this week

NEW METAL HIP GUIDANCE page 46 • **LAW: CHARLIE GARD CASE** page 52

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Surge in exceptional funding requests

The number of exceptional funding requests that doctors in England are making on behalf of their patients for treatments such as cataract removal, hip and knee replacements, and mental health interventions has increased markedly, an investigation by *The BMJ* has found.

Richard Vautrey, deputy chair of the BMA's General Practitioners Committee, said that the figures were a sign that clinical commissioning groups were under increasing financial constraint. "There is undoubtedly more pressure on CCG budgets and attempts to reduce referrals and costs, and the greater use of individual funding requests (IFRs) may be one way some are trying to do this," he told *The BMJ*.

Doctors made 73 900 IFRs to CCGs last year, a 47% rise from 2013-14, when they made 50 200, data collected by *The BMJ* under a freedom of information request show. In just the past year the number of requests rose by more than 20%, from 60 400. Just over half (52%) the requests made in 2016-17 were approved, but even patients who are granted access to treatment may have waited months for it.

IFRs, which first emerged in England in the 2000s, are made by GPs or consultants for treatments that are not routinely funded in their area. Local panels decide which to approve. Most are for cosmetic procedures or fertility treatment. But GPs in some areas are now being told to apply for exceptional funding for a wider range of treatments.

Chiltern and Aylesbury Vale CCGs in Buckinghamshire recently told doctors that all referrals for hip and knee surgery must go through an IFR process.

Stephen Cannon, vice president of the Royal College of Surgeons, said the move was a misguided attempt to save money. "These CCGs are unfairly and unnecessarily prolonging the time patients will spend in pain, possibly immobile and unable to carry out daily tasks or to work," he said.

Vautrey urged NHS England to set clear guidelines on which treatments should require an IFR ."It's clearly unfair for patients to be subjected to this postcode rationing, and it also adds further to GPs' workload," he told *The BMJ*.

Julie Wood, chief executive of NHS Clinical Commissioners, said that CCGs had to make "difficult decisions" on funding services. "Unfortunately the NHS does not have unlimited resources," she said.

Gareth Iacobucci, *The BMJ*

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COVER STORY, p 47

Treatments such as cataract surgery are becoming increasingly difficult to obtain in parts of England

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Pressure on NHS finances drives new wave of postcode rationing

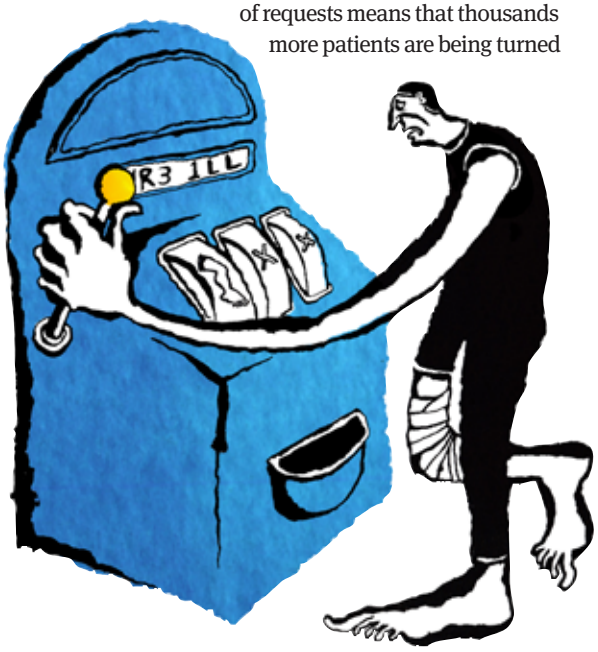
Patients around England are being denied access to care that just months ago was granted without question. **Gareth Iacobucci** reports

An investigation by *The BMJ* has shown stark local variation in the number of exceptional funding requests that doctors in England are having to make on behalf of their patients, and the types of treatment being restricted.

The analysis shows that the overall number of individual funding requests (IFRs) received by clinical commissioning groups in England increased by 47% in the past four years.

But there is substantial variation around the country. For example, Rushcliffe Clinical Commissioning Group in Nottingham received no IFRs last year, while Chiltern CCG in Amersham, Buckinghamshire, processed nearly 3800.

The proportion of IFRs being approved increased slightly in the past four years from 43% (20 515/47 626 with data available) to 52% (35 222/68 051). But the sharp increase in the overall number of requests means that thousands more patients are being turned down for funding each year, while many others are forced to wait for their treatment while their request is considered.

