complete consultation with staff to align IFR/exceptional case/MDT panels</td>
<td>9 April to 30 June 2018</td>
</tr>
<tr>
<td>Develop documentation for phase 2 of the SRP alignment</td>
<td>June 2018 to 30 September 2018</td>
</tr>
<tr>
<td>Commence consultation for phase 2</td>
<td>1 October 2018 – 31 December 2018</td>
</tr>
<tr>
<td>Develop revised policy reflecting consultation feedback</td>
<td>1 January 2019 – 31 January 2019</td>
</tr>
<tr>
<td>Joint Committee to review and approve policy changes</td>
<td>February 2019</td>
</tr>
<tr>
<td>Policy to be added to new contracts</td>
<td>March/April 2019</td>
</tr>
</tbody>
</table>

### 8. Recommendations

The Joint Committee are asked to approve:

- The revised Individual Funding Request Policy (IFR) for mid and south Essex CCGs; and
- A staff consultation to align the IFR panel across mid and south Essex CCGs.
# Individual Funding Requests Policy

<table>
<thead>
<tr>
<th>Policy Number:</th>
<th>CP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version:</td>
<td>3.1</td>
</tr>
<tr>
<td>Ratified by:</td>
<td></td>
</tr>
<tr>
<td>Date Ratified:</td>
<td></td>
</tr>
<tr>
<td>Name of originator/author</td>
<td>Paula Saunders – AD Involvement and Governance</td>
</tr>
<tr>
<td></td>
<td>Paul Balson – Head of Corporate Governance</td>
</tr>
<tr>
<td></td>
<td>Chief Pharmacist – Mid Essex CCG</td>
</tr>
<tr>
<td>Date Issued:</td>
<td>March 2018</td>
</tr>
<tr>
<td>Date Implemented:</td>
<td></td>
</tr>
<tr>
<td>Next Review Date:</td>
<td>March 2021</td>
</tr>
<tr>
<td>Target Audience:</td>
<td>CCG staff, Board members, patients and the public, primary and secondary care providers</td>
</tr>
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</table>
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2 Introduction

The NHS exists to serve the needs of all of its patients but also has a statutory duty to break even financially (National Health Service Act 2006). Clinical Commissioning Groups (CCGs) have a responsibility to provide health benefit for the whole of their population, whilst commissioning appropriate care to meet the clinical needs of individual patients.

NHS Basildon and Brentwood, NHS Castle Point and Rochford, NHS Mid Essex, NHS Southend and NHS Thurrock Clinical Commissioning Groups each receive a fixed budget from Central Government with which to commission the healthcare required by its population. Commissioned services include those provided through primary, secondary and tertiary care NHS providers, the independent sector, voluntary agencies and independent NHS contractors.

CCG investment and disinvestment decisions are driven by the annual planning guidance and set out in its commissioning intentions. CCGs do not expect to make significant decisions outside this process and in particular do not expect to commit significant new resources in year to the introduction of new healthcare technologies (including drugs, surgical procedures, public health programmes, equipment) since to do so risks ad-hoc decision making and can destabilise previously identified priorities.

The commissioning process, by its very nature, focuses on cohorts of patients with more common clinical conditions. It cannot meet every healthcare need of all patients in any one clinical group or address the specific needs of patients with less common clinical conditions. The fact that a CCG is not meeting a healthcare need due to resource constraints is an inevitable fact of life in the NHS and does not indicate that that CCG is breaching its statutory obligations.

CCGs are required to have a process for considering funding for individuals who seek NHS commissioned services outside established commissioning policies. There are in general two types of requests that come before an Individual Funding Request (IFR) Panel, namely:

- Requests for funding treatments for medical conditions where the CCG has no established commissioning policy (commonly called IFR requests), and
- Requests for funding treatments for medical conditions where the CCG does have an established commissioning policy for that condition but where the requested individual treatment is not in the CCG policy or does not meet the criteria set out in the policy.

This policy requires requests in the first category to be considered against the tests of clinical effectiveness, cost effectiveness and affordability provided the requesting clinician is able to demonstrate that the patient represents an Individual Patient and not typical of a group of patients e.g. the first in a cohort.
For patients in the second category the policy requires, as a threshold condition, the requesting clinician to demonstrate that the patient has exceptional clinical circumstances. If the clinician demonstrates that the patient has exceptional clinical circumstances (as defined in this policy) the request will also be considered against tests of affordability and clinical effectiveness.

This approach ensures that decisions relating to resource allocation are made transparently and consistently in relation to treatment for those patients with rare conditions, those patients for whom treatments of uncertain or unproven medical benefit are sought, or where treatment costs requested may be out of proportion with the benefit to the patient.

NHS Basildon and Brentwood, NHS Castle Point and Rochford, NHS Mid Essex, NHS Southend and NHS Thurrock Clinical Commissioning Groups are accountable for the management of Individual Funding Requests. This policy will be used to consider:

- requests for any form of medical treatment or care which is not included within existing commissioned service agreements;
- requests for any form of medical treatment or care which, for this particular patient, are outside the parameters set by existing commissioned service agreements;
- requests for any form of medical treatment or care where the treatment or care proposed could not be considered to be ‘mainstream’.

Working in collaboration, NHS Basildon and Brentwood, NHS Castle Point and Rochford, NHS Mid Essex, NHS Southend and NHS Thurrock Clinical Commissioning Groups established this policy to consider such applications.

Overall responsibility for the management and administration of the process has been delegated to the Individual Funding Request team in NHS Basildon and Brentwood CCG by NHS Castle Point and Rochford, NHS Mid Essex, NHS Southend and NHS Thurrock Clinical Commissioning Groups.
3 Purpose and scope

This policy will be used to consider individual requests for funding where a service, intervention or treatment falls outside existing service agreements or requests for any form of medical treatment or care where the treatment or care proposed could not be considered to be ‘mainstream’.

All CCG commissioning decisions need to be made in accordance with these principles:

- the CCG requires clear evidence of clinical effectiveness before NHS resources are invested in the treatment,
- the CCG requires clear evidence of cost effectiveness before NHS resources are invested in the treatment,
- the cost of the treatment for this patient and others within any anticipated cohort is a relevant factor,
- the CCG will consider the extent to which the individual or patient group will gain a benefit from the treatment,
- the CCG will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community,
- The CCG will consider all relevant national standards and take into account all proper and authoritative guidance,
- Where a treatment is approved, the CCG will respect patient choice, within existing commissioned pathways and CCG policies, as to where a treatment is delivered.

When considering an Individual Funding Request, the CCG will also ensure that decisions:

- comply with relevant national policies or local policies and priorities that have been adopted by the CCG concerning specific conditions or treatments,
- are based on the available evidence concerning the clinical and cost effectiveness of the proposed treatment, and;
- are taken without undue delay.

The CCG considers the lives of all patients to be of equal value and in making decisions about funding treatments will seek not to discriminate on the grounds of age, sex, sexuality, race, religion, lifestyle, occupation, family and caring responsibilities, social position, financial status, family status (including responsibility for dependents), intellectual/cognitive functioning or physical functioning save where a difference in the treatment options made available to patients is directly related to the patient’s clinical condition or is related to the anticipated clinical benefits for this individual to be derived from a proposed form of treatment.
These principles and the following process will ensure that each request for individual funding is considered in a fair and transparent way.

This policy covers Individual Funding Requests pertaining to patients in the catchment areas of NHS Basildon and Brentwood, NHS Castle Point and Rochford, Mid Essex, NHS Southend and NHS Thurrock Clinical Commissioning Groups.

4 Definitions

4.1 Individual Funding Request

An Individual Funding Request is a request to an NHS commissioning organisation (such as a Clinical Commissioning Group) to fund healthcare for an individual who falls outside the range of services and treatments that the organisation has agreed to commission (NHS Confederation 2008).

4.2 Exceptionality

The words “exceptional”, “exceptionality” and “exceptional clinical circumstances” bear their natural meanings as defined in Oxford English Dictionary. However, the CCG recognises that the meaning of these words has given rise to considerable difficulty in the past and offers the following guidance to assist the IFR Panel and clinicians as to how to approach the meaning of the words.

There is a difference between “individual” and “exceptional”. Every patient has features of his or her condition which are specific to that individual and are not likely to be repeated in other patients with the same clinical condition at the same stage of progression of the condition. Exceptionality is not the same as individuality.

In order to be able to consider whether a patient has exceptional clinical circumstances the IFR Panel will focus on the following issues:

1. Are there any clinical features of the patient’s case which make the patient significantly different to the general population of patients with the condition in question at the same stage of progression of the condition?

2. Would the patient be likely to gain significantly more clinical benefit from the requested intervention than might be normally expected for the general population of patients with the condition at the same stage of the progression of the condition?

In line with the principle that patients with rare conditions should neither be advantaged nor disadvantaged simply because their condition is uncommon where treatments, devices or pieces of equipment can be used to treat various conditions it is the presenting need that will assessed against the same criteria as everyone else requiring the intervention. This applies particularly to equipment requests.

Example

Policy Date: March 2018
Review Date: March 2021
A woman has a rare form of a disease which requires her to use a wheelchair. There are no other patients with this form of the disease which require their use of a wheelchair. She will be assessed for wheelchair funding against the same eligibility criteria in the same way that other people with more common conditions requiring similar equipment is undertaken, ie for her mobility needs rather than the rarity of her form of the disease.

The implications of this approach are that if a patient can be seen to be part of a group of patients for whom a treatment is not made available by the CCG under the CCG's existing policies then exceptionality for this individual patient is unlikely to be demonstrable. In this case the appropriate process for obtaining funding for the requested treatment will be for the CCG to change its policy. Such a change must happen through the commissioning process (which will require the development of a business case and for the treatment to be prioritised against other developments) or through the CCG agreeing to make a change to its policy outside the commissioning process. If the change is made it will apply to all similar patients. However, the IFR Process is not the procedure for the CCG to make such policy changes.

The CCG is required to achieve financial balance each year and therefore has a default policy of not funding a treatment where no specific policy exists to approve funding for the treatment. If the CCG has not previously been asked to fund an intervention that has the potential to affect a number of patients, the application should be made by clinicians for the CCG to consider the intervention through its general commissioning policy and not by way of an IFR application.

The CCG policy is that the IFR Panel should consider requests for treatments that are not routinely available based on the patient's clinical circumstances. This means that social and personal factors such as age, gender, education, caring responsibilities and family circumstances can only be taken into account where they are relevant to the patient’s clinical outcome. Whilst a patient's professional, economic or social standing or their family responsibilities are important to individuals, the CCG policy is that they are not relevant in assessing whether a patient has exceptional clinical circumstances.

4.3 Individual Patient

For the purposes of this policy, an Individual Patient is determined by reviewing the incidence and prevalence of the requested intervention for a particular condition at the same stage of progression of that condition. If the CCG has no policy for the intervention being requested for a particular condition, then an IFR Panel can only consider the request if both the incidence and prevalence criteria that are set out below are met or the patient has exceptional clinical circumstances compared to the cohort of patients (however small) with the presenting condition. In some cases, CCGs may have adopted policies for small numbers of patients which have often
been developed regionally. If the request is covered by such a policy then it should be viewed as a request to change the policy and therefore will not be considered by the IFR Panel, even if the incidence and prevalence criteria are met.

An IFR request for an individual patient will be considered by the IFR Panel on its individual merits with the decision on whether to fund a requested intervention based on the evidence of clinical and cost effectiveness and affordability. If both the prevalence and incidence criteria are not met, then the CCG will not consider that the request represents an individual patient. In these circumstances, funding can only be provided if a decision is made by the CCG to develop a policy for the requested intervention for a group of patients, including the requesting patient; unless the patient has exceptional clinical circumstances compared to the cohort of patients (however small) with the presenting condition. Such a change must happen through the commissioning process (which will require the development of a business case and for the treatment to be prioritised against other developments) or through the CCG agreeing to develop a policy outside the commissioning process. Once the policy is developed it will apply to all similar patients. However, the IFR Process is not the procedure for the CCG to develop such policy.

4.4 Incidence

The number of new cases of a disease in a defined population within a specified period of time. The intervention for a particular condition at the same stage of progression of that condition is expected to be initiated for two or fewer patients per million population per year.

4.5 Prevalence

The number of cases of a disease in a defined population at a point in time. The total number of patients on the intervention for a particular condition at the same stage of progression of that condition is less than 10 patients per million population at any one time.

4.6 Cohort

For the purpose of this policy a cohort is a group of patients who have shared a particular event together during a particular time span.
5 The process for managing Individual Funding Requests

START

Letter or Individual Funding request received and logged by Individual Funding Request Team
See section 5.1

IFR team conducts initial screening
See section 5.2

Request covered by existing commissioned services
See section 5.4

Request is not covered by existing commissioned services
See section 5.5

Request is process as a ‘Fast Track’ case
See section 5.6

5 working days
See section 5.3

Requester informed
See 5.7

Requester asked to complete an Individual Funding treatment request form (if not already completed at 5.1) or any additional information requested.

Where Clinical opinion is required, a ‘Clinical review panel’ will convened
See section 5.8

Treatment request refused

Treatment request endorsed to Individual Funding Request Panel

40 working days
See section 5.3

Individual Funding Request Panel convened
See section 5.9

Funding of treatment is endorsed to the patient’s Clinical Commissioning Group
See note 5.10

Requester informed and mechanism agreed for delivery of treatment and monitoring

Funding NOT approved for treatment
See note 5.10

Requester informed and advised of right to request a review via the Process Appeal panel
See note 5.11

If requester has significant new clinical evidence they did not submit which they believe could alter the decision:
- a new IFR may be submitted,
- Requester considers alternative commissioned treatment
- Requester makes a complaint to CCG regarding IFR process

END

Requester informed
See 5.7
5.1 **Letter or Individual Funding request received and logged by Individual Funding Request Team**

An NHS doctor, or other health care professional directly involved in the care of a patient, can make a request for an intervention not routinely funded by the CCG. It is the referring NHS clinician’s responsibility to ensure the treatment request form is completed as accurately and comprehensively as possible to avoid possible delays in considering the request.

A patient, or a non-clinical representative, cannot submit an IFR as a NHS clinical sponsor is required. However, the IFR team will provide guidance to any patient who submits a request for treatment.

Correspondence from patients and requesters can be via email or letter.

All correspondence will be date stamped, processed and logged onto the CCG secure database by the IFR team at this point.

For each request received, a unique numbered case file will be generated with all paperwork pertinent to the case kept in chronological order. All decisions will be fully documented and all communication will be in writing. When telephone conversations take place, a file note will be added as a record of the conversation. Both the evidence considered and the decision made will be recorded in writing. All national and local NHS policies regarding confidentiality, retention and destruction of records will be adhered to. The case files will be regularly reviewed by the IFR Panel and an annual report of cases considered by the IFR Panel and Appeal Panel will be submitted to each CCG Governing Body.

5.2 **IFR team conducts initial screening**

Cases are initially dealt with, and screened, by the IFR team who will advise the referrer whether the Service Restriction Policies, portfolio of contracts, Service Level Agreements, or current commissioning policies would cover the request.

The IFR team will determine which set of CCG policies need to be applied to each case.

5.3 **Timeframes**

Requests will be managed within a maximum period of 40 working days from the date of the receipt of an IFR Treatment Request Form to the date of the letter from either CCG or the IFR Panel (excluding appeals and undue delays in responding to requests for further information).

Where the request is screened as a ‘Fast Track’ IFR, (see **5.6 Request is processed as a ‘Fast Track’ case**) the request will be managed within a maximum period of 5 working days from the date of the receipt of a Request Form to the date of the communication from the CCG informing the requestor of the decision.
The decision of an IFR panel will be communicated to the patient, requester or advocate within 10 working days of a panel.

At certain points in the process the IFR team have the option to “pause” the 40-day target; e.g. when the IFR team are awaiting further correspondence from the patient or requester.

5.4 Request covered by existing commissioned services

If a policy exists, and where appropriate, the IFR team will check whether the criteria within the policy can be applied and inform the requester.

If a policy exists, and where appropriate, the IFR team will check whether the criteria within the policy can be applied.

If an individual meets the criteria within a policy, and a decision to agree funding can be made at this point by the IFR team, then a response will normally be sent to the requester. The IFR team is unable to authorise referrals outside existing contractual arrangements.

5.5 Request is not covered by existing commissioned services

Where the request is not covered by an existing commissioned service, the request is progressed to the next stage.

If the IFR team has reason to consider that simple application of SLAs and/or current commissioning policies would be inappropriate for a case, then the IFR team will advise the requester, and the patient (or guardian / carer) that an Individual Funding Request should be submitted to the IFR team using the IFR Treatment Request Form (Appendix 1). A copy of the Guidance Notes for submission of a Treatment Request Form should be included (Appendix 5) and the Patient Information Leaflet explaining the process (Appendix 6). If a clinician wishes to discuss whether submission of a Treatment Request Form is appropriate, or would like help with completing the Treatment Request Form, then they should contact the IFR team.

5.6 Request is processed as a ‘Fast Track’ case

Some cases will require consideration on a shorter timescale. For example, where a patient has limited life expectancy or a treatment is required in circumstances of urgent clinical need. These will often be requests directly from providers for the funding of high-cost drugs for conditions such as cancer.

Where the IFR team determines that a case requires an urgent decision, they will fast-track that case ahead of others and convene a panel at short notice if required. It is expected that the IFR team will consult the Head of Corporate Governance, or equivalent, within the respective CCG on the handling of any cases which are either
marked as urgent by the referring clinician or which the IFR team considers may warrant urgent consideration.

