LIST PROCEDURES WITH RESTRICTIONS OR THRESHOLDS

Policy Number:	CLIN 13 (b)
Version:	1
Ratified by:	Quality and Performance Committee
Name of originator/author:	Public Health Directorate
Name of responsible committee/individual:	Public Health Directorate
Date issued:	(Treatments Not Routinely Funded Policy April 2008) Low Priority Procedures Policy (LPP) came into effect on 1st January 2010. The latest list of procedures with restrictions or thresholds was implemented on 1st October 2012
NHSLA Standard (if applicable):	
Standards for Better Health (if applicable):	
Last review date:	October 2012
Next review date:	April 2013

EQUALITY IMPACT ASSESSMENT TOOL

An equality impact assessment was completed by Public Health in February 2010.

If you have identified a potential discriminatory impact of this procedural document, please contact Tina Gull Equality and Diversity Lead.

VERSION CONTROL SHEET

Version	Date	Author	Status	Comment
1	January 12	Michael Baker & Maureen Hatch	Draft	List of Low Priority Procedures Policy (CLIN 13) separated into two Sections. Section (b) contains treatments that have restrictions or a specific threshold that need to be met before treatment can commence. Minor alternations include: Removal of: Cryotherapy for localised prostate cancer & Salvage cryotherapy for recurrent prostate cancer
1	February 12		Final	Approval by Quality and Performance Committee.
1	October 12	Maureen Hatch, Andrea Golding & Michael Baker	Final	Classification of varicose veins revised and appendix c removed.

CONTENTS

Low Priority Procedures with Restrictions or Thresholds

NHS Surrey has considered evidence of clinical effectiveness and experience, information on current activity, resources, costs and provision across the South East Coast in order to formulate the following restrictions and thresholds. NHS Surrey has also undertaken a comparative analysis with policies adopted by NHS West Sussex and the South Central (Berkshire PCTs) Priorities Committee and acknowledge with thanks the permission given to utilise their policy statements.

Patients who fulfil the criteria do not need prior approval. However, these procedures will be subject to periodic audits to ensure adherence to the criteria**.**

If patients do not meet the criteria there is an established mechanism for dealing with individual funding requests (IFR)/exceptions. The application form for clinicians wishing to request funding for individuals that are eligible against the definitions of **a "rarity request"** or an **"exceptionality request"** as set out in the NHS Surrey Policy and Operating Procedures for dealing with Individual Funding Requests (IFRs). The IFR application is attached to this document as Appendix B.

OPCS codes

Please note that the OPCS codes are included for NHS Surrey's use only. They are included so they can be used as part of a series of data challenges and the inclusion or exclusion of specific codes does not directly relate to whether that particular procedure is excluded or restricted.

Procedure/Treatment	LPP Guidance Notes	OPCS Code(s)
1. Dental		
Impacted third molars	Surgical extraction of asymptomatic impacted third molars is not routinely funded by NHS Surrey except in the circumstances recommended by NICE as set out below. NICE (TA1) have issued the following guidance: "Surgical removal of impacted third molars should be limited to patients with evidence of pathology. Such pathology includes unrestorable caries, non-treatable pulpal and/or periapical pathology, cellulites, abscess and osteomyelitis, internal/external restoration of the tooth or adjacent teeth, fracture of tooth, disease of follicle including cyst/tumour, tooth/teeth impeding surgery or reconstructive jaw surgery and when a tooth is involved in or within the field of tumour resection".	F09
Dental extraction of non-impacted teeth	Extraction of non-impacted teeth will not be routinely funded **in secondary care.** However, NHS Surrey will consider funding for patients with the risk factors listed below, through the agreed mechanism. NHS Surrey has a process for triaging dental referrals into secondary care; Dento-alveolar referral triage service (DARS). - Those at high risk of endocarditis who require intravenous antibiotics. - Those undergoing a course of intravenous bisphosphonates. - Those who have suffered a myocardial infarct or undergone coronary revascularisation within 6 months of referral. - Those who are known to have brittle asthma. - Those who have a clear need for a general anaesthetic.	F101, F102, F103, F104, F108, F109, F121, F122, F128, F129