Ideally all urgent cases will be considered by a face-to-face meeting, but exceptionally, where the clinical need makes this impossible, communication via phone or e-mail will be deemed appropriate. Decisions that are made urgently outside of a formal IFR Panel meeting will be taken for ratification to the next meeting of the IFR Panel.

Fast-track panels will also have different quoracy arrangements to facilitate convene at short notice. See Appendix 3: Terms of Reference for the Individual Funding Request Panel for more information.

Patients (or supporting clinicians on their behalf) will have full access to the External Review Process as with non-fast-track cases.

5.7 Requester informed

A letter of acknowledgement will be sent to the requester as soon as possible after the decision.

If a request is refused a letter will be sent to the clinician and the patient explaining the reasons for the decision and outlining the options that are available, including using the NHS Complaints Procedure.

The requester is responsible for ensuring that the patient (or carer / guardian) is notified of the progress of the application. It will be the responsibility of the IFR team to manage all requests received and correspondence with the requester and where required the patient (or carer / guardian).

5.8 Triage of IFR Treatment Request Form

The IFR Treatment Request Form will be screened by the IFR team. The IFR team has the competencies to be able to appropriately triage the request. Where clinical advice is required, the IFR team has access to a ‘Clinical Review Panel’ who will provide clarity or guidance as to whether or not the request should progress to an IFR panel.

5.8.1 Clinical Review Panel

Where the IFR Team determine that the guidance of a Clinician is required, a Clinical Review Panel will be convened to:

- Ask for further information from the requester
- Refuse the request without reference to the IFR Panel
- Refer to the IFR Panel
- Agree the request
5.9 Individual Funding Request Panel convened

The IFR team will arrange the date of the panel and contact the requesting clinician to ask if they wish to submit any further information.

The IFR team will provide written correspondence to the patient (or guardian / carer) to inform them of the date set for consideration by the Panel, to list the items of information that will be presented to the Panel, and invite them to attend in person. The patient may also provide written information to the Panel if preferable.

The IFR team shall remind the patient that decisions can only be made on the grounds of the patient’s clinical circumstances and not on the basis of the patient’s social or personal circumstances. If a patient wishes to provide written information, they should be directed to seek assistance from the clinical requester who completed the application with this. The patient will also have an opportunity to ask the panel questions about the process.

The IFR team may also write to other health professionals with clinical involvement in the patient’s care (for example consultant, therapist etc.), or to others with specialist knowledge with regard to the condition/intervention, for clarification of the patient’s needs, evidence base etc., if appropriate.

The patient (or a nominated representative) has the opportunity to attend the Panel to give a presentation of their case. The patient may be accompanied by a supporter (who may be a relative, friend or independent advocate) who can assist the patient in the presentation of their case. However, the patient cannot be formally represented and may not be accompanied by a member of the press. The patient may submit any further evidence they feel may support the funding request.

Having received all the evidence, submissions and representations, the Panel will consider the case privately. The patient and requester will be provided with a written explanation of the Panel’s decision within 10 working days of the panel date.

The IFR team, with the support of panel members will produce a summary of the case which will be considered by the IFR Panel. All the documentation that has been received regarding the request will also be made available to the panel in an anonymised form to protect confidentiality.

The IFR Panel shall determine, based upon the evidence provided to the panel, whether the patient has demonstrated exceptional clinical circumstances. The evidence to show that, for the individual patient, the proposed treatment is likely to be clinically effective may be part of the case that the patient’s clinical circumstances are asserted to be exceptional.
In determining whether a clinician is able to demonstrate that a patient has exceptional circumstances the IFR Panel shall compare the patient to other patients with the same presenting medical condition at the same stage of progression.

The IFR Panel shall take care to avoid adopting the approach described in the “the rule of rescue”. The fact that a patient has exhausted all NHS treatment options available for a particular condition is unlikely, of itself, to be sufficient to demonstrate exceptional circumstances. Equally, the fact that the patient is refractory to existing treatments where a recognised proportion of patients with same presenting medical condition at this stage are, to a greater or lesser extent, refractory to existing treatments is unlikely, of itself, to be sufficient to demonstrate exceptional circumstances.

The IFR Panel shall be entitled but not obliged to commission its own reports from any duly qualified or experienced clinician, medical scientist or other person having relevant skills concerning the case that is being made that the treatment is likely to be clinically effective in the case of the individual patient.

The IFR Panel is not required to accept the views expressed by the referring clinician concerning the likely clinical outcomes for the individual patient of the proposed treatment but is entitled to reach its own views on:

- The likely clinical outcomes for the individual patient of the proposed treatment; and
- The quality of the evidence to support that decision and/or the degree of confidence that the IFR Panel has about the likelihood of the proposed treatment delivering the proposed clinical outcomes for the individual patient.
- The IFR Panel shall, so far as it is able to do so and relying on the information before it, apply the principles set out in the CCG policy on cost effectiveness when reaching a view as to whether the requested treatment is likely to be cost effective.
- In making the decision as to whether the costs of a requested treatment are justified, the IFR Panel is required to bear in mind that the resources requested to support the individual patient will reduce the availability of resources for other investments. The IFR Panel shall have a broad discretion to determine whether the proposed treatment is a justifiable expenditure of the CCG’s resources.
- The IFR Panel shall consider whether the request is a request for a policy variation. If the IFR Panel determines that the case does not refer to an Individual Patient, as defined in this policy, then it shall not be entitled to make a decision on the request (unless the patient demonstrates exceptional clinical circumstances in which case the matter shall be considered as an IFR request). In the event that the case does not refer to an Individual Patient the IFR Panel shall consider the request for policy variation to be considered through the relevant CCG clinical commissioning process.
• This step is required because the IFR process is not designed to create precedents which may result in the CCG providing or being obliged to provide the same or similar treatment to other patients. Accordingly, if the IFR Panel considers this is not a request about an individual patient then funding can only be provided for the requested treatment if a decision is made by the CCG to amend its policies to provide the treatment for a group of patients, including the requesting patient.

The IFR team will record the decision of the IFR Panel against each of the questions on the Decision Framework Document (see Appendix 4: Decision framework document for Individual Funding Request panel, together with the record of attendance, will form the minutes of the meeting. The minutes will be approved by the Chair of the Panel.

5.10 Outcome of the IFR Panel

5.10.1 Funding of treatment is endorsed
• The IFR team will inform the patient/guardian or carer that funding was agreed.
• The IFR team will develop a mechanism to monitor the clinical outcome in order to determine whether the treatment has resulted in benefit to the patient.

5.10.2 Funding is not approved for treatment
• If funding was not agreed, the IFR team will inform the referring clinician, and the patient/guardian or carer, detailing the appeals process.

5.11 Appeal process

The Process Appeal Panel will determine whether the original decision is valid in terms of process followed, the evidence/factors considered and the criteria applied; and not the decision itself.

The IFR team will determine when new information or other additional representations can be presented.

The Process Appeal Panel will be able to reach one of two decisions:

• To confirm that the correct process was followed by the IFR Panel and therefore the decision reached is legitimate, or
• It shall refer the matter back to the IFR Panel with specific points for reconsideration in the event that the Appeal Panel consider that either:
  o the decision may not have been consistent with the CCG Commissioning Principles; or
  o the IFR Panel may not have taken into account and weighed all the relevant evidence; or
  o the IFR Panel may have taken into account irrelevant factors; or
  o the IFR Panel may have reached a decision which a reasonable IFR panel was not entitled to reach,
If the original IFR Panel decision is upheld, the IFR team will inform the referring clinician, and the patient or guardian / carer, of their remaining options - either to pursue a complaint through the relevant CCG Complaints Procedure or to take their case to the Parliamentary and Health Service Ombudsman. The CCG Complaints Policy may be used to review the decision making process for an individual case and may result in the matter being reconsidered by the IFR Panel.

If the Process Appeal Panel determines that the IFR panel needs to reconsider the case, the IFR Panel should reconsider at the next scheduled IFR Panel. The IFR Panel will reconsider its decision and in doing so will formally address the detailed points raised by the Process Appeal Panel. The IFR panel is not bound to change its decision as a result of the case being referred for reconsideration, but if it confirms its original decision, then reasons will be given for not agreeing to fund the treatment request.

6 Training

Members of a Clinical Review Group, IFR Panel and Process Appeal Panel should together have the skills and expertise necessary to enable them to make effective decisions. Members will need on-going training to undertake this role, in particular to enable them to comprehend and interpret complex data, and also in the legal and ethical aspects of the panel’s work. It is also important to establish a ‘core’ group of individuals who are regularly involved in IFR decision making to gain the necessary breadth of experience from handling a wide range of clinical cases.

All Clinicians on the IFR panel, Fast track panel and appeal panel will have up to date registrations or equivalent.

All members of an IFR Panel (and Process Appeal Panel), in addition to their mandatory and statutory training, will undergo induction training organised by NHS Basildon and Brentwood CCG. This will cover both the legal and ethical framework for IFR decision making, the CCG commissioning processes and structures, and technical aspects of the interpretation of clinical evidence and research. This training will be regularly refreshed to ensure that all panel members maintain the appropriate skills and expertise to function effectively.

7 Monitoring

The IFR process will be monitored and reviewed, both to ensure that decision-making to be fair and consistent, and to make sure that the panel are considering the appropriate cases e.g. that both the triage of requests and the panel work effectively.

The IFR team will present a quarterly report for the Governance Committees (or equivalent) of the CCGs that reviews:

- compliance with the timescales laid out in this policy, and

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• consistency of decision making,

The CCG will also put in place a mechanism to receive feedback by patients and requesting clinicians as part of the evaluation of the IFR policy and to contribute to on-going process improvement.

An annual report will also be presented to the Governance Committee (or equivalent).

8 Roles and responsibilities

8.1 CCG Governing Bodies / Boards

Each CCG Governing Body is responsible for ensuring that the CCG has systems and processes in place to meet its statutory requirements with respect to IFRs.

8.2 Nominate individuals to serve on the panel that have the appropriate delegated authority.

8.3 Accountable Officer

The Accountable Officer for each CCG is the Executive responsible for the day-to-day implementation of this policy.

8.4 Head of Corporate Governance

The Basildon and Brentwood CCG Head of Corporate Governance is responsible for the oversight of the operational implementation of policy and line management of the IFR / CHC Governance Officer and to lead on the monitoring and compliance with this policy.

8.5 IFR / Continuing Healthcare Governance Officer

The post holder's duties include:

• Date stamping and logging the initial letter or IFR upon receipt.
• Conduct the ‘Initial screening process’ to determine which CCGs catchment area the patient is under and therefore which services are / are not commissioned by that CCG.
• Liaise with the requester on all case related communications and requests for additional information.
• Manage all requests received and correspondence with the requester and where required the patient (or carer/guardian).
• Conduct screening and triage of cases, referring to the Clinical Review Panel where appropriate
• Facilitate the IFR panels including production of agenda’s and preparation of cases and provision of minute taking.
• Organise induction training for IFR panel members
8.6 Public Health Representatives, GP, Medicines Management Representatives and Chief/Senior Nurses

These post holders will provide clinical advice and support to the IFR Service and Panel.

8.7 IFR Administrator

To deputise for the IFR / Continuing Healthcare Governance Officer where appropriate or necessary.

8.8 The requesting clinician

The requesting clinician is required to present a full report to the IFR Panel using the IFR Treatment Request Form which sets out a comprehensive and balanced clinical picture of the history and present state of the patient’s medical condition, the nature of the treatment requested and the anticipated benefits of the treatment. If the report does not illustrate exceptional circumstances, then it will be returned to the requester.

The referring clinician shall:

- describe the anticipated clinical outcomes for the individual patient of the proposed treatment and the degree of confidence of the referring clinician that the outcomes will be delivered for this particular patient;
- refer to, and preferably include, copies of any clinical research material which supports, questions or undermines the case that is being made that the treatment is likely to be clinically effective in the case of the individual patient.
- set out the full attributable costs of, and those associated costs relating to, the treatment. The IFR Panel shall be entitled but not obliged to commission its own reports from any duly qualified or experienced clinician or other duly qualified person concerning the full attributable costs of and those associated costs relating to the treatment.

8.9 All Employees and Governing Body Members

All Governing Body members and CCG staff have a responsibility to appraise themselves of the correct action to take in the event that they receive an IFR or wish to make such a request on behalf of a patient / client.

8.10 Essex STP IFR Panel

The Essex STP IFR Panel is responsible for considering IFRs which have been assessed through the CCG’s screening process as falling outside approved policy and where no precedent can be established as a basis for approving funding.
The case files will be regularly reviewed by the IFR Panel and an annual report of cases considered by the IFR Panel and Appeal Panel will be submitted to the CCG Governing Body.

Write a quarterly report of cases considered by the IFR Panel and Appeal Panel will be submitted to the Governance Committee (or equivalent in each CCG).

The panel is responsible for making recommendations on Individual Funding Requests that enable each CCG’s delegated authorised representative to make decisions on behalf of their own CCG.

The IFR Panel does not make policy decisions for the CCGs, it will endorse the funding of treatment to the relevant CCG.

8.11 Delegated CCG representative

The mandated officer, who is authorised by that CCG’s Governing Body to make decisions on behalf of the CCG in relation to IFRs.
9 CCG commissioning principles that underpin IFR decision making

9.1 Declarations of Interest and Conflicts of Interest

Declarations of interest are requested at the beginning of Panel meetings. Such declarations of interest may relate to involvement with pharmaceutical companies or membership of committees that may potentially conflict with Panel Member’s role on the funding request panel, or personal experience/ involvement with support/charitable groups relating to the condition for which treatment is being requested.

All panel members should follow their local conflicts of interest policy.

If an IFR Panel member believes they may have a conflict of interest in a particular case, this must be disclosed to the Panel before that case is discussed. Conflicts of interest may arise, for instance, if the member has recently been involved with the care of the patient. In the event of a potential conflict of interest, the Panel will take a view as to whether the member should be involved in consideration of the request.

The panel will consider on individual basis; what action is required where the panel member knows the patient.

9.2 Decision making framework of the IFR Panel

The IFR Panel is a Committee of the CCG Governing Body and its membership is made up of individuals with delegated authority to make decisions in respect of funding for individual cases. It is not the role of the IFR Panel to make commissioning policy on behalf of the CCGs. Consideration by the IFR Panel will always start from the overall policy position (whether or not the intervention has been prioritised through commissioning) and will seek to determine exceptionality.

9.3 Introduction of New Drugs and Technologies

The CCGs will not introduce new drugs/technologies on an ad-hoc basis through the mechanism of individual case funding. To do so risks inequity, since the treatment will not be offered openly and equally to all with equal need. There is also the risk that diversion of resources in this way will destabilise other areas of health care which have been identified as priorities by the CCG/s. The CCGs expects consideration of new drugs/technologies to take place within the established planning frameworks of the NHS. This will enable clear prioritisation against other calls for funding and the development of implementation plans which will allow access for all patients with equal need.

9.4 NICE New Technology Appraisals (TAs).

Drugs and technologies that are approved as the result of a NICE Technology Appraisal (TA) need to be implemented within 3 months of the appraisal being
published. The CCG will, within resource constraints, seek to ensure implementation of NICE TAs without delay but recognises that the CCG may take the full period of 3 months before a new commissioning policy can be brought into place where significant service change and/or development are required as part of the implementation. NICE also produces other guidelines which are a valuable source of good practice which the CCG will take into account in developing policy but the CCG retains discretion and is not mandated by Directions to implement such Guidance within a fixed time period or at all.

9.5 Treatments Covered by CCG Commissioning Policies

The CCG policy is that treatments not currently included in established care pathways (as identified for example in the Schedules to the service agreements with acute care providers) or identified for funding through the commissioning process are not routinely funded. For a number of these interventions the CCG has published specific policy statements setting out restrictions on access based on evidence of effectiveness or relative priority for funding. These are available on each CCG website.

Policy development is an on-going process and future policy on further treatments, in response to NICE Guidance/Guidelines, health technology assessments etc. will be produced and published periodically.

9.6 Treatments Not Covered by CCG Commissioning Policies

Specific groups of patients may not be covered by CCG Commissioning Policy including:

- Patients with conditions for which the CCG does not have an agreed policy, including patients with rare conditions and whose proposed treatment is outside agreed service agreements.

- Patients with conditions for which the CCG does have an agreed policy but who may have exceptional clinical circumstances which lead to their clinician seeking a treatment that is not routinely available

- Patients with conditions that are the commissioning responsibility of NHS England, including patients with rare conditions and whose proposed treatment is outside agreed service agreements. Many of these will be covered by the National Commissioning Board Specialist Commissioning Policies. [http://www.england.nhs.uk/ourwork/d-com/policies/](http://www.england.nhs.uk/ourwork/d-com/policies/) Consideration of funding against these policies is outside the remit of the CCG.

In such circumstances the CCG will not have given approval in advance to fund the treatment and approval will therefore be required under this policy. The treating clinician should consider, before making the application, whether the requested
treatment is an appropriate request judged against the CCG Commissioning Principles.

The role of the IFR Panel is to make decisions on individual cases. It cannot be used as a means of ‘creeping implementation’ for new technologies. Consideration therefore needs to be given as to the likelihood of other patients having the same clinical need who could also benefit from the proposed treatment. If there are or are likely to be other patients then, properly considered, the request is for a service development and not an individual application. Where a decision may affect other patients, the application should be considered as a service development and not through the IFR process.

Patients with rare conditions should neither be advantaged nor disadvantaged simply because their condition is uncommon. This means that the same approach will be taken in applying the principles of clinical effectiveness and cost effectiveness to patients with rare conditions as should be applied to all other patients.

9.7 Requests to continue funding for patients coming off drugs trials

The CCG does not expect to provide funding for patients to continue medication/treatment commenced as part of a clinical trial. In line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki, the responsibility lies with those conducting the trial to ensure a clear exit strategy from a trial AND that those benefiting from treatments provided within the trial setting will have on-going access to those treatments. The initiators of the trial (provider trusts and drug companies) have a moral obligation to continue funding patients benefiting from treatment until such time as the CCG agrees to fund through the commissioning process. Where the treatment is not prioritised through commissioning, the responsibility remains with the trial initiators. The Research Ethics Committee should require this assurance as part of the approval for the trial.

9.8 Requests to Continue Funding for Treatments Commenced ‘at risk’ by Providers or by others (Including Patients)

On occasions, a request is received where a provider Trust has commenced an unfunded treatment prior to asking for or receiving confirmation that the CCG will approve funding. Evidence that the patient is responding to the treatment is then presented as part of the case for CCG funding.

The provider trust’s decision to commence treatment in advance of any decision by the CCG to fund is a clear risk taken by the trust and/or patient. The CCG accepts no responsibility for the decision taken by the provider trust in these circumstances.

In considering a request for funding the CCG will apply the criteria set out in this policy as it would for any other request, and accords no special privileges because the unfunded drug was given by a provider trust.
The CCG policy is that, unless a decision has been taken to approve routine funding for a treatment, the treatment will only be commissioned for an individual patient if the clinician is able to demonstrate that the patient has exceptional clinical circumstances. The fact that a patient has responded to a drug or other treatment in a manner which was anticipated for a proportion of patients who are commenced on the treatment is unlikely to be sufficient to demonstrate exceptional clinical circumstances.

Where such an application is approved on the basis of the clinician demonstrating that the patient has exceptional clinical circumstances (as defined in this policy), the CCG will not accept responsibility for the costs of any treatment provided by the provider trust prior to authorisation being given by the CCG.

A similar approach will be adopted if a treatment has been funded initially by a pharmaceutical company or other third party.

There are occasions where the initial stages of an unfunded treatment have been funded privately by the patient. The CCG will consider any information submitted on behalf of a patient in support of their case that the patient has exceptional clinical circumstances. This may include evidence derived from treatment that has been purchased privately and used by the patient. However, this potentially opens the way for a limited group of patients who can afford to fund a treatment that the CCG does not usually fund to be able to demonstrate benefit by virtue of access to private care and then submit this as a reason to justify NHS funding for the treatment in their particular case. This is a potentially inequitable approach and, in order to ensure that the CCG does not act in an inequitable manner, the issue of exceptional clinical circumstances will therefore continue to be the criteria applied by the IFR process. Accordingly, the CCG adopts no presumption in favour of continuing treatment which has been previously paid for privately by the patient. As stated above, evidence that a treatment works as anticipated for a proportion of patients in the patient’s clinical circumstances is unlikely, in itself, to provide evidence of exceptionality.

9.9 Requests to continue funding of care commenced privately e.g. reverting to NHS care

Patients who are having private treatment have a right to revert to NHS funded treatment at any point during their care. However, if they wish to exercise this right, the CCG will expect their care to be transferred to local pathways but not necessarily with the same clinician who the patient had consulted with when a private patient even if the clinician is contracted by the NHS. Where personal clinical circumstances may make such funding appropriate the case will require consideration by the IFR process.
9.10 Decisions inherited from other Commissioners e.g. patients who move

Occasionally patients move into the area and become the responsibility of the CCG (by registering with a GP in one of the CCGs) when a package of care or treatment option has already been approved by the CCG that was previously responsible for the patient’s care. The mid and south Essex CCGs’ IFR policy is that, subject to resource constraints, it will normally agree to continue the treatment where the CCG is the responsible commissioner in line with policies in place at the time of application to the new CCG. Approval for applications to continue treatment will only be given if to do so is equitable and in line with treatments commissioned for the CCG population. The care pathway will have been initiated by a responsible NHS consultant and the requested treatment remains clinically appropriate. The CCG retains the right to ask for a review of treatment and benefit.

9.11 Treatment in another country

Requests for treatment in another EU, EEU country or Switzerland will be considered in accordance with arrangements set out by NHS England. Applications must be submitted by the patient to the NHS England European Team using the application form available on the NHS Choices website: www.nhs.uk/NHSEngland/Healthcareabroad/plannedtreatment Enquiries can be addressed to: england.europeanhealthcare@nhs.net.

10 Equality and Quality Impact Assessment

The CCGs are committed to carrying out a systematic review of all its existing and proposed policies to determine whether there are any equality implications.

This policy has been assessed using the CCG’s Equality and Quality Impact Assessment framework and identified as having the following impact/s upon equality, diversity and quality issues:
### Version control

<table>
<thead>
<tr>
<th>Version</th>
<th>Author:</th>
<th>Date Policy Issued</th>
<th>Date Policy Due to be Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Policy approved by the Governing Bodies of all South Essex CCGs</td>
<td>August 2013</td>
<td>August 2014</td>
</tr>
<tr>
<td>1.1</td>
<td>Policy subject to slight amendments as requested by CP&amp;R CCG Governing Body</td>
<td>28th November 2013</td>
<td>1st November 2014</td>
</tr>
<tr>
<td>1.2</td>
<td>Policy reviewed to reflect change in organisational home for the South Essex IFR Service</td>
<td>27th February 2015</td>
<td>1st October 2016</td>
</tr>
<tr>
<td>1.3</td>
<td>Annual review of policy to reflect post CSU changes.</td>
<td></td>
<td>August 2016</td>
</tr>
<tr>
<td>2.0</td>
<td>Review of policy across South Essex CCGs</td>
<td>November 2016</td>
<td>August 2018</td>
</tr>
<tr>
<td>3.0</td>
<td>Policy amended to cover mid and</td>
<td>March 2018</td>
<td>March 2021</td>
</tr>
<tr>
<td>south Essex CCGs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exceptionality definition clarified and example given especially in regard to equipment requests</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Individual funding request (IFR)

Individual funding requests should only be made where the patient has exceptional clinical circumstances, and will be subject to audit.

Return to: IFR Team, [Contact details]

Incomplete applications OR illegible will be returned and may result in a delay in the decision making process.

What needs to be filled out:

1. If you are seeking funding for a treatment that is usually excluded or partially excluded from the NHS as indicated in the Service Restriction Policy (SRP), only complete Section 1.
2. If you are seeking funding for a new treatment/technology you must complete in full Sections 1 and 2 of this application.

- The fact that the diagnosis is very rare, or that the treatment might be efficacious for the patient is not, in itself, grounds for exceptionality. If a patient’s clinical condition matches the ‘accepted indications’ for a treatment that is not funded, they are by definition, not exceptional.
- Only evidence of clinical exceptionality will be taken into consideration.

<table>
<thead>
<tr>
<th>The patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is clinically significantly different from the general population of patients with the same diagnosis/condition in question.</td>
</tr>
<tr>
<td>AND</td>
</tr>
<tr>
<td>2. As a result of this clinical difference is more likely to benefit from this treatment/intervention than might be expected for the average patient with the diagnosis/condition.</td>
</tr>
</tbody>
</table>

- It is the responsibility of the requesting clinician to demonstrate exceptionality.
- Requests can only be made on an individual, named patient basis and should be completed by an appropriate referring clinician prior to referral for treatment. It is not guaranteed that such treatment will be necessarily funded in the case of similar subsequent cases if the CCG does not consider it as clinically effective or cost effective.
- The following criteria should be used to identify how urgent a request is:
  - Urgent/Fast track response within 5 working days (refer to policy for definition/criteria)
  - Routine application received to decision 2 months
A: Patient details

Patient NHS Number:  

Patient first names:  

Patient last name:  

UBRN:  

Date of birth (DD/MM/YY):  

Gender:  

Female  Male

Patient address (1st Line):  

Patient town:  

Patient postcode:  

Patient contact number (home):  

Patient contact number (mobile):  (not mandatory)

Patient email address:  (not mandatory)

Interpreter required:  

No  Yes, language:  

Transport required:  

No  Yes, state type:  

B: GP details

P name:  

GP Practice address:  

GP practice code:  

GP contact no.:  

GP email address:  
C: Applicant clinician details

GP/Consultant’s name: 
Address: 
Contact no.: 
Email address: 
Section 1: All applicant clinicians must complete this section

1. What is the patient's condition/diagnosis?

2. Patient BMI: (if relevant)

3. What is the proposed treatment?

4. What treatments has the patient received to date for this condition?

5. Exceptionality Test 1
   How is the patient significantly different from other patients in this patient population? (The onus is on the applicant clinician to demonstrate that this patient is significantly different from other patients in a similar situation to justify departure from the usual clinical management)

6. Exceptionality Test 2
Will this patient benefit to a greater degree from receiving this treatment than others in this patient population/cohopt? (The onus is on the applicant clinician to demonstrate that there are factors about this specific patient that indicate a departure from the usual clinical management will result in a gain for this patient that is significantly greater than that normally expected of this patient population in general.)

7. How many patients in a 12 month period would you expect to seek similar treatment for?

8. How much does the intervention cost?
Section 2: Must be completed for applications involving new treatments or techniques

The proposed intervention should have a high likelihood of success or should substantially reduce the risk associate with the standard intervention. Please provide evidence (e.g. papers outlining the intervention outcome with patient specific information sufficient to identify the proposed patient as being similar to the study in which the benefit was seen).

The Panel will base its deliberations on the information provided.

1. Safety
   a. Is the proposed intervention safe?
   b. Is the treating clinician adequately qualified/experienced to perform this treatment? Please provide evidence.

2. Effectiveness
   a. Is the intervention effective?
   b. Why is the proposed intervention thought to be superior to the standard treatment in this patient’s case?
   c. Have clear outcomes been set with the patient?
   d. What level of response will be considered ineffective?
   e. How is response to the intervention to be monitored?
   f. What is the end point at which the intervention will stop?
   g. What are the longer-term follow-up arrangements?
   h. Are these the responsibility of the unit in which the intervention took place or a unit more local to the patient’s home?
   i. Do the follow-up arrangements attract additional resource?
3. Equity and fairness

a. What are the local treatment options for this patient?
b. What is the cost of the standard intervention vs. the proposed intervention?

Treatment Requested:

Clinical Information:

Patient BMI: (if relevant)
Other Clinical Information: (please attach prescription history, clinical letters, etc.)

To obtain an electronic copy of this form, please email Fundingrequests.south@nhs.net
Guidance for the use of the individual funding request submission form

Individual funding requests should only be made where the patient has exceptional clinical circumstances, and will be subject to audit.

Completing the form:

- This form must be completed by the requesting consultant for all off-protocol requests requiring CCG funding.
- The form must be completed electronically giving full details. Boxes will expand. Failure to provide full information may result in a delay in reaching a final decision.
- Your submission will be greatly supported if you directly answer these two ‘tests’ of exceptionality in section 10, and give appropriate evidence in the other sections.

The patient

1) Is clinically significantly different from the general population of patients with the same diagnosis/condition in question.

AND

2) As a result of this clinical difference is more likely to benefit from this treatment/intervention than might be expected for the average patient with the diagnosis/condition.

- The fact that the diagnosis is very rare, or that the treatment might be efficacious for the patient is not, in itself, grounds for exceptionality. If a patient’s clinical condition matches the ‘accepted indications’ for a treatment that is not funded, they are by definition, not exceptional.
- Only evidence of clinical need will be taken into consideration. Factors such as gender, ethnicity, age, lifestyle or other social factors such as employment or parenthood will not be considered on grounds of equality.
- It is the responsibility of the requesting clinician to demonstrate exceptionality.

1. Requests can only be made on an individual, named patient basis and should be completed by an appropriate referring clinician prior to referral for treatment. Trusts should treat all urgent and life-threatening situations based on the clinical need. It is not guaranteed that such treatment will be necessarily funded in the case of similar subsequent cases if the CCG does not consider it as clinically effective or cost effective.

2. The CCG will not normally fund a patient's treatment to continue following a clinical trial. In line with the Medicines Act 2004 and the Declaration of Helsinki, the responsibility for ensuring a clear exit strategy from a trial and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial.
3. Mid and south Essex CCGs will not normally fund novel or uncertain treatments. Funding for new, rarely used, **unlicensed** and/or investigational drugs outside of a research trial will remain the responsibility of the provider unless a business case is submitted in advance to the commissioner to take through the due process.

4. The following criteria should be used to identify how urgent a request is:

   - **Most urgent**
     - response within 3 working days as the patient’s life may be in danger
   - **Immediate**
     - decision needed within 3 weeks as delay will not be clinically appropriate
   - **Routine**
     - decision needed in 4 to 6 weeks

   *The requesting clinician is asked to provide clinical feedback on the outcomes of treatment (ideally following clinical review in 3 months or as appropriate).*

**Deadline:**

- Each CCG has a monthly meeting to review these submissions; the deadline is 1 week before the meeting.
- You will be informed of the decision, at the very latest, within 4 weeks of this meeting.
- If your patient needs to have a decision before this deadline, please inform the CCG directly when you submit this form.

**Submitting the form:**

<table>
<thead>
<tr>
<th>Applications to be sent to:</th>
<th>Basildon and Brentwood CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Castle Point and Rochford CCG</td>
</tr>
<tr>
<td>Please note that emails must be sent from an nhs.net address to an nhs.net address.</td>
<td>Mid Essex CCG</td>
</tr>
<tr>
<td>Alternatively fax request to</td>
<td>Southend CCG</td>
</tr>
<tr>
<td></td>
<td>Thurrock CCG</td>
</tr>
</tbody>
</table>

Policy Date: March 2018
Review Date: March 2021
Appendix 2: Individual Funding Request for review of an exception to CCG policy

INDIVIDUAL FUNDING REQUEST

For review of an exception to CCG policy

*Full published papers, rather than abstracts, should be submitted, unless the application relates to the use of an intervention in a rare disease where published data is not available.*

Form to be completed electronically giving full details. Boxes will expand.

**CONTACT INFORMATION**

<table>
<thead>
<tr>
<th>Trust Name</th>
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<tbody>
<tr>
<td>1. Address</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Applicant Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Designation:</td>
<td></td>
</tr>
<tr>
<td>Tel:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Address to which funding decision to be sent. N.B. Land address must be given for hard copy. Electronic copy may be sent to nhs.net email addresses only.</th>
<th>NHS.net email:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4. Patient Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initials:</td>
<td></td>
</tr>
<tr>
<td>NHS No:</td>
<td></td>
</tr>
<tr>
<td>Hospital ID number:</td>
<td></td>
</tr>
<tr>
<td>Postcode:</td>
<td></td>
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<tr>
<td>DoB:</td>
<td></td>
</tr>
<tr>
<td>Registered Consultant:</td>
<td></td>
</tr>
<tr>
<td>Registered GP name:</td>
<td></td>
</tr>
<tr>
<td>Registered GP postcode:</td>
<td></td>
</tr>
</tbody>
</table>
Referred by (other than GP):

Referred from:

Date of referral:

5. Application reviewed by Chief Pharmacist or nominated deputy (in the case of a drug intervention)

Name:

Signature or email confirmation:

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

6. Patient Diagnosis (for which intervention is requested)

7. Clinical history*

Please provide a brief clinical history of the patient outlining

- current problems,
- any co-morbidities,
- investigation results for current problem,
- treatments given so far
- abilities in independence and self-care

Attach most recent correspondence between GP and referring consultants if appropriate.

(Please extend space if necessary)
8. Details of intervention (for which funding is requested). If the intervention forms part of a regimen, please document the full regimen.

<table>
<thead>
<tr>
<th>Name of intervention:</th>
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<tbody>
<tr>
<td>Dose and frequency:</td>
</tr>
<tr>
<td>Planned duration of intervention:</td>
</tr>
<tr>
<td>Route of administration:</td>
</tr>
<tr>
<td>HRG (activity)code:</td>
</tr>
<tr>
<td>Anticipated cost of drug (Inc. VAT):</td>
</tr>
</tbody>
</table>

N.B. This must be completed

9. Is requested intervention part of a clinical trial?

Delete as appropriate: **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**

10. (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 clinical circumstances that make the standard intervention inappropriate for this patient?

(d) How does this patient differ clinically from the general population of patients with this condition?
(e) Why is this patient more likely to respond to the requested therapy (as a result of this clinical difference) than the population of interest with the same condition? See 10 (c) above

(f) What is the patient's clinical severity? (Where possible use standard scoring systems e.g. WHO, DAS scores, walk test, cardiac index etc.)

11. Summary of previous intervention(s) this patient has received for the condition.
   * Reasons for stopping may include:
     - Course completed
     - No or poor response
     - Disease progression
     - Adverse effects/poorly tolerated

<table>
<thead>
<tr>
<th>Dates</th>
<th>Intervention (e.g. drug / surgery)</th>
<th>Reason for stopping* / Response achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

12. Anticipated start date

   Each CCG has a monthly meeting; deadline is 1 week before. You will be informed of the decision, within 4 weeks of this meeting.

   Please contact the relevant CCG to establish the Panel process timeline or to confirm that an urgent decision is required.