2. Dermatology

Removal of benign skin lesions	Where malignancy is suspected, the patient should be referred to an appropriate service. Clinically benign lesions should not be removed for cosmetic reasons and such procedures will not be funded by NHS Surrey. Benign skin lesions maybe considered for removal only in the following circumstances:- • Obstruction of an orifice or impingement of visual field • Recurrent infection • Recurrent bleeding not amenable to cryotherapy • Subject to recurrent trauma because of the site of the lesion • Significant pain • Limitation of function All clinicians must be prepared to justify to NHS Surrey the criteria applicable for the treatment of any benign skin lesions. Any treatment of skin lesions outside of the criterion will not be funded by NHS Surrey.	E094, S051, S052, S053, S054, S055, S058, S059, S061, S062, S063, S064, S065, S068 S069, S081, , S083, S091, S092, S093, S094, S095, S098, S099, S101, S102, S103, S104, S105, S108, S109, S111, S112, S113, S114, S115, S118, S119,Y088, H482, S028, S029, S031, S032, S033, S038, S039,
Viral warts procedures	Viral warts are usually of aesthetic significance only and surgical removal and / or laser treatment is not routinely funded by NHS Surrey. NHS Surrey will fund removal of viral warts in patients who are immunocompromised. There are no restrictions on treatment of genital or anal warts.	

3. Ear Nose and Throat

Adenoidectomy	Adenoidectomy for Otitis Media in children will not be routinely funded but, combined with grommets, will be considered in children who fulfil the criteria (see section on grommets).	E201, E208, E209
Bone anchored hearing aid - unilateral	This is funded in line with South Central Priorities Committee (April 2009), for Unilateral Bone Anchored Hearing Aid: "South Central Priorities Committee have considered the evidence for clinical and cost effectiveness of bone anchored hearing aids and consider that THERE IS SUFFICIENT EVIDENCE to justify their use in selected groups of patients with conductive or mixed deafness, in whom air conduction hearing aids are ineffective or inappropriate. This may include patients with bilateral or unilateral hearing loss and a variety of causes of conductive or mixed deafness (including chronic suppurative otitis media)."	D131, D132, D133, D134, D135, D136, D138, D139,
Bone anchored hearing aids - bilateral	There is insufficient evidence to justify the use of bilateral bone anchored hearing aids (i.e. one on each side).	As above
Cochlear implants	This intervention is funded under the criteria stated in NICE Technology Appraisal Guidance 166 (January 2009).	D241, D242
Grommets	Grommets for children should be undertaken in accordance with NICE Clinical Guidance 60 (Feb *2008) Surgical Management of Otitis Media with Effusion in Children (Under 12 years old).* This procedure is not routinely funded for **people over the age of 12** except under the following conditions: - A middle ear effusion causing measured conductive hearing loss and is resistant to medical treatments. The patient must be experiencing disability due to deafness.	D151

	OR - Persistent Eustachian tube dysfunction resulting in pain (e.g. whilst flying). OR - As one possible treatment for Meniere's disease. OR - Severe retraction of the tympanic membrane if the clinician feels this may be reversible and reversing it may help avoid erosion of the ossicular chain or the development of cholesteatoma. OR - Grommet insertion as part of a procedure for the diagnosis or management of head and neck cancer and/or its complications.	
<u>Pinnaplasty/Otoplasty</u>	This procedure is not routinely funded for adults on cosmetic grounds. NHS Surrey will consider funding for children when: - the child is aged between 5 and 16 years old; **and** - the surgeon has defined the deformity to the ear(s) as severe enough to require surgical correction; **and** - the child has clearly expressed concerns to the clinician which in their opinion or following a psychological assessment, it is considered that this is likely to be remedied through correction of the ear deformity. Details of the child's psychosocial concerns must be clearly described in the IFR application.	D033
<u>Rhinoplasty and Septorhinoplasty</u>	These procedures are not routinely funded. NHS Surrey will **only** fund these procedures for the following conditions: • Correction of nasal deformity causing nasal blockage. OR • Correction of nasal deformity arising from direct nasal trauma. OR • Correction of nasal deformity associated with named facial congenital disorders. These procedures should not be carried out for cosmetic reasons.	E023, E024, E025, E027, E031, E032, E034, E036, E037 E07