CLINICAL EVIDENCE

13. Is requested intervention licensed for use in the requested indication in the UK?
   Delete as appropriate: Yes/No (refer to pharmacy if required)

14. Has the Trust Drugs and Therapeutics Committee or
   Delete as appropriate:
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>equivalent Committee approved the requested intervention for use? (if drug or medical device).</td>
<td>Drugs and Therapeutics Committee <strong>Yes/No</strong> If <strong>No</strong>, Committee Chair or Chief Pharmacist approved: <strong>Yes / No</strong></td>
</tr>
<tr>
<td>15. Give details of National or Local Guidelines/recommendations or other published data supporting the use of the requested intervention for this condition?</td>
<td><em>PUBLISHED</em> trials/data - please furnish electronic copies of journal articles/ scanned/ faxed/weblinks</td>
</tr>
<tr>
<td>16. (a) How will you monitor the effectiveness of this intervention?</td>
<td></td>
</tr>
<tr>
<td>(b) Detail the current status of the patient according to these measures.</td>
<td></td>
</tr>
<tr>
<td>(c) What would you consider to be a successful clinical outcome for this intervention in this patient? Please state added benefits of this treatment, e.g. QOL, life expectancy, impact on or facilitating subsequent treatment, etc.</td>
<td></td>
</tr>
<tr>
<td>17. What is the anticipated toxicity of the intervention for this patient?</td>
<td></td>
</tr>
<tr>
<td>18. What are your criteria for stopping treatment? Define fully using objective measurements or recognised assessment scales.</td>
<td></td>
</tr>
<tr>
<td>19. Are there any additional patient factors (clinical) that need to be considered?</td>
<td><strong>Delete as appropriate: Yes/No</strong> If <strong>Yes</strong>, please give details:</td>
</tr>
</tbody>
</table>

1. Full published papers, rather than abstracts, should be submitted, unless the application relates to the use of an intervention in a rare disease where published data is not available.

Policy Date: March 2018
Review Date: March 2021
### CCG USE ONLY

**Record of communication:**

- 
- 

**Points for Discussion:**

- 

**Recommendation from Exceptional Clinical Circumstances Panel (or other route):**

**Clinical:**

**Financial:**

**Signature:**

**Chief Pharmacist Date:**

---

Policy Date: March 2018

Review Date: March 2021
Mid and South Essex Clinical Commissioning Groups
Individual Funding Requests (IFR) Panel

Terms of Reference

1  Role

1.1  Purpose
- To ensure decisions are made about commissioning healthcare interventions for individual patients that are based on the best available evidence of their clinical effectiveness.
- To review requests for treatment or services not routinely funded by the relevant NHS Commissioning organisation.

1.2  Objectives:
To review individual funding requests and make recommendations as to whether treatment should be commissioned in the following circumstances:

- Cases where a refusal to treat decision has been made by the Referral Management Centre or a provider on the basis that the patient does not meet the agreed criteria
- Cases where a request has been made for treatment or services not normally provided in the mainstream NHS.

2  Status
The IFR panel is a working group of the mid and south Essex CCGs who comprise NHS Basildon and Brentwood, NHS Castle Point and Rochford, NHS Mid Essex, NHS Southend and NHS Thurrock CCGs. It is not a committee of the CCGs and its role is advisory only. It does not have delegated authority to exercise functions on behalf of the CCGs.

3  Accountability
The panel is accountable to the Quality & Governance Committees (or equivalent) of the CCGs.

3.1  Key Relationships:
- CCG Governance Leads and Clinical Governing Body Members
- Referral Management Centre where applicable
- External Review Panel
4 Decision making and delegated authority

In these terms of reference, the expression “authorised representative” means a member of a CCG’s Governing Body, or a mandated officer, who is authorised by that CCG’s Governing Body to make decisions on behalf of the CCG in relation to IFRs. It is the responsibility of each CCG to nominate individuals to serve on the panel and to ensure that they have the appropriate delegated authority.

Each of the CCGs has agreed that when an authorised representative of its CCG is serving on an IFR panel, he or she will have a delegated limit of £50,000 per case, irrespective of his or her usual delegated limit (as set out in the relevant CCG’s Scheme of Delegation).

The panel must take reasonable steps to estimate the total cost of any decision to approve an IFR, including travel and similar costs as well as any costs that are likely to span more than one financial year.

If the total estimated cost is less than £50,000, then a CCG’s authorised representative will make a final decision for his or her CCG, taking account of the recommendation of the IFR panel.

If the total estimated cost exceeds £50,000 then the panel will make a recommendation to the relevant CCG. The final decision will rest with either the Clinical Executive Group or Governing Body of the relevant CCG.

5 Priorities

To consider each case individually, while making the best and fairest use of resources available for healthcare within the mid and south Essex area.

Where panel members have a conflict of interest either by virtue of a connection with the patient or in terms of a vested interest as a potential service provider, the CCG should send an alternative individual.

6 Monitoring and reporting

6.1 Monitoring:

The Panel will monitor itself against its objectives and undertake a review of its performance annually. This review will be led by one of the Panel Chairs and will involve all panel members and the IFR Co-ordinator. An annual report from the panel will be submitted each year to the Quality & Governance Committees (or equivalent) of the CCGs.

6.2 Reporting:

IFR Panel cases will only be reported to a CCG’s Governing Body where an appeal has been submitted and considered by the External Appeal Panel and where the External Appeal Panel has disagreed with the original decision.
In cases where the External Appeal Panel disagrees with the original decision, the CCG’s Governing Body (excluding the authorised representative who made the original decision) shall determine whether to uphold the original decision or to accept the recommendation of the External Appeal Panel.

In cases where the External Appeal Panel uphold the decision of the authorised representative, then the authorised representative’s decision will be the final decision and there will be no recourse to the CCG’s Governing Body.

7 Membership

The core members of the panel consist of

1. An authorised representative from the CCG for which the case originates; and

2. Insofar as the authorised representatives who are present do not between them hold the following positions, members of one or more of the CCGs who hold the following positions:
   - A lay member;
   - A public health specialist;
   - A senior commissioner;
   - A GP;
   - A chief nurse.

In the event that more than one authorised representative of a CCG attends a meeting of the panel, the authorised representatives shall agree which of them shall act as the CCG’s authorised representative for the purpose of the relevant Panel meeting and the decision shall be recorded in the minutes of the meeting.

7.1 Chair

A CCG lay member shall chair the meetings of the Panel.

7.2 Co-opted members (attendees by invitation):

- CCG Governance Leads
- Medicines Management Team
- Children’s Service’s team

The panels will be arranged and administered by the IFR Coordinator or his/her deputy.

8 Quorum

8.1 For regular scheduled IFR panels

The quorum shall be the core members as set out in section 7.
8.2 For panels convened to consider urgent cases
Panels that are convened to consider cases defined as urgent/fast-track have a reduced quorum to facilitate quick decision-making. In such cases the following members will be required:

- The authorised representative of the CCG with responsibility for the patient in question; and
- Either a public health specialist or a GP or Executive Nurse from any mid or south Essex CCG.

There is no requirement for the same individuals to attend the panel on each occasion. Whilst in some respects this would be preferable in order to maintain continuity and consistency, the main tool for ensuring consistency and organisational memory is through the IFR Co-ordinator who will attend panels and will advise members as to the existence of any relevant previous case decisions.

8.3 Voting rights
Only the core members have a vote on recommendations to authorised representatives and CCGs.

The delegated representative for the CCG whose case the case relates to can choose to accept the recommendations or not, based on their own professional opinion.

9 Frequency of meetings
The Panel will meet as frequently as required by its caseload. The indicative frequency will be monthly and panels will be arranged in advance.

10 Review of terms of reference
The Terms of Reference will be reviewed at the same time as the IFR Policy is reviewed and need to be agreed by the Panel and ratified by the Governance Committees (or equivalent) of the mid or south Essex CCGs.
Appendix 4: Decision framework document for Individual Funding Request panel

IN STRICTEST CONFIDENCE IFR DECISION FRAMEWORK DOCUMENT

PANEL MEETING DATE__________________________________________PATIENT No:______________________________________

Essex STP CCGs

DECISION FRAMEWORK DOCUMENT FOR INDIVIDUAL FUNDING REQUEST PANEL

STRICTLY PRIVATE & CONFIDENTIAL
Notes of Guidance:

1. This form is completed for each person in respect of whom an application is being considered
2. The completed form will be retained by the Individual Funding Request Coordinator
3. The Framework will be used to inform the letter to be written by the Chair of the IFR Panel

Panel Members:

Intervention Requested

Documents pertaining to the case:

<table>
<thead>
<tr>
<th>Brief background to intervention requested</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>No</td>
</tr>
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<tr>
<td>1</td>
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<tr>
<td>2</td>
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<tr>
<td>3</td>
</tr>
</tbody>
</table>
effective in this individual case and that they will gain significantly greater clinical benefit than other patients with the same clinical condition and stage of disease.

4 Does the panel consider that there is enough evidence to make a decision regarding the cost effectiveness of this drug/intervention? (NICE, Appraisals) and does that evidence indicate the treatment requested will be cost-effective in this individual case?

<table>
<thead>
<tr>
<th>No</th>
<th>Affordability</th>
<th>Discussion notes</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>What are the absolute costs involved in funding this treatment, in relation to the overall resources of the CCG for health care?</td>
<td></td>
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</table>

**Equity/ Needs of the Community**

<p>| 6  | What will the anticipated impact be on the rest of the patient population should this treatment be funded? | | |
| 7  | Will it be equitable to the wider population to fund this treatment after consideration of the clinical needs of this patient? | | |</p>
<table>
<thead>
<tr>
<th><strong>Other factors</strong></th>
<th></th>
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<tbody>
<tr>
<td>Are there any other factors which were considered relevant by the Panel?</td>
<td></td>
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</table>
Appendix 5: Guidance notes for Clinicians

1. How should I decide whether to make an Individual Funding Request?

The criteria on who is eligible to be considered as an Individual Funding Request have been clarified by the IFR policy and will now be applied consistently across the CCG. The key consideration is whether the treatment that you wish to request for your individual patient will meet the definition for ‘exceptional clinical circumstances' that is set out in the policy.

2. What is meant by ‘exceptional clinical circumstances’?

The CCG cannot fund requests that should be fairly applied to other patients who have similar clinical circumstances and who should rightly also be offered the treatment if your patient was to be approved. This would require the CCG to agree a new commissioning policy (or amend an existing one) setting out that the treatment was now available for a new group of patients and setting out how this group had been identified. Therefore, to meet the definition of ‘exceptional clinical circumstances' you must demonstrate that your patient is both:

Significantly different clinically to the group of patients with the condition in question and at the same stage of progression of the condition e.g. metastatic bowel cancer

AND

Likely to gain significantly more clinical benefit than others in the group of patients with the condition in question and at the same stage of progression of the condition

In other words, you must show that your patient is very different from others in group of patients with the same condition/stage of the disease and has clinical features that mean that they will derive much more benefit from the treatment you are requesting.

In line with the principle that patients with rare conditions should neither be advantaged nor disadvantaged simply because their condition is uncommon where treatments, devices or pieces of equipment can be used to treat various conditions it is the presenting need that will assessed against the same criteria as everyone else requiring the intervention. This applies particularly to equipment requests.
Example

A woman has a rare form of a disease which requires her to use a wheelchair. There are no other patients with this form of the disease which require their use of a wheelchair. She will be assessed for wheelchair funding against the same eligibility criteria in the same way that other people with more common conditions requiring similar equipment is undertaken, i.e. for her mobility needs rather than the rarity of her form of the disease.

3. Why are only clinical features taken into account?

The CCG must make decisions fairly about funding treatments and not on the basis of age, sex, sexuality, race, religion, lifestyle, occupation, family status (including responsibility for caring for others) social position, financial status etc. unless these directly affect the expected clinical benefit that an individual will derive from a treatment e.g. the effect of the increasing age of a woman on fertility.

4. How do I make an Individual Treatment Funding Request (IFR)?

All requests must be made on a standard treatment request form which can be obtained electronically from [http://basildonandbrentwoodccg.nhs.uk/about-us/policies-and-procedures/service-restriction-policy/1111-3-0-ifr-policy](http://basildonandbrentwoodccg.nhs.uk/about-us/policies-and-procedures/service-restriction-policy/1111-3-0-ifr-policy) or the IFR department on 01268 594480 or email [Contact details]. It is the responsibility of the referring clinician to ensure that the form is completed accurately by seeking specialist information from other clinicians as required.

The form aims to ensure that all the necessary information is obtained so it is important that it is completed comprehensively and accurately, along with any relevant research papers, by the referring clinician to avoid delays in reaching a decision. The form can either be returned electronically using nhs.net secure email or by post.

5. How can I get advice on what to include when completing a treatment request form?

You can phone or e-mail the IFR department on [Contact details] or email @nhs.net for advice on whether to submit a treatment request form and what to include.

6. Who will make the decision on whether the Individual Funding Request (IFR) is approved?
All new Individual Funding Requests are ‘screened’ by the Clinical Review Panel. If there is no evidence of exceptional circumstances (often because the patient is clearly part of a definable cohort) then the request is declined at this stage. If evidence of exceptionality is presented, or if the screeners are uncertain whether the case is exceptional or not, then the case will be forwarded to the CCG IFR Panel. They will determine whether there is a case for exceptionality and whether the intervention is safe and clinically and cost-effective.

7. How will I be informed of the CCG decision?

If your request is being taken to the CCG IFR Panel you will be informed of the date of the panel and will receive a letter outlining the decision of the panel within 10 working days after the panel meeting.

8. How will my patient be informed of whether the request has been approved?

All correspondence relating to the outcomes of Panels will be copied to the patient and to the referring Clinician (Consultant or GP) and the patients GP if they are not making the request.

9. Can either the patient, or a clinician involved in their care, attend the panel?

Yes. The patient (or a nominated representative) has the opportunity to attend the Panel to give a presentation of their case. The patient may be accompanied by a supporter (who may be a relative, friend or independent advocate) who can assist the patient in the presentation of their case. However, the patient cannot be formally represented and may not be accompanied by a member of the press. The patient may submit any further evidence they feel may support the funding request. Having received all the evidence, submissions and representations, the Panel will consider the case privately.

10. Can I or my patient appeal, against the CCG decision?

There is no right to appeal against the decision at the ‘screening’ stage although it is possible to complain under the CCG Complaints Policy. However, this will not overturn the decision of the screening stage but will examine whether the IFR policy was properly followed.
If the IFR Panel does not approve your request you, or your patient, are entitled to ask for a review of the process that was undertaken by the IFR Panel. The Process Appeal Panel will decide if the IFR Panel followed the correct procedures and the IFR Panel reached a decision that was rational and based on all the evidence that was presented.

If the original IFR Panel decision is upheld, you or your patient, may either to pursue a complaint through the CCG Complaints Procedure or to take the case to the Healthcare Ombudsman. The CCG Complaints Policy may be used to review the decision making process for an individual case and may result in the matter being reconsidered by the IFR Panel.

11. What can I do if my patient is not exceptional e.g. represents a group of patients in similar clinical circumstances

If you disagree with an existing policy then you can try to change it but this cannot be achieved through the IFR process. If the treatment or services is covered by CCG, it will need the support of all the relevant clinicians through a clinical network, if one exists, or by a direct approach to the CCG.

Please note that it would be unusual to introduce a new development in year as each year resources are already committed through an annual round of prioritisation. Hence new developments will usually require reallocation of resources from existing services.
INDIVIDUAL FUNDING REQUEST (IFR)

PATIENT INFORMATION FACT SHEET

NHS Clinical Commissioning Groups (CCGs) are responsible for looking after the health needs of the local population within the funds allocated.

Your CCG has close working relationships with healthcare professionals such as GPs and pharmacies, as well as with hospital consultants.

What is the Individual Funding Request (IFR) Panel?

If you have received this information leaflet your doctor or consultant is probably asking your CCG to consider funding a treatment that is outside the normal range of treatments funded by the NHS.

These treatments are often considered to be of low priority and include, for example, cosmetic surgery.

The IFR Panel will not consider an application without the support of a patient’s GP or hospital doctor.

Screening Process?

Upon receipt, all IFRs will undergo a screening process by the IFR Team with clinical or public health input as required.

Who sits on the panel?

The Panel normally consists of a Lay representative (Chair), Public Health Advisor, Doctor, Nurse, Prescribing Advisor and CCG Commissioning Manager.
Any colleagues new to the IFR Panel Process may be present for training purposes. This ensures that patients experience minimal delays when awaiting their case to be considered.

In addition, an administrator will always be present to take the minutes of the Panel meeting.

Each case is treated in the strictest confidence.

What are the Panel looking for?

The IFR Panel looks at cases where there may be exceptional circumstances, and to ensure that decisions are made about treatments that:

- Are based on the best available evidence (for example, medical research)
- Look to improve the patient’s condition and not make it worse
- Take account of the views of the patient and their doctor, inviting patients to give evidence in person to the Panel if they wish
- Make best use of the resources available for healthcare within the Essex STP area

The definition of exceptionality used under the IFR policy is:

- 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 from the intervention than might be normally expected for patients with that condition

In line with the principle that patients with rare conditions should neither be advantaged nor disadvantaged simply because their condition is uncommon where treatments, devices or pieces of equipment can be used to treat various conditions it is the presenting need that will assessed against the same criteria as everyone else requiring the intervention. This applies particularly to equipment requests.

Example

A woman has a rare form of a disease which requires her to use a wheelchair. There are no other patients with this form of the disease which require their use of a wheelchair. She will be assessed for wheelchair funding against the same eligibility criteria in the same way that other people with more common conditions requiring similar equipment is undertaken, ie for her mobility needs rather than the rarity of her form of the disease.

Updated March 2018
How does the panel work?

Panel meetings are normally held at the local NHS offices in [Contact details]. You will have a choice whether to attend the panel in person, state your case in a letter or speak to one of the Panel members on the telephone.

Your invitation to attend the Panel is your opportunity to discuss your case and explain your view as to why your circumstances are exceptional, to supplement the information submitted by your doctor.

The Panel members may ask a few questions to help them understand your circumstances better.

It might feel formal attending the Panel meeting; you are welcome to bring someone with you if you feel this would help.

When you have finished explaining why you want a particular treatment you will be able to leave. A decision is not made while you are there. You will be informed of the Panel’s decision within 10 working days of the meeting.

The IFR Panel will not take account of personal, demographic or social factors and will only consider factors which are clinical in nature.

What happens if I disagree with the Panel’s decision?

If you feel the process followed by the Panel was not correct you have the right to appeal. This will need to be put in writing to the IFR Team within 28 days of receiving a letter notifying you of the Panel’s decision.

Please note that appeals will only be accepted if there is any indication that the appeal is based on a flaw in the process followed by the Panel. Appeals based purely on a
disagreement with the panel’s decision are not permitted. A panel from a neighbouring CCG will review appeals that are accepted.

Contact details: 

IFR Team

[Contact details] 

Telephone number for Individual Funding enquiries:

Tel:
18 References

1. National Prescribing Centre and Department of Health. Supporting rational local decision-making about medicines (and treatments) (February 2009). Available from: 
   www.npc.co.uk/policy/resources/handbook_executive.pdf

   www.dh.gov.uk/en/managingyourorganisation/commissioningdh_093414

3. Improving Access to medicines for NHS patients. A report for the Secretary of State for Health by Professor Mike Richards CBE. (November 2008). Available from: 


<table>
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<tr>
<th><strong>Report to:</strong> Part I STP Joint Committee</th>
<th>Meeting Date: 6 April 2018</th>
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<tr>
<td><strong>Agenda No:</strong></td>
<td>7</td>
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<tr>
<td><strong>Report Title:</strong></td>
<td>Cancer Update</td>
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<tr>
<td><strong>Submitted by</strong></td>
<td>Carol Anderson, Chief Nurse, Joint Commissioning Team</td>
</tr>
<tr>
<td><strong>Written by</strong></td>
<td>Carol Anderson, Chief Nurse. Joint Commissioning Team</td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
<td>To approve revised cancer trajectory and note update report</td>
</tr>
<tr>
<td><strong>Approval Route</strong></td>
<td>Mid and South Essex STP Cancer Board</td>
</tr>
<tr>
<td><strong>Recommendation</strong></td>
<td>The Board is requested to approve the revised Cancer Trajectory for Mid Essex Hospitals NHS Trust and Basildon and Thurrock University Hospitals NHS Trust</td>
</tr>
</tbody>
</table>
1. Introduction

Each year around 6,500 people are diagnosed with cancer in Mid and South Essex STP, with an equal split between men and women overall. Within the STP more than 32,000 residents live with and beyond a cancer diagnosis.

The National Cancer Strategy 2015 outlined a programme of transformational change until 2020/21 for cancer services across England. This involves ensuring compliance with new care models and service specifications, the provision of access to quality, safe and financially sustainable services at the appropriate place and time.

Cancer Alliances were developed across England to support the implementation of the Cancer Strategy. Mid and South Essex STP is within the boundaries of the East Of England Cancer Alliance.

Linked to the National Cancer Strategy a Cancer Transformation Fund has been established which STPs are able to bid against to implement its priorities in Cancer Services Transformation. Unfortunately for the majority of 2017 access to this fund was restricted to systems achieving the delivery of the 62 day cancer standard which meant Mid and South Essex STP did not receive any monies from the first tranche of transformational funding.

In December 2017 there was a change in this stance with Mid and South Essex STP receiving funding for implementing the National Optimal Lung Cancer Pathway.

We have recently been informed that transformation funding will be made available to systems not achieving the 62 day cancer standard, however the amount of monies received would be based on actual performance in Quarter 3 2017/18, Mid and South Essex achieved at aggregate 74.3% and therefore were able to bid for 50% of the original Mid and South Essex allocation. A final bid for this money was submitted on Friday 23 March 2017 and decision will be made by the National team and announcements of success will be available from 09 April 2018.

Mid and South Essex has 6 Key Objectives (listed below) in its Cancer Work Plan covering the period of 2017-2021, with much of the transformation linked to and reliant upon the receipt of national transformation monies.

- Modernising Cancer Services
- Improving Patient Experience
- Earlier Diagnosis
- Cancer Waiting Times
- Implement Best Practice Pathways
- Survivorship

2. Modernising Cancer Services

The Mid and South Essex STP aims to implement transformational and sustainable change to local cancer services, which will involve streamlining, innovating and modernising cancer care across all three providers.
A Mid and South Essex Cancer Board has been established to oversee the delivery of this programme.

Each STP is required to appoint a Lead Responsible Officer for Cancer (Carol Anderson for Mid and South Essex), a Clinical Lead for Cancer (Dr Donald McGeachy for Mid and South Essex), a Finance Lead for Cancer (Jason Skinner for Mid and South Essex) and a Cancer Programme Manager (out to advert). Both the Clinical Lead and Cancer Programme Manager are funded via the EoE Cancer Alliance and McMillan Funding for the next 2 years. Furthermore in Mid and South Essex McMillan has funded a 2 year Commissioning Transformation Lead post to support the changes in commissioning cancer services.

In addition to this the msb group has established a Director of Cancer Services to oversee the integration of cancer services across Mid Essex Hospitals NHS Trust (MEHT), Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH) and Southend University Hospitals NHS Foundation Trust (SUHFT).

3. Improving Patient Experience

The 2015 National Cancer Strategy outlined an ambition to place patient experience on an equal footing with other patient outcomes such as safety. This will involve a cultural shift in health care services, and how clinicians and patients work together.

In Mid and South Essex STP the aim to empower clinicians and patients to drive forward the Mid and South Essex STP Cancer Work Plan and ensure all service delivery improvements are co-produced with patients. In order to achieve this a SPT Cancer Patient Forum has been established who oversee the Mid and South Essex STP Cancer Work Plan.

Going forward in 2018/19 we have commissioned, and will work in collaboration with, Healthwatch Essex (in partnership with Healthwatch Southend and Healthwatch Thurrock) to establish Cancer Ambassadors whose roles will be to co-produce service delivery and transformation across the STP.

Currently the Cancer Patient Forum is overseeing delivery of the Annual Cancer Patient Experience Action Plan with updates to every STP Cancer Board (appendix 1) and is directly involved in service transformations such as the implementation of the National Optimal Lung Cancer Pathway (NOLCP).

We will use patient stories and the annual National Cancer Patient Experience Survey will form the primary evidence for improvements in patient experience over time.

4. Earlier Diagnosis

Stage at diagnosis is a key prognostic indicator, so earlier diagnosis is crucial in improving outcomes for patients. In Mid and South Essex STP more than half (55%) of stageable cancers were diagnosed at an early stage (stages I or II) and whilst this places the STP in the top quartile nationally further work is required to ensure as a system we meet the 28 day to diagnosis target which will be implemented in shadow form, reporting will commence in July 2018.

Vague Symptoms Pilot
Mid and South Essex was one of 3 STPs successful in bidding for McMillan Funding to pilot a Vague Symptoms Pilot to support early diagnosis.

Within the STP 2 pilots were commenced. One in MEHT led by Dr Malcolm Lawson and Dr Liz Towers and one in SUFHT led by Dr Madhavan both had the following objectives.

1. Provide a rapid route to diagnostics tests for patients with non-specific, vague symptoms which are of a concern to the GP;
2. Provide a more supportive route for patients to be seen other than the emergency route;
3. Evaluate the pilot service improvement model to develop a proposed service through the development of a business case for further adoption and spread;
4. Evaluate the service against GP and patient experience satisfaction.
Over 140 referrals have been made across both pilots which are currently in the evaluation stage. Final evaluations are being presented to the STP Cancer Board in April 2018. McMillan have extended pilot funding until June 2018 and the first priority on any transformation monies received is to continue with the best of both pilots for roll out across the STP.

Primary Care referral to a Cancer Pathway
The McMillan GPs with support from Cancer Research UK have been supporting Primary Care colleagues to optimise referral methods for patients with suspected cancer. In 2017/18 working with primary care colleagues revisions have been made to the 2 week cancer referral forms to make them user friendly and ensure patients are aware they have been referred on a cancer pathway.

The following referral forms have been revised and are being rolled out across the STP
- Urology 2 week referral form
- Lung 2 week referral form
- Upper GI 2 week referral form
- Lower GI 2 week referral form

The new 2 week urology form is attached for example as Appendix 2.

Colorectal Cancer
To increase earlier diagnosis in colorectal cancer the East of England Cancer Alliance are supporting STPs to roll out Quantitative Faecal Immunochemical Test (qFIT) as a ‘rule-out’ test of colorectal cancer in primary care for patients with suspicious lower abdominal symptoms. The initial meeting of stakeholders was held on 13 March 2018. Further work is required to establish if the pathology systems across the STP are able to link to the Regional Lab where tests will be processed.

Neutropenic Sepsis
The East of England Cancer Alliance has undertaken for the past 6 years an annual audit of door to needle times for patients with Neutropenic Sepsis. The last audit was in November 2017 and identified significant areas for improvement across the 3 hospitals trusts in Mid and South Essex STP.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>1-hour DTN Time Compliance</th>
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<tr>
<td></td>
<td>Data collection Period</td>
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<tr>
<td>BTUH</td>
<td>1 October 2016 - 31 March 2017</td>
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<tr>
<td>MEHT</td>
<td>1 October 2016 - 31 March 2017</td>
</tr>
<tr>
<td>SUHFT</td>
<td>1 October 2016 - 31 March 2017</td>
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A task and Finish Group has been established to improve door to needle times across the hospitals which is being led by Dr Catherine O’Doherty with significant input from the Patient Forum. An action plan (appendix 4) has been developed and updates are reported to the STP Cancer Board.

5. Cancer Waiting Times

It has been a very disappointing year in relation to cancer waiting times. As you will see from Appendix 3 none of the hospitals within Mid and South Essex STP are meeting the 62 day Cancer access target. NHS Improvement has been working with the Trust to agree further trajectories for improvement.

Currently SUHFT has recovered all internal pathways but they will not meet the 62 day recovery until BTUH Recover due to the number of shared care pathways.

BTUH are forecasting recovery by July 2018. However MEHT is not forecasting recovery of this target until September 2018.
The Trusts use a common methodology for undertaking the harm reviews, which has been agreed with commissioners. Harm reviews have been commenced for patients who have not been seen within 62 day and 104 day cancer standards. Whilst as commissioners we are confident in the process relating to harm reviews we have not been happy with the time it has taken for the Trusts to undertake the harm review. Therefore we have contractually agreed a timeframe for completion as part of the 2018/19 contracting round. This will ensure patients receive timely review and mitigate risk of further harm.

6. Implementing Best Practice Pathways

Mid and South Essex STP has commenced the delivery of best practice pathway review workshops for Breast, Lung, Colorectal and Prostate, in collaboration with the East Of England Cancer Alliance, to identify barriers and facilitate change across the three trusts. Clinical Leads have been appointed for each of the pathways.

As stated earlier some transformation monies were received in December 2017 to facilitate improvements in the lung cancer pathway. As a STP we received £174k to implement the National Optimal Lung Cancer Pathway (NOLCP). There has been significant improvement in the pathway including:-

- Currently only patients using SUHFT have access to direct referral for PET (positron emission tomography) scans, therefore to ensure rapid diagnostic pathway, the ability for patients to be referred straight to PET is being rolled out in BTUH and MEHT.
- One stop Clinical Nurse Specialist (CNS) led clinics are being rolled out in MEHT and SUFHT, based on the BTUH model.
- Each of the Trusts have appointed a Lung Navigator role to ensure rapid progress through the pathway
- Additional capacity for CT guided Lung biopsy across the STP

A full report on the project achievements and requirements for sustainability is currently being drafted and will be shared with Board members when available.

7. Survivorship and Risk Stratified Follow up

When asking patients what they would prioritise in the cancer transformation bid, every single response received was to support improvements for those struggling to return to their life beyond cancer.

Risk stratified follow up is in place in pockets across the STP for colorectal and breast cancer patients, however there is varied practice in each hospital Trust. The National Cancer Strategy (2015-2020) recommended implementation of stratified follow up in breast, colorectal and prostate cancers and rollout across other tumor types by 2020. As an STP we have recently submitted a bid to McMillan for 2 year support to lead work on survivorship and risk stratification with the aim to standardise process across the STP.

By implementing the Recovery Package work stream, the STP aims to inspire our patients, carers and families to live well and confidently beyond their diagnosis and back to rich and fulfilling lives. The recovery package and risk stratification process consists of:

- Holistic Need Assessments (HNA)
  - Macmillan Cancer Support (2012) advises that HNA should be undertaken at diagnosis and re-evaluated at strategic points in every patient’s journey. This ensures that concerns are addressed as early as possible, thereby reducing distress. Lack of HNA has been shown to contribute to poorer outcomes for people living with and beyond cancer. Across Mid and South Essex STP there is a real passion by all clinical teams to push forward to implement HNA’s for all patients at critical steps on their pathway.
- Treatment summaries and Care Plans
The treatment summary produced by secondary care at the end of a person’s phased treatment provides GPs and patients with important information, including side effects and/or consequences of treatment, signs and symptoms of recurrence and highlights any actions for the GP. Summaries are in place in some areas across the STP but not all areas and there is significant variation in the robustness of them.

- **Cancer Care Plan Reviews**
  - Primary care continues to strive to complete a Cancer Care Review with a patient within three months of their cancer diagnosis and to focus on what the patient identifies as important to them.
  - In Mid and South Essex, the Macmillan GPs already deliver a Cancer related Practice Nurse course. Cancer care plan reviews are covered during the teaching sessions but it is acknowledged that these are not consistently occurring in all areas across the STP.

- **Health and Well Being**
  - These are key intervention for patients and have proven to greatly improve outcomes for people living with cancer. Across the STP these events are led by Clinical Nurse Specialists and other key clinicians. There are 12 events planned across the STP in 2018/19.

### 8. Recommendations

The Committee is asked to:

- Approve the revised trajectories for improving 62 day cancer target
- Note the report and action plans

### 9. Appendices and Supporting Documentation

Appendix 1 – March Highlight Report on the Cancer Patient Experience Action Plan
Appendix 2 – Example of Revised 2 week wait referral form
Appendix 3 – 62 day cancer waiting times
Appendix 4 – Neutropenic Sepsis Action Plan
Mid and South Essex Cancer Patient Experience Action Plan - Highlight Report

Author(s): Karen Hull – Macmillan Commissioning Transformation Lead for Cancer Services – Mid and South Essex STP

Date: 22nd February 2018

Reporting period: December 2017 – February 2018

Status Summary: Last period (R/A/G) N/A

Status Summary: This period (R/A/G)

CPES description:
The STP Action Plan is based on responses to the National Cancer Patient Experience Survey (CPES). The survey is commissioned by NHS England and published by Quality Health. In 2016 the full CPES cohort included all adults over age 16 with a confirmed primary diagnosis of cancer and discharged after a cancer-related inpatient episode or day case between April and June 2016. The sample size was 109,663, from which there were 72,788 responses, yielding a response rate of 66%. There were 1,149 respondents from the Mid and South Essex STP trusts.

Further information about the 2016 CPES can be found here: https://www.quality-health.co.uk/surveys/national-cancer-patient-experience-survey.

Vision
The Mid and South Essex STP CPES Action Plan aims to improve the care experience for all patients diagnosed with cancer in the STP, by facilitating a consistent approach to holistic cancer care across all three acute trusts and five Clinical Commissioning Groups.

Current Landscape
There is variation in cancer patient experience across the Mid and South Essex STP. While there is evidence that patients are satisfied with their overall care and we have areas for celebration, we also acknowledge that there is room for improvement. This Mid and South Essex STP CPES Action Plan aims to celebrate success and address variation between the trusts and CCGs in our footprint; establishing a more consistent approach to cancer care for the benefit of patients.

Our key objective is to improve patient experience for people diagnosed with cancer, so that future CPES results and other patient feedback mechanisms indicate an improvement in our patients’ perception of their cancer care.