Tonsillectomy	This procedure is not routinely funded except in persons who meet the criteria in the SIGN 117 guidance published April 2010: • Sore throats that are due to acute tonsillitis AND • Episodes of sore throat that are disabling and prevent normal functioning AND • Seven or more well documented, clinically significant, adequately treated sore throats in the preceding year. OR • Five or more such episodes in each of the preceding two years. OR • Three or more such episodes in each of the preceding three years. Other indications of why tonsillectomy is required can also include peritonsillar abscess or pharyngeal obstruction/ obstructive sleep apnoea.	F341, F342, F343, F344, F345, F346, F347, F348, F349, F361, F368, F369
4. Gynaecology		
Dilation and curettage	NHS Surrey will fund dilation and curettage for diagnostic purposes for suspected malignancy and for evacuation of retained products of conception. The procedure will not be routinely funded for other reasons.	Q103, Q108, Q109
Female genital prolapse (surgical management of)	This procedure is not routinely funded for asymptomatic or mild pelvic organ prolapse. Referral for specialist assessment is indicated for: • Prolapse combined with urethral sphincter incompetence or faecal incontinence. • Moderate to severe symptoms. • Failure of pessary.	P221, P222, P223, P228, P229, P231, P232, P233, P234, P235, P236, P237, P238, P239

Female sterilisation	Sterilisation will not be available on non-medical grounds unless the woman has had at least 12 months' trial using Mirena or Implanon and found it unsuitable. NHS Surrey will fund this procedure : - Where sterilisation is to take place at the time of another procedure such as caesarean section. OR - Where there is a clinical contraindication to the use of a Mirena/Implanon. OR - Where there are severe side effects with the use of Mirena/Implanon. OR - Where there is an absolute clinical contraindication to pregnancy. These are:- - young women (under 45 years of age) undergoing endometrial ablation for heavy periods. - women with severe diabetes. - women with severe heart disease. AND Women should be informed that vasectomy carries a lower failure rate in terms of post-procedure pregnancies and that there is less risk related to the procedure.	Q271,Q272, Q278,Q279, Q351,Q352, Q353,Q358, Q359,Q361, Q368,Q369,
Hysterectomy for heavy menstrual bleeding	This procedure will only be funded in line with NICE guidance (CG44). NICE: Pharmaceutical treatment should be considered as first line intervention for women with no structural or histological abnormality suspected or fibroids less than 3cm in diameter. In women with heavy menstrual bleeding alone, with a uterus no bigger than a 10 week pregnancy, endometrial ablation should be considered preferable to hysterectomy. Hysterectomy should only be considered when: • other treatment options have failed, are contraindicated or are declined by the woman. • there is a wish for amenorrhoea. • the woman (who has been fully informed) requests it. • the woman no longer wishes to retain her uterus and fertility.	Q072, Q074, Q075, Q082,

5. Musculoskeletal

Arthroscopy of the knee	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) 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 OR • Meniscal surgery (repair or resection) OR • Ligament reconstruction/repair (including lateral relapse) OR • Synovectomy OR • Treatment of articular defects eg micro-fracture Knee arthroscopy should not be carried out for any of the following indications: • Investigation of knee pain • Treatment of osteoarthritis (except in line with NICE guideline (CG59)) It is anticipated that approximately 5% of knee arthroscopies may not lead to the anticipated therapeutic intervention, and therefore will be coded as diagnostic arthroscopies. Surgeons are asked to ensure that coding of the arthroscopy is undertaken after the procedure has taken place.	W871, W878, W879
Arthroscopy of the Hand/Wrist	It is anticipated that approximately 25% of hand/wrist arthroscopies will be necessarily diagnostic. Surgeons are asked to ensure that coding of the arthroscopy is undertaken after the procedure has taken place.	W888 +Z735, W888 +Z739, W888 +Z828, W888 +Z829, W888 +Z894, W889 +Z735,

		W889 +Z739, W889 +Z828, W889 +Z829, W889 +Z894,
Arthroscopy of the Elbow	It is anticipated that approximately 5% of elbow arthroscopies will be necessarily diagnostic. Surgeons are asked to ensure that coding of the arthroscopy is undertaken after the procedure has taken place.	W888 +Z815 W889 +Z815
Carpal tunnel syndrome (Surgical techniques for the treatment of)	NHS Surrey will only fund this intervention if: Acute, severe symptoms persist after conservative therapy with either local corticosteroid injection by a trained, competent practitioner, and/or nocturnal splinting. OR Mild to moderate symptoms persist for at least 4 months after conservative therapy with either local corticosteroid injection (if appropriate) and/or nocturnal splinting (used for at least 8 weeks). OR There is neurological deficit e.g. sensory blunting, muscle wasting or weakness of thenar abduction, or proven neurophysiological changes. OR Severe symptoms significantly interfere with daily activities. **Patients who are diabetic, and those who are aged 65 and over, should be referred urgently, without first attempting conservative therapies**.	W021, W022, W023, W024, W028, W029, A 651, A658
Balloon kyphoplasty for vertebral compression fractures	**NICE Interventional Procedure Guidance 166** supports the use of balloon kyphoplasty if the procedure is undertaken following discussion with a specialist multidisciplinary team that includes a radiologist and a spinal surgeon. The guidance also states that there should be good imaging facilities, arrangements for access to a spinal surgery service and that clinicians reach an appropriate level of expertise before carrying out the procedures. The PCT expects this service to be provided at centres that fulfil all the conditions stipulated by NICE.	V445

Discectomy for Lumbar Disc Prolapse (elective)	This procedure is not routinely funded unless: • The patient has had appropriate imaging e.g. MRI or CT showing disc herniation (protrusion, extrusion, or sequestered fragment) at a level and side corresponding to the clinical symptoms. • AND the patient has radicular pain (below the knee for lower lumbar herniations; into the anterior thigh for upper lumbar herniations) 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^{o} and 70^{o} or positive femoral tension sign). • AND symptoms persist despite some non-operative treatment for at least 6 weeks (e.g. analgesia, physiotherapy, bed rest etc), provided that analgesia is adequate and there is no imminent risk of neurological deficit.	
Dupuytren's contracture -Surgical Treatment/Interventional Procedures including Needle Fasciotomy	NHS Surrey will only fund surgical treatment/interventional procedures if: There is a metacarpophalangeal joint contracture of 30^{o} or more. OR any degree of proximal interphalangeal joint contracture. OR patients under 45 years of age with disease affecting 2 or more digits and loss of extension exceeding 10^{o} or more. If an exact measurement is not possible the clinical assessment should include an evaluation of the extent of disease and an estimate of severity/deformity.	T521, T522, T525, T526
Ganglions: Wrist and foot: surgical techniques for the treatment of	This procedure is not routinely funded unless there is evidence of nerve or blood vessel compression or evident functional impairment. This procedure will not be funded for cosmetic reasons.	T591, T592, T593, T594, T598, T599, T601, T602, T603, T604, T608, T609

Hallux valgus: Surgical treatment of	Hallux valgus is a common foot condition which can present with a very broad range of symptoms, from the purely cosmetic to major deformity, pain and disability. Some feet deteriorate over time. Surgery is simpler and more successful in the earlier stages but prophylactic or cosmetic surgery is not justified, even with the lower risks and higher success rates of modern techniques. Several types of operation are available, each appropriate to particular clinical circumstances. Surgery is offered if symptoms are severe or deteriorating and the risk-benefit ratio is judged favourable. During clinical consultation, the following principles influence whether or not to offer surgery and can be used to select those patients most suitable for referral to the specialist orthopaedic foot and ankle service;
	
	• No surgical procedure should be carried out for cosmetic reasons.
	• Surgery is more likely to be appropriate if any of the following is present and not responsive to non-surgical treatment;
	  ○ functional impairment
	  ○ daily bunion pain
	  ○ inability to wear suitable shoes
	  ○ any pain under the ball of the foot
	  ○ the second toe starting to lift or flex (clawing), whether the bunion itself is painful or not
	  ○ the deformity is deteriorating (eg shoes wearable last year no longer fit)
	• Before consulting a specialist for surgery, patients must accept that they will be unable to drive for 6 weeks (or 2 weeks after surgery on the left foot if driving an automatic car) and will be off work for 2 weeks for a sedentary job.
		W791, W151
		W152, W153
		W154, W155
		W156, W158
		W159, W161
		W591, W592, W593, W594, W595, W596, W598, W599

Spinal fusion for the treatment of lower back pain	This procedure will only be funded in line with NICE guideline (CG88). This treatment will be funded for patients who: • have completed an optimal package of care, but have failed all conservative treatment. • still have severe lower back pain for which they would consider surgery.	W281 – Pedicle Screw Fusion **As above**
Trigger finger: surgical techniques for the treatment of	This procedure is not routinely funded. NHS Surrey will fund this procedure when the following criteria are met:	T711,T723, T744