With more than 50 CPES questions and a variety of tumour sites to consider, we aim to:

1. Place patients at the heart of the development of our Action Plan.
2. Convene a working group comprised of patients and representatives from primary care, Clinical Nurse Specialists, CCGs, NHS managers, the STP, the Cancer Alliance, Cancer Research UK and Macmillan Cancer Support to support the development and implementation of the Action Plan.
3. Collate and synthesise trusts’ Action Plans, to create an over-arching Cancer Patient Experience Action Plan to cover all of the Mid and South Essex STP footprint.
   a. We aim to target areas of concern by focusing on responses for all cancers combined that indicated a significantly poorer response than expected, according to the latest 2016 CPES results.
   b. We aim to be led on tumour-specific actions by trusts’ Tumour Site-Specific Groups (TSSGs).
4. Take into consideration that some of the national benchmarks are low.
   a. Where this is the case, we have commented as such in the Action Plan table and have instead identified an aspirational target based on achievable, higher targets met by tumour-specific teams within the trusts.
5. Operate in the framework of current projects on-going within the trusts, CCGs and STP; so that where a relevant project group has already been convened, we will ask that our key actions be embedded into their programmes of work.
### Project Update:

<table>
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<th>Topic</th>
<th>Lead(s)</th>
<th>Action required</th>
<th>Rationale</th>
<th>Outcome(s) expected</th>
<th>Success measure/KPI</th>
<th>Estimated timescale</th>
<th>Sustainability</th>
<th>Progress</th>
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</thead>
<tbody>
<tr>
<td>Free parking for Haematology chemotherapy patients on treatment</td>
<td>Parking</td>
<td>BTUH: Lead Cancer Nurse: Emma Chaplin</td>
<td>Patients have requested this be added to our Action Plan, as a priority. This is to provide a consistent approach and equity of service across all trusts in the STP</td>
<td>To enable all cancer patients within the STP to have free parking when on treatment</td>
<td>Change to parking practices at BTUH</td>
<td>Feb-18</td>
<td>On-going</td>
<td>November 2017: Emma Chaplin has contacted the Parking Services Manager at BTUH</td>
<td>January 2018: Haematology patients on chemotherapy treatment now able to have free parking at BTUH</td>
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<tr>
<td>To implement Oncology Teaching Programme within the Trust, open to all Health Care Professionals</td>
<td>Oncology study events</td>
<td>BTUH; Lead Cancer Nurse: Emma Chaplin, Macmillan Learning and Development</td>
<td>To increase local ward nurse knowledge and expertise in Cancer care.</td>
<td>Improve cancer care across the sites and specialities, and information sharing to patients</td>
<td>Number of staff who sign up, and evaluation forms after events</td>
<td>Mar-18</td>
<td>On-going timetable for the course</td>
<td>5th November 2017: Health care support workers ‘Introduction to Cancer’ study day across STP February 2018: Teaching Programme in place March 2018.</td>
<td></td>
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<tr>
<td>To promote ward staff to attend the local Cancer and Palliative care course provided, which is free</td>
<td>Cancer and Palliative Care course</td>
<td>BTUH: Lead Cancer Nurse: Emma Chaplin</td>
<td>BTUH have significantly poorer performance for GPES 2016 Q14: Patient given practical advice and support in dealing with the side effects of treatment and for Q17: ‘Always treated with respect and dignity by staff’</td>
<td>Ward staff to understand side effects to better support patients</td>
<td>2018 survey: Patients will improve their responses to Q14 and Q17</td>
<td>Apr-18</td>
<td>Ongoing monitoring</td>
<td>February 2018: Cancer and Palliative Care course completed January 2018.</td>
<td></td>
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</tr>
<tr>
<td>To improve patient experience and to come up to same level of support as other information centres in STP</td>
<td>Macmillan Infospace</td>
<td>BTUH: Lead Cancer Nurse: Emma Chaplin and STP Cancer Patient Representation Group</td>
<td>To ensure all patients across the STP have access to confidential space to discuss concerns and receive information on cancer services and support.</td>
<td>Relocation of Infospace</td>
<td>Mar-18</td>
<td>On-going</td>
<td>November 2017: Discussions on-going January 2018: Room in Main Outpatients confirmed and move scheduled April 2018. It will include space for counselling/therapy in addition, space allocated in main entrance 2019/20 planning.</td>
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<tr>
<td>Clear and simple patient leaflet designed by patients</td>
<td>Patient pathway education</td>
<td>STP Cancer Patient Representation Group (SPRG)</td>
<td>Patients have been unclear on their pathway from diagnosis</td>
<td>Leaflet signed off by STP and the Alliance and circulated to patients</td>
<td>Feb-18</td>
<td>Re-visit of leaflet at SPRG when changes made or six-monthly</td>
<td>November 2017: Sue White presented the leaflet to the SPRG; Macmillan have helped to format the leaflet January 2018: Diagnostics leaflet shared with BTUH and pilot in place for March 2018 in Gynaecology service for 3 months.</td>
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</table>

### Health and Well Being events:

- **MEHT**
  - 20 April 2018 - Braintree & Bocking Community Centre
  - 15 June 2018 - MAU Broomfield Hospital
  - 5 October 2018 - County Hotel, Chelmsford

- **BTUH**
  - 15 March 2018 – Kingswood Leisure Centre Basildon
  - 14 June 2018- Kingswood Leisure Centre Basildon
  - 13 September 2018- Kingswood Leisure Centre Basildon
Appendix 1

- 15 November 2018 - Kingswood Leisure Centre Basildon

  - **SUFT**
    - July 2018
    - November 2018
    - March 2019

- **Action Kathy:** To confirm Health and Well Being Event Dates/Venue for SUFT

**Risk Log**

No identified Risks associated with the CPES Action Plan and Time-table of events at this stage.

**Recovery and Risk Stratification contained in the CPES Action Plan**

There is a separate Recovery and Risk Stratification action plan and the following actions have been removed into this plan.

- Health and Well Being Events
- HNA’s, Treatment Summary and Care Plan Reviews

Recovery and Risk Stratification action plan to be shared at the Mid & South Essex STP Cancer Board April 2018.

**Core Actions due for completion April 2019**

1. Macmillan Infospace move to Main Outpatients.
2. Schematics of Hospital Organisational Structures for STP Patient Representation Group and wider audience
3. Glossary of Acronyms used in Hospitals and CCGs for STP Patient Representation Group and wider audience
4. Patient feedback to Trust Staff – Suggestion of Patient Newsletter (EC) to Acute Trusts from Patients (discussion at STP Representation Group – 15/03/18)
5. SUFT appointment letters to be altered to ensure the patient understands that they may be accompanied to appts.
6. Pilot of What Happens next! – diagnostic leaflet update on trial being undertaken in BTUH gynaecology department.
7. Update on New Tranquility Room at SUFT and usage to enhance patient privacy
8. SUFT increased patient awareness of on-going Clinical trials and research through increased advertising via posters, annotation on clinic letters, screen shots and videos.
9. Recruitment of substantive Oncology Consultants across the STP
11. Practice Nurse Education Events - Update on Progress - course in place Jan –April 2018
12. Oncology Nursing Rotation Programme - Update on Progress
**UROLOGY SUSPECTED CANCER REFERRAL FORM**

**Date of GP decision to refer:**

**No. of pages sent:**

**NOTE:** This form is NOT for use for patients under 16

**INFORMATION PROVIDED TO PATIENT (To be provided by referring Dr)**

<table>
<thead>
<tr>
<th>Please tick</th>
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<tbody>
<tr>
<td>Patient has been informed that cancer needs to be excluded</td>
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<tr>
<td>Patient has been given written information leaflet regarding the 2 week wait pathway</td>
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<tr>
<td>Patient has confirmed they are available for the next 14 days</td>
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</table>

**PATIENT DETAILS – Must provide current telephone number**

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<th>Last name:</th>
<th>First name:</th>
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<tbody>
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<td>Gender:</td>
<td>DOB:</td>
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<td>Address:</td>
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<td>Tele (Day):</td>
<td>Tele (Evening):</td>
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<tr>
<td>Mobile No:</td>
<td>Patient happy for a message to be left</td>
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**GP DETAILS**

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**WHO PERFORMANCE STATUS**

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**ADDITIONAL CONSIDERATIONS**

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<td>Language/Hearing difficulties?</td>
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<td>Learning difficulties?</td>
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<tr>
<td>Mental capacity assessment required?</td>
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<tr>
<td>Known safeguarding concerns?</td>
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<tr>
<td>Mobility requirements (unable to climb on/off bed)?</td>
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**BACKGROUND INFORMATION/RISK FACTORS**

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<td>BMI</td>
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<td>Smoking</td>
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<td>Alcohol</td>
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<td>Other please specify</td>
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<tr>
<td>Relevant family history</td>
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</table>
**REASON FOR REFERRAL**

| **Prostate:** All patients with an **ABNORMAL** digital rectal examination (DRE) should be referred on a 2 week wait pathway |
| **Prostate:** For those patients with raised **PSA** and **BENIGN DRE** it is necessary to exclude **UTI** as a possible cause as up to 15% of such patients will have a UTI to account for their elevated result. If infection is confirmed, treat appropriately and **REPEAT** the **PSA** 6 weeks later |

In those **WITHOUT INFECTION**, follow the management guidelines below:

- **All SYMPTOMATIC** patients with **PSA** above age-specific range refer as 2 week wait
- **All ASYMPTOMATIC** patients with **PSA** of 10 or more refer as two week wait

In **ASYMPTOMATIC** patients with borderline **SINGLE RAISED PSA** (we interpret this as **PSA less than 10**), a **REPEAT PSA** in 4 weeks is recommended **BEFORE** a two week wait referral is made. This is to exclude physiological or short term illness as a cause of the isolated **PSA** rise

- **Bladder/Renal**: Aged 45 and over **AND** unexplained visible haematuria without urinary tract infection
- **Bladder/Renal**: Aged 45 and over **AND** visible haematuria that persists or recurs after successful treatment of urinary tract infection
- **Bladder**: Aged 60 and over with unexplained microscopic haematuria and either **dysuria** **OR** a raised **WBC** count:
  - **Dysuria**
  - **Raised WBC count**

**Microscopic haematuria: 2 of 3 urine dip or > 12 RBC on microscopy**

**Tests:** Non-painful enlargement or change in shape/texture

**Penile**: A penile mass or ulcerated lesion, where an STI has been excluded

**Penile**: Persistent penile lesion after treatment for an STI has been completed

**Penile**: Unexplained or persistent symptoms affecting the foreskin or glans

**Patient does not meet NICE suspected cancer referral criteria but you have a ‘gut feeling’ that they warrant further investigation. Please provide full details in the clinical information section.**

**ESSENTIAL PRE-REFERRAL INVESTIGATIONS**

| PSA – see recommendation above | Creatinine/eGFR |
| WBC | Mass detected on imaging? (attach report) |
| Hb |

**Other, please give details:**

**CLINICAL INFORMATION (or attach letter)**

<p>| <strong>PATIENT MEDICAL HISTORY</strong> |
| <strong>Existing conditions (please list or attach summary)</strong> |
| <strong>Current medication (please list or attach list with</strong> |</p>
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## Cancer performance for patients on the 62 day pathway.

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# Mid and South Essex STP Neutropenic Sepsis Action Plan

This action plan is in response to the yearly audit of the Door to Needle (DTN) times for patients presenting with Neutropenic Sepsis (against the 1 hour standard) which has been undertaken locally (Mid Essex Hospitals NHS Trust [MEHT], Basildon and Thurrock University Hospitals NHS Foundation Trust [BTUH] and Southend University Hospitals NHS Foundation Trust [SUHFT] by the East of England Cancer Alliance.

The audit was discussed at the March Mid and South Essex STP. The Board tasked a small working group (patient Forum representative, STP Chief Nurse, Consultant Oncologist, msb Cancer Programme Director and CNS') to agree an action plan for improvement. The working group were asked to identify other key stakeholders to include in the development of the action plan.

<table>
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<tr>
<th>Actions</th>
<th>Lead</th>
<th>Time frame</th>
<th>Update</th>
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<tr>
<td><strong>Immediate Actions</strong></td>
<td></td>
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</tr>
<tr>
<td>1 REVIEW OF AUDIT BY STP CANCER BOARD</td>
<td>STP SRO CANCER</td>
<td>Immediate (March 2018)</td>
<td>Discussion at February STP Cancer Board to establish task and finish group to develop and implement action plan</td>
</tr>
<tr>
<td>- Discussion at STP Cancer Board in relation to audit outcomes and impact on patient outcomes.</td>
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<tr>
<td>2 TASK &amp; FINISH GROUP:</td>
<td>Trust Lead Cancer Nurses, Trust Directors of Nursing</td>
<td>Immediate (March 2018)</td>
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<tr>
<td>- Establish an STP Door to Needle (DTN) task and finish group to focus improvement in the management of patients presenting with Neutropenic Sepsis. This group must include A&amp;E senior clinical representatives from across all hospitals in the STP</td>
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<tr>
<td>2 REPORTING/GOVERNANCE:</td>
<td>msb Cancer Programme Director Trust Lead Cancer Nurses, A&amp;E Matrons</td>
<td>Immediate (End April 2018)</td>
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<tr>
<td>- Develop a local process for recording and reporting DTN times for patients with Neutropenic sepsis</td>
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<tr>
<td>- Detailed Review of current pathway for Neutropenic Sepsis to understand where delays occur – time to triage, time to antibiotic prescription, time to antibiotic delivery, external factors that effect DTN times</td>
<td>A&amp;E Matrons Trust Lead Cancer Nurses</td>
<td>Immediate (end April 2018)</td>
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</tr>
<tr>
<td><strong>Short term Actions</strong></td>
<td>Patient Forum Representative Consultant Oncologist msb Cancer Programme Director Chief nurse STP</td>
<td>3 month (May 2018)</td>
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<tr>
<td>- Explore and visit Hospitals and systems who are performing well in the delivery of the DTN 1 hour standard for Neutropenic Sepsis (for example Ipswich)</td>
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</table>
### REPORTING/GOVERNANCE:
- Review the reporting measures across the 3 Trusts for reporting of neutropenic sepsis and DTN times into the reporting of general sepsis to relevant trust clinical quality committees/boards.
- Neutropenic Sepsis DTN times to be reported to STP Cancer Board on a 6 monthly basis

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<th>Actions</th>
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<tr>
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<tr>
<td>PROTOCOLS:</td>
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<tr>
<td>Review protocols for in and out of hours management of neutropenic sepsis.</td>
<td>Consultant Oncologist, Cancer Nurse Lead</td>
<td>3 - 6 months (May - Aug 2018)</td>
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<td>Review approach to immune therapies with the aim of establishing a consistent approach across the STP</td>
<td>Consultant Microbiologist</td>
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<td>Ensure appropriate patient information available for high risk patients (such as alert cards and consideration of valid prescription for first dose IV antibiotics within treating trust (in line with microbiology advice/trust policy).</td>
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</tbody>
</table>

### TRAINING
- Identify key cohorts of staff who require training on the management of patients with neutropenic Sepsis including importance of 1 hour DTN time
- Develop and implement a consistent approach to training across MEHT, BTUH and SUHFT
- Each Trust A&E to identify and agree a key link into CNS for acute oncology

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<tr>
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<tr>
<td>PROTOCOLS:</td>
<td></td>
<td></td>
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<tr>
<td>Review protocols for in and out of hours management of neutropenic sepsis.</td>
<td>Consultant Oncologist, Cancer Nurse Lead</td>
<td>3 - 6 months (May - Aug 2018)</td>
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<tr>
<td>Review approach to immune therapies with the aim of establishing a consistent approach across the STP</td>
<td>Consultant Microbiologist</td>
<td></td>
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<tr>
<td>Ensure appropriate patient information available for high risk patients (such as alert cards and consideration of valid prescription for first dose IV antibiotics within treating trust (in line with microbiology advice/trust policy).</td>
<td></td>
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</table>

### INFRASTRUCTURE:
- msb Cancer Programme Director
- Trust Directors of Nursing
- Trust Lead Cancer Nurses,

<table>
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<td>Short term Actions</td>
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<tr>
<td>PROTOCOLS:</td>
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</table>
• Review Acute Oncology infrastructure across the trusts and develop a business case if necessary to ensure cover 24/7, 7/7

7 PROTOCOLS:
• All trusts to consider/review use of PGDs

<table>
<thead>
<tr>
<th>7</th>
<th>PROTOCOLS:</th>
<th>Trust Lead Cancer Nurses, Trust Directors of Nursing</th>
<th>9 months (Nov 2018)</th>
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<tbody>
<tr>
<td>8</td>
<td>PATIENT INFORMATION:</td>
<td>Patients Trust Lead Cancer Nurses/ Cancer Clinical Lead</td>
<td>9 months (May 2018)</td>
</tr>
<tr>
<td></td>
<td>• Review STP approach to neutropenic sepsis alert cards to ensure consistency.</td>
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</table>
Report to: Part I STP Joint Committee  Meeting Date: 6 April 2018

<table>
<thead>
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<th>8</th>
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<tbody>
<tr>
<td>Report Title</td>
<td>2018/19 Contract Baseline Refresh</td>
</tr>
<tr>
<td>Submitted by</td>
<td>Karen Wesson, Director of Commissioning and Performance, Joint Commissioning Team</td>
</tr>
<tr>
<td>Written by</td>
<td>Janette Joshi, Director of Contracting Essex Pod, North East London Commissioning Support Unit (NELCSU)</td>
</tr>
<tr>
<td>Purpose</td>
<td>To note the progress on the 2018/19 contract baselines</td>
</tr>
<tr>
<td>Approval Route</td>
<td>N/A</td>
</tr>
<tr>
<td>Recommendation</td>
<td>For noting</td>
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</table>
1. Introduction

1.1. This report captures the current status of the 2018/19 contract baseline negotiations of the provider contracts that are the formal responsibility of the Joint Committee.

1.2. The task for commissioners and providers was to update the 2018/19 year of existing two-year plans to take account of the national planning guidance ‘Refreshing NHS Plans for 2018/19’.

1.3. Where the 2018/19 plans have changed, and these changes needed to be reflected in the finance, activity or other schedules for the second year of two-year contracts, a contract variation should be agreed to this effect, and signed by 23 March 2017.

1.4. For non-hosted contracts, where the STP CCGs are an associate to a contract held by a CCG outside of the STP area, it is common for such providers to agree their baselines with their local commissioners first, and then cascade agreements reached through the financial baseline offers to the associate Commissioners. Therefore there is generally a small delay in securing either the baseline proposal, or agreement to the baseline proposal for these providers.

1.5. It should therefore be recognised that this report captures the current position, with a number of baselines subject to change as the final contract values are agreed, through on-going negotiation with providers.

1.6. The Mid & South Essex Shared Contact management and Finance Service will support the Joint Committee of the CCGs to manage the providers in accordance with their contracted terms; ensuring payments made in respect of services delivered are valid and accurate.