	• The patient has failed to respond to conservative treatment (including at least 2 corticosteroid injections). OR • The patient has a fixed flexion deformity that cannot be corrected. **Patients with diabetes should be referred without first attempting conservative management**	
Vertebroplasty (Percutaneous)	This procedure will only be funded in line with **NICE IPG 12**.	V444
Pain Management		
Epidural Injections for Sciatica	The PCT will fund lumbar transforaminal and caudal epidural injections for patients with radicular pain due to herniated disc (sciatica) when the following criteria have been met: • The patient has radicular pain (below the knee for lower lumbar herniations; into the anterior thigh for upper lumbar herniations) 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^{o} and 70^{o} or positive femoral tension sign). • Symptoms persist despite some non-operative treatment for at least 3 weeks (e.g. analgesia, physiotherapy). Further Epidural injections should only be provided as part of a comprehensive pain management programme.	
Facet Joint Injections: Therapeutic	The PCT will fund medial branch blocks for the management of cervical, thoracic and lumbar back pain as specified below: • All conservative management options, (physiotherapy, exercise, pharmacoptherapy including analgesia) have been tried and failed. • AND the pain has resulted in moderate to significant impact on daily functioning.	

	• The treatment of facet joint pain is provided as part of a comprehensive pain management programme. Further facet joint injections will only be funded if the initial facet joint injection has had a proven therapeutic benefit and the patient is not suitable for Thermal Radiofrequency Denervation (RFD) or a Pain Management Programme (PMP). For those who are not suitable for RFD or PMP (patients with multiple co-morbidities; cardiological and or respiratory dysfunction; cardiac pacemaker or other nerve stimulator; frail patients; elderly patients), up to two injections per year will be funded in line with the Pain Management Pathway for Chronic Facetal Pain. Intra articular injections will only be funded according to the criteria above. **Note: (diagnostic facet joint injections used by spinal surgeons as part of a diagnostic pathway prior to making a decision to proceed to surgery, will be funded).**	
Radiofrequency facet joint denervation (RFD) of lumbar and cervical facet joints for chronic facetal pain (adapted from SWL Guidance)	Radiofrequency facet joint denervation of the medial branch of the dorsal rami of the lumbar and cervical facet joints (medial branch neurotomy) will be funded in the following circumstances: ▪ Patients aged over 18. ▪ Non-radicular lumbar (all levels) or cervical (C3-4 and below) facet joint pain. ▪ Failure of an appropriate trial of non-invasive therapy, such as medication and physiotherapy. ▪ One anaesthetic diagnostic block, which must be of the medial branch of the dorsal rami innervating the target facet joint. A significant reduction in pain following the block during activities that normally generate pain should be demonstrated and recorded. The pain relief must be consistent with the expected duration of the anaesthetic block. ▪ All procedures must be performed under fluoroscopy (x-ray guidance*)* Thermal radiofrequency denervation is provided as part of a comprehensive Pain. Management Programme (PMP). Cryoneurolysis or laser denervation will not be funded.	V485

	Up to four facet joint denervations on one occasion (one treatment episode) will be funded. Re-treatment at the same location will not be funded, unless at least twelve months have elapsed since prior treatment. This procedure will not be funded for early management of persistent non-specific low back pain (NICE CG 88).	
Metal on metal hip resurfacing	In line with South Central Priority Committee policy recommendation 105 metal on metal hip resurfacing is a low priority for all women and men over the age of 55.	
6. Ophthalmology		
Cataract surgery	Any suspicion of cataracts in children should be referred urgently**.** Adults with a visual acuity of 6/9 or better in either eye are considered a low priority for cataract surgery. Referrals from community services should only be made after an assessment by an optometrist unless there are exceptional reasons why this is not possible. Optometrists should take into account the referral thresholds and the impact of the cataract(s) on the patient's life. Referral of patients to ophthalmologists should be based on the following indications: 1. Best corrected visual acuity must be worse than 6/9 (6/9.5 and worse) in the first affected eye OR the patient wishes to/is required to drive and does not meet the Driving & Licensing Authority (DVLA) eyesight requirements. 2. AND impairment of lifestyle such as; • The patient is at significant risk of falls. • Or the patient's vision is substantially affecting their ability to work. • Or the patient's vision is substantially affecting their ability to undertake.	C751, C711, C712, C713, C718, C719, C721, C722, C723, C728, C729, C731, C732, C733, C734, C738, C739, C741, C742, C743, C748, C749, C751, C752, C753, C754, C758, C759

	leisure activities such as reading, recognising faces or watching television. 3. AND willingness to have cataract surgery; • The referring optometrist or GP has discussed the risks and benefits and ensured the patient understands and is willing to undergo surgery prior to referral. Patients should only undergo surgery of the second eye when that eye meets the thresholds of 6/18 or worse visual acuity. <u>Exceptions</u> Cataract surgery can continue to be performed for medical reasons such as glaucoma and diabetes and on patients with severe anisometropia who wear glasses. The clinical reason for the surgery should be clearly documented. **NB; This policy has been submitted for consideration of review by South East Coast Health Policy Support Unit.**	
<u>Excision of Chalazion</u>	This procedure is not routinely funded. Chalazia (meibomian cysts) are benign, granulomatous lesions that will normally resolve. Treatment consists of regular (four times daily) application of heatpacks. NHS Surrey will fund excision of chalazia when **all** of the following criteria are met: - The chalazia has been present for more than 4 months. - Where it is causing blurring of vision. In common with all types of lesions, NHS Surrey will fund removal where malignancy is suspected.	C121

7. Other surgery		
Inguinal hernia in adults (Elective surgical repair of)	This procedure is not routinely funded for asymptomatic or mildly symptomatic inguinal hernias in adults. Patients should be referred for surgical assessment if they meet the following criteria: 1. A history of incarceration of, or real difficulty reducing, the hernia. 2. An inguino-scrotal hernia. 3. Increase in size month to month. 4. Pain or discomfort significantly interfering with activities of daily living. 5. Work related issues e.g. of work/missed work/unable to work/on light duties due to hernia. Patients with femoral hernias should be referred for consultation.	T191, T192, T193, T198, T199, T201, T202, T203, T204, T208, T209, T211, T212, T213, T214, T218, T219
Umbilical hernia in adults (elective surgical repair)	Surgical treatment should only be offered when one of the following criteria is met: 1. Pain/discomfort interfering with activities of daily living. **OR** 2. Increase in size month on month. **OR** 3. To avoid incarceration or strangulation of bowel.	
Incisional hernia in adults (elective surgical repair)	Surgical treatment should only be offered when **both** of the following criteria are met: 1. Pain/discomfort interfering with activities of daily living. **AND** 2. Appropriate conservative management has been tried first e.g. weight reduction where appropriate.	

8. Urology		
Circumcision	This procedure is not routinely funded. NHS Surrey will fund circumcision when the procedure is for: - Patients with severe phimosis. OR - Severe recurrent balanitis. OR - Where cancer is suspected.	N303
9. Vascular Surgery		
Varicose veins	Procedures for this are not routinely funded in line with the South East Coast Policy Recommendation Committee (PR 2010-01) threshold referral criteria for the specialist assessment of varicose veins which stipulates that patients should only be referred if: □ Venous oedema where 6 months of compression therapy has been unsuccessful in controlling symptoms **AND** □ Superficial thrombophlebitis, **OR** □ Varicose veins with limited skin changes at the ankle with the possibility of further complications, **OR** □ Skin changes ascribed to venous disease, **OR** □ Late stage venous disease. Referral criteria summarised below:	L841, L842, L843, L844, L845, L846, L848, L849, L851, L852, L853, L858, L859, L861, L862, L868, L869, L871, L872, L873, L874, L875, L876, L877, L878, L879, L881, L882, L883, L888,

	<table><tr><th>CEAP Classifications</th><th>Description</th><th>Signs</th><th>Consider referral to specialist</th></tr><tr><td>Class 1</td><td></td><td>None</td><td>No</td></tr><tr><td>Class 2</td><td>Varicose Veins</td><td>None</td><td>No</td></tr><tr><td>Class 2T</td><td>Varicose Veins with Superficial Thrombophlebitis</td><td>Superficial Thrombophlebitis</td><td>Yes</td></tr><tr><td>Class 3</td><td>Varicose Veins with limited skin changes at the ankle with the possibility of further complications</td><td>Oedema, venous eczema, superficial phlebitis</td><td>Yes</td></tr><tr><td>Class 4</td><td>Skin changes ascribed to venous disease</td><td>Oedema, venous eczema, lipodermosclerosis, superficial phlebitis</td><td>Yes</td></tr><tr><td>Classes 5 and 6</td><td>Late stage venous disease</td><td>Severe skin changes, active or healed ulceration, bleeding from varicose vein</td><td>Yes</td></tr></table>	