2. 2018/19 Contract baseline negotiation status

Local NHS providers

2.1. Following extensive negotiations between the Commissioners, led by the Joint Commissioning Team and the Providers, led by the MSB group, the following contractual arrangement has been agreed for the contract year 2018/19.

2.2. The parties have agreed that payment under the MSB contracts shall be through a Cost and Volume (PbR) basis.

2.3. The Commissioning for Quality and Innovation (CQUIN) payments will apply in line with national guidance, where they are a two year CQUIN. NHS England are still to publish 2018/19 CQUIN Guidance. Under a PbR contract, CQUIN awards will need to be earned in line with guidance.

2.4. In 2018/19, the contractual performance sanctions, as set out in the NHS Standard Contract will apply. Providers who accept their control totals, and so have access to the Sustainability Transformation Fund (STF) for 2018/19 will continue to be exempt from the application of an
agreed range of contractual sanctions, as outlined in paragraph 2.8 of the ‘Refreshing Plans for 2018/19’ guidance.

2.5. Local prices in 2018-19 will be uplifted by the 0.1% tariff inflator.

2.6. The parties agree to work together to deliver agreed improvement trajectories against the national standards for Cancer, A&E, Diagnostics, RTT 52 week waits and Ambulance handover. In line with the Regulator Planning Guidance:

- The RTT waiting list, measured as the number of patients on an incomplete pathway, will be sustained at March 2019 and no more than the reported 31 March 2018 position.
- Numbers by MSB site, of patients waiting more than 52 weeks for treatment at 31 March 2018 should be halved by March 2019.

2.7. The Commissioners and the Trust believe that the National Tariff will change in the next year or two to reflect the appropriate tariff for Ambulatory Care. Whilst the Commissioners agree with the Trust proposal for payment of Ambulatory Care activity in 2018/19 to be on a cost and volume basis; the Commissioners cannot agree to move to the current National Tariff for Ambulatory Care in 2019/20. The Trust and Commissioners have agreed a discount to be applied to this 2018/19 tariff.

2.8. The parties recognise the many challenges to the system, and the need to deliver a substantial Quality Innovation Prevention Productivity (QIPP) programme. The parties will work together to deliver agreed QIPP schemes, and will look at ways of strengthening joint working. For all QIPP schemes, the parties will agree actions and milestones, KPIs and metrics, and activity and financial assumptions, to enable delivery, with appropriate clinical sign off.

3. Other providers

3.1 For non-hosted contracts, where the STP CCGs are an associate to a contract held by a CCG outside of the STP area, it is common for such providers to agree their baselines with their local commissioners first, and then cascade agreements reached through the financial baseline offers to the associate Commissioners. Therefore there is generally a small delay in securing either the baseline proposal, or agreement to the baseline proposal for these providers.

3.2 This is reflected in the Summary table included in Appendix 1, whereby the values shared green have CCG have been agreed, the values shaded orange have been received, and are still being negotiated, and the values shaded red are where proposals have still yet to be made by Providers.

3.3 Cells in white reflect where no proposal is expected, as the provider is being managed on a non-contract basis, and activity is invoiced separately, due to small volumes (generally under £100k).

3.4 It is expected that the negotiation of these contracts will progress rapidly over the next week, and that good progression will be made on the outstanding values, drawing the negotiations to conclusion.

4. Recommendation

The Committee is asked to note the progression of the negotiation of contract baselines, as set out in Appendix 1.
## Appendix 1

### All CCG Summary of 2018/19 Contract Baselines

<table>
<thead>
<tr>
<th>Provider Offer 18/19</th>
<th>BB CCG</th>
<th>CPR CCG</th>
<th>Mid Essex CCG</th>
<th>Southend CCG</th>
<th>Thurrock CCG</th>
<th>ALL CCGs</th>
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</thead>
<tbody>
<tr>
<td><strong>2018-19 CONTRACT OVERVIEW</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Southend University Hospital Trust (Affordable Plan)</td>
<td>8,819,934</td>
<td>102,643</td>
<td>1,393,959</td>
<td>108,038</td>
<td>4,579</td>
<td>225,473</td>
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<td>Basildon Thurrock University Hospital Trust</td>
<td>122,093</td>
<td>9,846</td>
<td>3,814</td>
<td>3,677</td>
<td>84,995</td>
<td>224,425</td>
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<tr>
<td>Mid Essex NHS Trust (excl HC Drugs)</td>
<td>17,226</td>
<td>3,987</td>
<td>179,608</td>
<td>3,146</td>
<td>2,361</td>
<td>206,328</td>
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<tr>
<td>Total Local Acute Trusts</td>
<td>148,139</td>
<td>116,476</td>
<td>184,816</td>
<td>114,860</td>
<td>91,935</td>
<td>656,226</td>
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<tr>
<td>Barking, Havering And Redbridge University Hospitals NHS Trust</td>
<td>21,664</td>
<td>846</td>
<td>1,395</td>
<td>475</td>
<td>4,225</td>
<td>28,608</td>
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<td>Barts Health NHS Trust</td>
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<td>1,832</td>
<td>4,217</td>
<td>1,766</td>
<td>2,903</td>
<td>19,096</td>
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<td>Cambridge University Hospitals NHS Trust</td>
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<td>2,657</td>
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<td>3,006</td>
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<td>Chelsea and Westminster Hospital NHS Foundation Trust</td>
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<td>12</td>
<td>134</td>
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<td>423</td>
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<td>Colchester Hospital University NHS Foundation Trust</td>
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<td>21,497</td>
<td>71</td>
<td>96</td>
<td>22,136</td>
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<td>Dartford &amp; Gravesend NHS Trust</td>
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<td>-</td>
<td>-</td>
<td>-</td>
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<td>Great Ormond Street Hospital for Children NHS Foundation Trust</td>
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<td>505</td>
<td>1,395</td>
<td>475</td>
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<td>Guy’s And St Thomas NHS Foundation Trust</td>
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<td>976</td>
<td>715</td>
<td>941</td>
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<td>306</td>
<td>-</td>
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<td>228</td>
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<td>Moorfields Eye Hospital NHS Foundation Trust</td>
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<td>North West London Hospitals NHS Trust</td>
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<td>92</td>
<td>204</td>
<td>71</td>
<td>87</td>
<td>704</td>
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<td>Papworth Hospital</td>
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<td>-</td>
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<td>368</td>
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<td>Princess Alexandra Hospitals NHS Trust</td>
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<td>-</td>
<td>927</td>
<td>-</td>
<td>-</td>
<td>1,246</td>
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<tr>
<td>Royal Brompton &amp; Harefield NHS Foundation Trust</td>
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<td>138</td>
<td>177</td>
<td>94</td>
<td>184</td>
<td>774</td>
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<td>Royal Free London (including Barnet &amp; Chase Farm)</td>
<td>589</td>
<td>288</td>
<td>684</td>
<td>191</td>
<td>371</td>
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<tr>
<td>Royal National Orthopaedic Hospital NHS Foundation Trust</td>
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<td>799</td>
<td>945</td>
<td>747</td>
<td>694</td>
<td>4,285</td>
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<td>St George’s Healthcare NHS Trust</td>
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<td>85</td>
<td>-</td>
<td>74</td>
<td>95</td>
<td>398</td>
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<td>The Royal Marsden NHS Foundation Trust</td>
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<td>102</td>
<td>53</td>
<td>53</td>
<td>397</td>
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<td>University College London NHS Foundation Trust</td>
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<td>2,058</td>
<td>909</td>
<td>1,075</td>
<td>7,236</td>
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<td>West Suffolk Hospitals NHS Trust</td>
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<td>522</td>
<td>-</td>
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<td>Total Out of Area Acute Trusts</td>
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<td>39,948</td>
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<td>14,927</td>
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<td>BMI</td>
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<td>918</td>
<td>-</td>
<td>608</td>
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<td>Nuffield</td>
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<td>Ramsay Springfield</td>
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<td>12,737</td>
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<td>455</td>
<td>15,887</td>
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<tr>
<td>Ramsay Oakes</td>
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<td>-</td>
<td>881</td>
<td>-</td>
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<tr>
<td>Spire Hartswood</td>
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<td>533</td>
<td>-</td>
<td>492</td>
<td>354</td>
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<td>Spire Wellesley</td>
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<td>4,978</td>
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<td>Thames Ambulance</td>
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<td>-</td>
<td>-</td>
<td>847</td>
<td>2,212</td>
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<tr>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>2,404</td>
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<td>Total Ambulance/PTS Providers</td>
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<td>7,419</td>
<td>17,192</td>
<td>9,121</td>
<td>6,883</td>
<td>52,462</td>
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<td>Total Providers</td>
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<td>255,598</td>
<td>136,704</td>
<td>115,158</td>
<td>845,351</td>
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### Report to: Part I STP Joint Committee  
**Meeting Date: 6 April 2018**

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<tbody>
<tr>
<td><strong>Report Title</strong></td>
<td>Commissioning Support Services Lead Provider Framework Update</td>
</tr>
<tr>
<td><strong>Submitted by</strong></td>
<td>Louis Kamfer, Chief Finance Officer</td>
</tr>
<tr>
<td><strong>Written by</strong></td>
<td>Emma Timpson, Associate Director PMO</td>
</tr>
</tbody>
</table>

**Purpose**: To provide an update on the outcome and mobilisation of the Lead Provider Framework procurement, following the approval of award to Bidder 1 at the last Joint Committee meeting in March 2018.

**Approval Route**: The update has been discussed and agreed at the Commissioning Support Services Mobilisation Steering Group on 27th March 2018.

**Recommendation**: The Committee is asked to note this report.
LEAD PROVIDER FRAMEWORK UPDATE

Submitted by: Louis Kamfer, Chief Finance Officer, Joint Commissioning Team

Status: To note

1. Introduction

This paper provides an update on the outcome and mobilisation of the Lead Provider Framework (LPF) Procurement, following the approval of award to Bidder 1 at the last Joint Committee meeting in March 2018.

2. Update Report

Bidder announcement

Following the end of the statutory 10 day standstill period on 15th March 2018, Bidder 1 can now be confirmed as Arden & GEM CSU.

Staff that will be directly affected, Business Intelligence (BI) in Mid Essex CCG and Basildon & Brentwood CCG and NELCSU BI, HR and Financial services, were informed on 16th March 2018. An organisational communication then followed to inform all staff of the outcome of the procurement. External communications were aligned with Arden & GEM CSU and were issued on 19th March 2018. There has been one press enquiry from Thurrock Gazette relating to the impact of the change to Thurrock residents.

Governance

A formal project structure has been established and in operation since 6th February 2018. The Mobilisation Steering Group chaired by Louis Kamfer, CFO for Joint Commissioning Team reports to CFOs and AOs, and thence through to CCG Governing Bodies and the Joint Committee. The agreed Terms of Reference, membership and governance chart is attached at Appendix 1. The objectives of the Mobilisation Steering Group are:

- Establish shadow management arrangements for NELCSU Contract Management and Contract Finance services from 1st April 2018 and then complete the TUPE of staff to Mid Essex CCG by 1st July 2018.
- Ensure a smooth transition of BI services from existing providers (NELCSU, BB CCG & Mid Essex CCG) to Arden & GEM CSU to be completed by 1st July 2018.
- Ensure smooth transition of HR & Financial Services from NELCSU to Arden & GEM CSU to be completed from 1st July 2018.
- Ensure that business critical functions are delivered effectively during the transition period (1st April to 1st July 2018)
- Achieve Value for Money by delivering a financial saving on support costs against 2017/18 spend, collectively across the five CCGs

The membership of the Steering Group has since contract award been extended to include Arden & GEM CSU. There are two supporting transition working groups that feed into the Mobilisation Steering Group; one focusing on the Contract Management & Contract Finance transition; the other on BI services.

Business critical functions have been agreed by the Mobilisation Steering Group and are detailed within the Terms of Reference.
The Mobilisation Steering Group and both the Transition Groups maintain a risk register and these will feed into the overall CCG risk management processes as appropriate. Key risks are discussed below.

The project is formally supported by the Joint Commissioning Team Programme Management Office (PMO).

**Mobilisation Plan**

The new BI service for the five CCGs and provision of the HR and Financial Services for the South Essex CCGs will commence on 1\(^{st}\) July 2018. A detailed mobilisation plan is currently being developed by Arden & GEM CSU. An overview of the agreed mobilisation approach is set out below.

The key milestones of the project are:

<table>
<thead>
<tr>
<th>Description</th>
<th>Completed by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memorandum of Understanding signed with NELCSU</td>
<td>23/03/18</td>
</tr>
<tr>
<td>Shadow arrangements commence for NELCSU Contract Management &amp; Contract Finance staff</td>
<td>01/04/18</td>
</tr>
<tr>
<td>Draft Mobilisation Plan</td>
<td>13/04/18</td>
</tr>
<tr>
<td>TUPE staff consultation commences</td>
<td>09/04/18</td>
</tr>
<tr>
<td>Consultation ends includes formal appeals process</td>
<td>01/06/18</td>
</tr>
<tr>
<td>Arden &amp; GEM Services Lines Commence Engagement with Staff</td>
<td>22/04/18</td>
</tr>
<tr>
<td>Arden &amp; GEM commence discovery of existing services</td>
<td>22/04/18</td>
</tr>
<tr>
<td>Commence Statements of Work (SoW), which document understanding of required services</td>
<td>30/04/18</td>
</tr>
<tr>
<td>Finalise and agreed SoWs with CCG</td>
<td>18/06/18</td>
</tr>
<tr>
<td>Contract for BI and DSCRO*, HR &amp; Financial services signed with Arden &amp; GEM CSU</td>
<td>25/06/18</td>
</tr>
</tbody>
</table>

* Data services for Commissioners Regional Offices

Dates will be finalised and baselined following agreement of a Mobilisation Plan. The plan itself will be included in an electronic mobilisation pack which also includes a risk register that will be shared with the Mobilisation Steering Group.

Arden & GEM are actively seeking to appoint a Chief Operating Officer to lead the services in the region. Arden & GEM are aiming to have the individual in post from mid-May 2018. The team that will be supporting the mobilisation is set out in Appendix 2.
The particular area of complexity is mobilisation of the BI solution. It is currently Arden & GEM CSU intention to replace the NELCSU service offer with their BI solution. The existing Basildon & Brentwood CCG and Mid Essex CCG BI solutions would transfer across, as is, enabling dual running, reducing risk and supporting validation prior to the move towards one amalgamated BI system.

Arden & GEM have begun informal meetings with the BI teams to understand and begin to map the current processes and procedures.

**TUPE**

The number of staff currently identified that would be affected by the LPF Procurement are:
- 3 BI staff (2.5 WTE) in Mid Essex CCG
- 1 BI staff (1 WTE) in Basildon & Brentwood CCG
- 7 BI staff (7 WTE), 7 Financial Services staff (7 WTE) and 3 HR staff (2.4 WTE) in NELCSU

There are a number of TUPE processes that will be undertaken and timetables will be aligned wherever possible:
- BI staff from Basildon & Brentwood CCG and Mid Essex CCG to Arden & GEM CSU
- BI, HR and Financial Services staff from NELCSU to Arden & GEM CSU
- Contract Management and Contract Finance staff from NELCSU to Mid Essex CCG, as part of Joint Commissioning Team
- Corporate ICT from NELCSU to Arden & GEM CSU (this may run slightly behind the timetable above).

A clear timetable of HR actions has been developed and agreed.

‘Measures’ have been provided by Mid Essex CCG to NELCSU in respect of Contracting & Contract Finance staff transferring from NELCSU to Mid Essex and ‘measures’ will be sought from Arden & GEM CSU in respect of staff transferring from Mid Essex CCG to Arden & GEM CSU.

Workforce lists are being finalised in respect of staff transferring to and from the CCG’s / NELCSU / Arden & GEM CSU which includes one challenge to NELCSU in respect of the inclusion of a post which is not recognised collectively by the South Essex CCG’s as being aligned to support the business area which is transferring to Mid Essex CCG. It is unclear at this stage if the South Essex CCG’s (and therefore JCT) will have any stranded costs from any potential redundancy resulting from this TUPE challenge.

At this stage we do not believe that there will be any compulsory redundancies of staff transferring from the CCG’s to Arden & GEM CSU.

**Contract Management & Contract Finance support**

A Memorandum of Understanding has been signed with NELCSU, see Appendix 3. It confirms the shadow arrangements for their staff to report to and be under the direction of Louis Kamfer from 1st April 2018. An interim structure has been shared with staff and feedback is currently being collated.

A service specification that outlines the service the Contract Management and Contract Finance team will deliver on behalf of the CCGs and Joint Committee Team is currently being drafted. There are a number of interdependences with the BI system and processes that need to be agreed with Arden & GEM CSU. The service specification will be circulated to commissioners and

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1 ‘Measures’ are any actions, steps or arrangements which the incoming or outgoing employers may take or put in place in connection with the transfer. Measures could include a location change, pay date change or alteration to ‘ways of doing things’.

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signed off by the CFOs of their respective organisations. The service specification will incorporate KPIs that will enable the success of the in-house team to be measured.

**Risks**
The key risks summarised at Table 1 have been derived from risks rated High and with an Open status across the Steering and Working Group risk registers at the 26th March 2018.

All risks so far have been managed within the project and none have needed to be escalated to Joint Committee or individual CCG corporate risk registers or Board Assurance Frameworks.