10. Other Procedures/Equipment

Assistive communication assessments (ACA) and equipment	Assessment: NHS Surrey will fund an ACA assessment where it has been recommended by a Speech & Language Therapist for patients with ongoing complex communication needs. Equipment: Equipment recommended as a result of these ACA assessments is not routinely funded by the NHS.	
Open MRI scans	Open MRI scans should only be used for patients for whom can be demonstrated to be too obese to be able to be scanned on a closed MRI scanner or patients who have a genuine case of claustrophobia. Any patient that requires an Open MRI scan and meets the criteria above should be referred to an appropriate Open MRI scanner facility on a Provider to Provider basis. The cost for all types of MRIs is included in the patients care package and there should be no extra charge to the PCT.	
Continuous positive	NHS Surrey considers treatment for snoring to be a LOW PRIORITY and will not	

airway pressure for the treatment of obstructive sleep apnoea/hypopnoea syndrome	normally fund this where snoring is the sole problem. In line with NICE Technology Appraisal Guidance 'Continuous positive airway pressure for the treatment of obstructive sleep apnoea/hypopnoea syndrome' (TAG 139, March 2008). NHS Surrey recommend that patients should be referred for assessment and possible treatment to a specialist sleep unit, when at least one of the following are present in addition to snoring: 1) Daytime sleepiness (rather than tiredness). 2) Witnessed nocturnal apnoeic episodes of stopping breathing. 3) Waking with sensations of choking /obstruction. 4) Neck circumference 17ins or over. 5) A degree of retrognathia. NICE Technology appraisal (TAG 139, March 2008) on "Continuous positive airway pressure (CPAP) for the treatment of obstructive sleep apnoea/hypopnoea syndrome (OSAHS)" concluded as follows: 1. CPAP is recommended as a treatment option for adults with **moderate or severe symptomatic OSAHS**. 2. CPAP is only recommended for adults with **mild OSAHS** if: - they have symptoms affecting their quality of life and ability to go about their daily activities **AND** - lifestyle advice and any other relevant treatments have been unsuccessful or are considered inappropriate. 3. The diagnosis and treatment of OSAHS, and the monitoring of the response, should be carried out by a specialist service with appropriately trained medical and support staff.	

APPENDIX A

Alphabetical List of Procedures/treatments

APPENDIX B

INTERVENTIONS INDIVIDUAL FUNDING REQUEST FORM – Effective April 2012
Please complete all sections and provide supporting information. Incomplete application forms received will be returned to the requesting clinician.

PART 1: DETAILS OF CLINICIAN SUBMITTING REQUEST AND PATIENT

1. Details of clinician submitting the request	Name	
	Designation:	
	GP Practice:	
	NHS Trust:	
	Correspondence address:	
	Tel:	
	Email:	

2. Patient details	Surname:			
	First Name:			
	Address (including Postcode):			
	NHS Number:			
	Date of Birth:		Gender:	
	Registered GP Name, Practice and Code:			

3. Instructions for communicating with the patient	Does the patient or his/her representative wish to receive letters regarding this request? □ yes □ no	
	If YES are the letters to be sent to the patient at the address above? □ yes □ no	
	If letters are to be sent to anyone other than the patient, please provide the following information, and obtain the patient's written agreement:	
	Name	
	Relationship to patient	
	Address (including Postcode)	

PART 2: INFORMED CONSENT AND PROVIDER TRUST APPROVAL

4. Clinician's affirmation of patient's consent	I affirm that I have discussed this Individual Funding Request with my patient. This request is being made with his/her consent. The instructions for communicating with the patient at Q3 are his/her expressed wishes.	
	Signature:	
	Name:	
	Designation:	

5. Which organisation will be providing the treatment requested?	☐ NHS Trust ☐ GP Practice ☐ Private sector ☐ Other
	Name of NHS Trust/GP Practice:
	If provider is outside the NHS, please give details of name and location

6. If this funding request is approved, the NHS provider will be notified. Please give details for the person who should be notified:	Name of representative:	
	Designation:	
	Email address:	
	Postal Address:	

PART 3: STATEMENT TO CONFIRM APPROPRIATENESS FOR CONSIDERATION AT IFR TRIAGE/IFR PANEL

I confirm that it is not expected that there will be more than one patient from within the PCT population who is, or is likely to be, in the same or similar clinical circumstances as the requesting patient in the same financial year and who could reasonably be expected to benefit to the same or a similar degree from the requested treatment unless similar patients are expected to be from the same family group.

☐ YES ☐ NO

PART 4: DIAGNOSIS AND PATIENT'S CURRENT CONDITION

7. Diagnosis (for which the intervention is requested)			
8. Has a second consultant opinion been obtained?	If YES, please give details		
9. Current status of the patient: What is the patient's clinical severity? (Where possible use standard scoring systems e.g. WHO, PASI, DAS scores, walk test, cardiac index etc.)			
10. Please summarise the current status of the patient in terms of quality of life, symptoms etc.			
11. Summary of previous interventions for this condition Reasons for stopping may include: - course completed - no or poor response - disease progression - adverse effects / poorly tolerated	Dates	Nature of intervention	Reason for stopping*/ response achieved

PART 5: INTERVENTION FOR WHICH FUNDING IS REQUESTED

12. Nature of the intervention If combination, tick all that apply	□ Surgical procedure □ Medical device □ Therapy □ Other (give details)
13. Name of intervention	
14. Where will intervention be provided? Also indicate whether in-patient, out-patient, daycase	
15. Is the requested intervention a continuation of existing treatment funded via another route?	□ YES □ NO If YES, give details of existing funding arrangement and why ceased
16. Is the intervention experimental, part of a trial or research?	□ YES □ NO - give details

PART 6: INTERVENTIONS INVOLVING SURGICAL PROCEDURES, THERAPIES, DEVICES

17. Describe the intervention as it applies to this patient		
18. Is this intervention listed in the PCTs Low Priority Procedures (LPP) Policy?	□ YES □ NO	
19. Photographic evidence is required (with patient consent) to support applications for <u>all</u> external procedures (i.e. breast surgery, facial procedures, body contouring, skin lesions etc)		
20. Patients Body Mass Index (BMI)		
21. Specify any devices, prostheses, etc. and the manufacturer		
22. Estimated costs	Anticipated cost (inc VAT)	
	Are there any offset costs?	□ YES □ NO
	Describe the type and value of offset costs	

	Funding difference being applied for:	

PART 7: PROJECTED OUTCOMES

23. Is there a standard intervention for this patient at this stage of their condition? If so, please describe the standard intervention	
24. What would be the expected outcome from the standard intervention?	
25. Why is the standard intervention inappropriate for this patient?	
26. What would you consider to be a successful outcome for the requested intervention in this patient?	This may include likely OS, TTP or improvement in QOL. Please relate to measures describing patient's condition in Part 4.
27. Please outline any anticipated or likely adverse effects of the requested treatment for this patient	
28. How would you monitor the effectiveness of the requested intervention?	Please refer to the measures used to describe the patient's condition in Part 4
29. What is the minimum timeframe/course of treatment after which a clinical response can be assessed?	
30. What are the likely clinical consequences for the patient if this request is not approved?	

PART 8: STATEMENT OF EXCEPTIONALITY OR RARITY

31. On which basis are you making this request?	☐ Exceptional clinical circumstances OR ☐ Rarity of condition or presentation
32. For exceptional clinical circumstances, please describe as clearly as possible why the patient's clinical circumstances are exceptional. **<u>You must give specific information to indicate how this patient is significantly different to the population considered in the existing policy.</u>** **Psychological distress does not make a case exceptional.**	
33. For rarity of condition or presentation, please describe as clearly as possible why this patient's condition or clinical presentation is so unusual that there is no relevant commissioning arrangement.	

PART 9: EVIDENCE OF CLINICAL EFFECTIVENESS

34. Give details of published data supporting the use of the requested intervention for this condition. Please provide references or attach articles.

PART 10: URGENCY

35. Only a small minority of requests can be decided using the PCT's fast-track procedure. If there are compelling clinical reasons why this patient's request should be fast-tracked, please state them here.

Thank you for completing this form.

Please send as an electronic attachment to tnrf@nhs.net

Alternatively, post to;

IFR/LPP/TNRF Team, NHS Surrey
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