Table 1: Summary of high, open risks at 26 March 2018

<table>
<thead>
<tr>
<th>Description</th>
<th>L</th>
<th>I</th>
<th>LxI</th>
<th>Mitigation</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a risk that insufficient time has been allowed for mobilisation,</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>1. BI transition group to undertake pre-mobilisation work to assist incoming LPF provider.</td>
<td>BI</td>
</tr>
<tr>
<td>with 3.5 months being very tight, resulting in not all business critical</td>
<td></td>
<td></td>
<td></td>
<td>2. Business critical functions to be signed off by Steering Group.</td>
<td></td>
</tr>
<tr>
<td>functions being delivered in July 18.</td>
<td></td>
<td></td>
<td></td>
<td>3. Mitigating actions to be agreed with successful LPF bidder.</td>
<td></td>
</tr>
</tbody>
</table>

3. **Recommendation**

The Committee is asked to note this report.

4. **Appendices and Supporting Documentation**

   - **Appendix 1** Commissioning Support Services Mobilisation Steering Group Terms of Reference
   - **Appendix 2** Arden & GEM organisation structure
   - **Appendix 3** Memorandum of Understanding between NELCSU and CCGs for shadow arrangements
Commissioning Support Services Mobilisation Steering Group Terms of Reference

Commissioning Support Services (CSS) Mobilisation Steering Group Terms of Reference

Purpose

The purpose of CSS Mobilisation Steering Group is to oversee the transition of:

- Contract Management and Contract Finance services from NELCSU to the Joint Committee
- BI services from NELCSU, Basildon & Brentwood CCG and Mid Essex CCG to the successful LPF bidder
- HR and Financial Services from NELCSU to successful LPF Provider

It will oversee:

- Establishment of a SLA/Memorandum of Understanding between JC and CCGs for delivery of Contract Management and Contract Finance Services

Context

From 1 April 2018, the provision of CCG support services (BI, contract management and contract finance) will be managed under the Joint Committee structure. A business case to in-house contract management and contract finance across the 5 CCGs was approved by NHSE. BI services are being procured via the Lead Procurement Framework, with service commencement from 1st July 2018.

There has been agreement with NELCSU, supported by NHSE, to establish shadow management arrangements from 1 April 18, ahead of the TUPE transfer of staff on 30th June 2018.

Developing a unified approach across the STP footprint will support the delivery of best value for money, reduce impact of stranded costs and improve quality and efficiencies that will support the significant transformation agenda.

The mobilisation of the GP IT and Corporate IT contract is outside the scope of this project.

Objectives

- Establish shadow management arrangements for NELCSU Contract Management and Contract Finance services from 1st April 2018 and then TUPE of staff by 1st July 2018.
- Ensure a smooth transition of BI services from existing providers (NELCSU, BB CCG & Mid Essex CCG) to successful LPF provider from 1st July 2018.
- Ensure smooth transition of HR & Financial Services from NELCSU to successful LPF provider from 1st July 2018.
- Ensure that business critical functions are delivered effectively during the transition period (1st April to 1st July 2018)
- Achieve Value for Money by delivering a financial saving on support costs against 17/18 spend, collectively across the five CCGs

Timescales

The project plan is subject to review and based upon dependencies listed below.

The plan will need to align with the mobilisation plan of the successful LPF bidder.
Accountability

The CSS Mobilisation Steering Group is accountable to the Chief Finance Officers. It is accountable for:

- Creation of a single business support team
- Implementation of the LPF Procurement outcome
- Delivery of the financial savings
- Escalation of key issues and risks to CFOs and Accountable Officers.

- **Joint Committee**
- **CCG Boards**
- **CSS Mobilisation Steering Group**
- **AOs**
- **CFOs**

**Contract Management & Contract Finance Transition Group**
- NELCSU
- CCGs

**BI Transition Group**
- NELCSU
- CCGs
- LPF Provider

**LPF Mobilisation Arrangements**
- BI
- HR
- Financial Services

*Arrangements will merge if internal work has progressed significantly*
Delegation

The CSS Mobilisation Steering Group will delegate tasks to the following working groups:

- **Contract Management and Contract Finance Transition Group.**
  - Development and implementation of shadow management arrangements for NELCSU staff from 1st April 2018.
  - Delivery of business critical functions during transition period.
  - Establish required IT/IM&T (e.g. transition server) to allow effective transition including implementing Information Sharing Agreement, if required.
  - Development and implementation of SLA between JC and CCGs for delivery of contract management and contract finance function.

- **BI Transition Group.**
  - Development of transition packs for BB CCG and Mid Essex CCG BI processes for LPF Provider.
  - Overseeing the development of the transition packs for NELCSU BI processes for LPF Provider.
  - Establish required IT/IM&T (e.g. transition server) to allow effective transition including implementing Information Sharing Agreement, if required.
  - Delivery of business critical functions during transition period.

- **LPF Mobilisation Arrangements**
  - Align with LPF Provider mobilisation plan – separate structure may not be required as work can be amalgamated into existing transition groups and steering group.
  - Oversee the TUPE of staff from NELCSU, BB CCG and Mid CCG to LPF Provider.
  - Oversee the transition of HR and Financial Services from NELCSU to LPF Provider.
  - Track operational transition progress against plan.

Dependencies

The project is dependent upon the award of the BI, Financial Services and HR contract to the LPF provider and their proposed mobilisation plan.

There are multiple interdependencies between the services and across providers. An overview is shown below.

Membership

- Louis Kamfer, CFO Basildon & Brentwood CCG
Dee Davey, Chief Finance Officer, Mid Essex CCG
Emma Timpson, Associate Director PMO, Basildon & Brentwood CCG
Matthew MacDonald, Programme Director, NELCSU
Sadie Nichols, Business Manager, NELCSU
Janette Joshi, Director of Contracting (Essex POD), NELCSU
Emily Hughes, Associate Director of Commissioning, Castle Point & Rochford CCG & Southend CCG
Julie Burton, Head of Human Resources, Mid Essex CCG
Prakash Chauhan, Interim Deputy Director of Finance, Basildon & Brentwood CCG
Rachel Harkes, Head of Communications & Engagement, Mid Essex CCG
Andrew Imrie, Director Bids & Business Development, Arden & GEM CSU
Helen Seth, Director for BI & Provider Management, Arden & GEM CSU
Paul Birch, Associate Director of Analytics and New Models of Care, Arden & GEM CSU
Jason Bloomfield, Associate Director of Finance, Arden & GEM CSU
Cath Bick, Head of Corporate HR, Arden & GEM CSU.

Quorum

The Group will be considered quorate when at least two CCGs and NELCSU representatives are present at the meeting.

Meeting frequency

The CSS Mobilisation Steering Group should meet formally on a fortnightly basis.

Minutes of meetings

An action log will record the decisions and actions taken at the meeting. This will be made available electronically to all members and presented and agreed at the next available meeting.

JC PMO function will provide administrative support to the Group in terms of agenda and, action log.
Business critical functions

**BI**
- Production of monthly contract reconciliations in line with SUS timetable and agreed contractual requirements
- Submission of automated and manual challenges in line with SUS timetable and agreed contractual requirements
- Statutory reporting (Unify submissions) in accordance with national timetable
- Availability of DSCRO service to support providers upload of data in accordance with agreed contractual timetable
- No interruption to existing DSCRO data flows
- Production of Key BI monthly reporting outputs (to be determined by Commissioners)
- Availability to support urgent ad-hoc requests & deep dives, as required
- High Level Variance Reports for Acute Associate Contracts
- Detailed Variance Report (Activity & Finance) for Hosted Major Acute Contracts
- Detailed Variance Report (Activity & Finance) for Hosted Independent Sector Contracts
- Attendance and input at appropriate Contract meetings for Key Contracts (ie CTG, APRG)
- Continued read and write access to the current performance information data tables within a SQL server database warehouse through both Microsoft SQL Server Management Studio and SQL Server Integrated Services.

**Contract Finance NELCSU**

<table>
<thead>
<tr>
<th>TASK</th>
<th>OUTPUT/FORM</th>
<th>DEADLINE</th>
<th>OWNER</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Level Variance Reports &amp; Forecasts for Acute Associate Contracts</td>
<td>Excel Report</td>
<td>WD 3</td>
<td>ST</td>
</tr>
<tr>
<td>Detailed Variance Report &amp; Forecast (Activity &amp; Finance) for Hosted Independent Sector Contracts (Spire &amp; BMI)</td>
<td>Excel Report</td>
<td>WD 3</td>
<td>TR/AS</td>
</tr>
<tr>
<td>Monthly CCG Finance &amp; Activity Report Packs (Full Portfolio)</td>
<td>Powerpoint Report</td>
<td>WD 10</td>
<td>ST</td>
</tr>
<tr>
<td>Contract Reconciliation Meetings &amp; Reports - Hosted Contracts</td>
<td>Excel Report</td>
<td>WD ? (As per SUS timetable and local meeting schedule)</td>
<td>TB/AS</td>
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<tr>
<td>Invoice Validation &amp; Approval – All Contracts</td>
<td>SBS Invoice Approval</td>
<td>Weekly</td>
<td>All CF staff</td>
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</table>
## Contract Finance BBCCG & Mid Essex CCG

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<tbody>
<tr>
<td>Maintain a contract database</td>
<td>Database</td>
<td>Ongoing</td>
<td>All CM staff</td>
</tr>
<tr>
<td>Draft new contracts/local variations for existing contract portfolio</td>
<td>Contract Particulars/Contract Variations</td>
<td>23rd March/Ongoing</td>
<td>All CM staff</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Draft entirely new contracts (new provider/service to portfolio) ad-hoc as requested.</td>
<td>Contract Particulars</td>
<td>Ongoing (ad-hoc)</td>
<td>All CM Staff</td>
</tr>
<tr>
<td>Provider performance management meetings (Service Performance Reviews/CMMs, Technical Sub Groups, and attendance only at CQRGs). Key Hosted Contracts: SUHFT, EPUT MH, EPUT COMM, NELFT, SPIRE, BMI, BTUH, MEHT, Ramsay CHUFT</td>
<td>Co-ordination, preparation &amp; administration (Agenda &amp; Papers)</td>
<td>Monthly</td>
<td>All CM staff</td>
</tr>
<tr>
<td>Monitor and manage provider performance to contract terms. Recommend enactment of contract mechanisms, drafting necessary materials (e.g. Notices), and managing communication with the provider – All Hosted Contracts</td>
<td>Contract Notices &amp; Formal Correspondence</td>
<td>Monthly/As required</td>
<td>All CM staff</td>
</tr>
<tr>
<td>Prepare Contract Briefing Reports – Key Hosted Contracts (EPUT), Finance &amp; Performance (F&amp;P) and Audit Committee.</td>
<td>Word Report / Powerpoint</td>
<td>WD 12</td>
<td>AW</td>
</tr>
<tr>
<td>Procurement process support, current examples IUC (Integrated urgent Care), PTS, IRN (Integrated Residential &amp; Nursing) and Equipment Service.</td>
<td>Process, Implementation, Meeting and contract document support</td>
<td>Varied</td>
<td>All CM Staff</td>
</tr>
</tbody>
</table>

### NHSE Operational Planning Support

<table>
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<tr>
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<th>OWNER</th>
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</thead>
<tbody>
<tr>
<td>Completion of Templates for Activity Plan &amp; Contract Finance Plan</td>
<td>Excel Template</td>
<td>As per notified timetable/As Required</td>
<td>MD</td>
</tr>
</tbody>
</table>

### Business Important functions

<table>
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<th>DEADLINE</th>
<th>OWNER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detailed written narrative to collaborative commissioners for hosted contracts</td>
<td>Word/Powerpoint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support contract negotiations</td>
<td>Attendance at meetings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support to audit programme</td>
<td>Excel</td>
<td>As per agreed audit schedule</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2

Arden & GEM organisation structure

Arden & GEM Mobilisation Structure
Memorandum of Understanding

To describe the relationship between

North East London Commissioning Support Unit

and

Mid and South Essex CCGs

(Basildon & Brentwood CCG, Castle Point & Rochford CCG, Mid Essex CCG, Southend CCG and Thurrock CCG)
1. **Introduction**

Service Level Agreements (SLA) are in place between North East London Commissioning Support Unit (NELCSU) and Castle Point & Rochford CCG, Southend CCG and Thurrock CCG for the provision of support services that include Contract Management and Contract Finance services. These SLA’s have been extended until 30 June 2018.

Following the approval by NHS England, Contract Management and Contract Finance services will be in-housed on the 1 July 2018. The host of in-housed Contracting and Contract Finance services/staff will be Mid Essex CCG (as the host of the Joint Committee).

Provision of BI services will be out-sourced to a LPF provider – also effective from 1 July 2018. A procurement process is underway.

NELCSU have been working closely with the CCGs to support the production of the business case that was approved by NHSE and in ensuring that the transition of services and staff, in-housing and out-sourced, is a smooth as possible. It has been recognised by all parties that there is value in working in shadow form from 1 April 18 to the formal TUPE of staff on 30 June 18. This shadow period will allow staff to take steps towards working as an integrated team so that the formal transfer on 1 July is managed effectively and with a minimum level of anxiety and disruption.

This Memorandum of Understanding (MoU) describes the relationship between the Mid and South Essex CCGs and NELCSU, during the shadow arrangements period.

2. **Key Principles**

The parties agree to adopt the following Key Principles during the shadow arrangement period:

- Collaborate and co-operate
- Ensure that the staff group affected by the TUPE process is regularly engaged with and clear about the process they are subject to
- Be open. Communicate openly about concerns, issues or opportunities.
- Share information, experience, materials and skills to learn from each other and develop effective working practices
- Work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce costs
- Adopt a flexible approach during the transition process
- Comply with the requirements of the existing Data Sharing Agreement
- Act in good faith to support compliance with these Key Principles

3. **Responsibilities**

NELCSU would have the following responsibilities:

- Permit NELCSU staff to comply with instructions and operational policies in relation to provision of Contract Management and Contract Finance services
- Continued provision of service in accordance with agreed SLAs
• Provide the CCGs with access to relevant data sources, in line with Data Sharing Agreement
• Continue to provide formal line management and employer responsibilities for all CSU staff

The CCGs would have the following responsibilities:
• Engage with staff regarding the integration of structures
• Provide Contract Management and Contract Finance staff with clarity on its priorities
• Provide overall leadership to the shadow team in terms of priorities and key decisions

4. Operational Implementation on 1 April 2018
In the spirit of joint working and collaboration both parties recognise the need for agile and flexible working during the shadow period. In order to provide some level of certainty to staff however it is important to be clear on the following as of 1 April 2018:

• NELCSU Contract Management and Contract Finance staff will take their operational direction from the Joint Committee Team leadership in terms of prioritisation and escalation for key decisions
• Discussion and agreement of portfolio changes to be mutually undertaken with Joint Committee leads and senior NELCSU staff
• The day to day management of NELCSU Director of Contracting (Essex POD) will transfer to Louis Kamfer, whilst maintaining a formal management line to the NELCSU Interim POD Director
• Staff from Basildon and Mid-Essex CCG forming part of the integrated function will take management direction from senior NELCSU staff where indicated in the proposed shadow management arrangements (appendix 1)
• Any concerns expressed by staff should in the first instance be raised with their substantive employer and then resolved through open dialogue between the senior management leads in the Joint Committee and the employing organisation
• Annual leave requests, sickness reporting and flexible working arrangements will continue in line with the employing organisation’s policies and practices.

Should there be any significant concerns regarding the operation of the shadow arrangements during the period 1 April to 30 June these will be escalated to the lead contacts (see section 5) for resolution and an agreed way forward.

5. Lead Contacts in relation to the MoU
The key contracts in relation to this MoU are:

For the CCGs: Louis Kamfer, Chief Finance Office, Joint Committee Team, Mid and South Essex STP

For the CSU: Helen Hughes, Interim Director of Technical Services and Operations, NELCSU
6. **Staff management**
During the shadow arrangements (1 April to 30 June 18) NELCSU will continue to be the employer of the Contract Management and Contract Finance staff. There will be no change to staff contracts or to terms and conditions. Staff will continue to operate under the NELCSU HR policies and procedures.

Job roles and functions will not change. However, this does not preclude changes in portfolio’s, which happens as part of normal practice in responding to business need. The integration of the existing in-house teams with the NELCSU staff has inevitably identified areas of duplication and the proposal it to move towards an integrated structure during the shadow arrangements period. The proposed interim structure is detailed in Appendix 1.

Louis Kamfer as CFO across JC will lead and take responsibility for the team, providing direction during shadow arrangements.

6. **SLA monitoring**
The existing SLA’s will continue to operate with delivery in accordance with the detailed service specification. The Chief Finance Officers from Castle Point & Rochford CCG, Southend CCG and Thurrock CCG will delegate authority for monitoring of the SLA to Louis Kamfer from 1 April 2018.

There is an ongoing responsibility on all parties to support delivery in line with the specification. If this is not the case, this should be raised with the relevant service delivery lead. All reasonable endeavours at local level will be completed before escalation to the lead contract representatives Louis Kamfer and Helen Hughes.

7. **Authorised signatories**
The authorised signatories to this agreement are:

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Signature</th>
<th>Party</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louis Kamfer</td>
<td>Chief Finance Office</td>
<td></td>
<td>Joint Committee Team, Mid and South Essex STP</td>
<td>23/03/18</td>
</tr>
<tr>
<td>Helen Hughes</td>
<td>Interim Director of Technical Services and Operations</td>
<td></td>
<td>North East London CSU</td>
<td>23/3/18</td>
</tr>
</tbody>
</table>
Appendix 1  Shadow structure arrangements

The structure may be amended following feedback from staff.