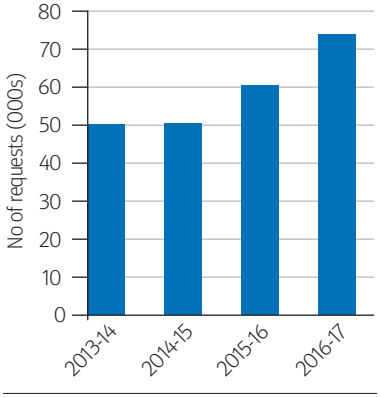


Again, there is much variation in how many requests are approved. Southern Derbyshire CCG received just 14 requests last year for procedures such as cataract surgery but approved none. In contrast, Stafford and Surrounds CCG processed 2123 requests, including 764 for skin excision, 232 for cataracts, and 163 for hip or knee replacement, but approved them all.

IFRs are made by GPs, consultants, or other health professionals for treatment and are not routinely funded in their area. CCGs decide which treatments are subject to IFR, and host panels of lay people, GPs, and other clinicians to decide whether to fund treatments. Doctors' leaders told *The BMJ* that the increase in the requests and the wide variation in access was discriminating against patients in some parts of the country.

One patient whose request for treatment for rheumatoid arthritis has to be resubmitted as an IFR every six months told *The BMJ* that the process was slow, stressful, and painful (see p 49).

The findings come against a backdrop of unprecedented financial pressures in the NHS. NHS Clinical Commissioners, the organisation that represents CCGs, recently warned that CCGs would have £5.72 less to spend per person in 2019-20 than in 2016-17 under the current funding settlement from the government.



No of individual funding requests received by CCGs

In common with previous years, most IFRs in 2016-17 were for surgical procedures such as excision of skin tags, removal of varicose veins, and other forms of plastic and cosmetic surgery.

What might be more surprising is the surge in requests for hip and knee surgery, cataract removal, and carpal tunnel surgery over the past four years and the consistently high number of mental healthcare requests. These areas were all among the top 10 most commonly requested treatment areas in 2016-17. In 2013-14 only mental health featured in the top 10.

HOW *THE BMJ* CARRIED OUT ITS INVESTIGATION

The BMJ sent freedom of information requests to each of England's 207 clinical commissioning groups. It asked each group to disclose the number of IFRs it had received in each of the past four years, the number of requests that it approved, and the three most common treatment categories in which IFRs were submitted. A total of 192 CCGs (93%) had responded in time for *The BMJ*'s deadline. Of these, 10 responding CCGs did not supply figures as their IFR process is overseen by neighbouring CCGs, and 13 supplied incomplete data that could not be included in the results.

WHAT'S CAUSING THE INCREASE IN IFRs?

The overall rise in IFRs seen over the past few years is largely down to stricter enforcement of rules on what treatments CCGs will fund.

In 2015-16 Aylesbury Vale CCG and Chiltern CCG in Buckinghamshire decided not to pay providers for activity if the referring doctor did not follow their policies and submit IFRs where necessary. The move led to a fivefold increase in the number of IFRs over two years (from 1226 in 2014-15 to 6400 in 2016-17). Recently, the CCGs decided that all referrals for hip and knee surgery must be done through an IFR.

Strict enforcement

Christine Campling, a GP and executive lead for elective care for Aylesbury Vale and Chiltern CCGs, told *The BMJ* that stricter rule enforcement was needed because "a huge number" of procedures were going ahead despite being listed as requiring prior funding approval—to the tune of £1.7m a year.

"From that, we realised a) that we couldn't afford that activity and b) that there's no point having policies if they are not going to be practised," said Campling. "We ramped up our contractual challenges on IFR procedures, so that unless the providers could prove why there was a very good reason why an IFR had not been obtained, they wouldn't get paid for the procedure. It helps to reduce the amount of clinical variation in what happens to patients."

CHRISTINE CAMPLING, GP AND EXECUTIVE LEAD FOR ELECTIVE CARE FOR AYLESBURY VALE AND CHILTERN CCGs

Campling said she was very aware that some patients may be disadvantaged and delayed by having to seek funding for their care, and the CCG has tried to make allowances for them. For example, although the Buckinghamshire CCGs' default policy is for patients who need joint replacements to go through IFR, the CCG permits patients with severe rheumatoid arthritis to bypass this process with a letter from the consultant rheumatologist to another clinician.

But Campling said that the group's IFR policy "has absolutely proved cost effective." If we took our foot off that pedal and allowed patients to have operations without having to hit thresholds, then, we know that in other CCGs [which are not enforcing it] their activity has gone up,"Campling told *The BMJ*.

In other areas, stricter enforcement has accompanied changes to how IFRs are classified. Three CCGs in south Staffordshire (Stafford and Surrounds CCG, South East Staffordshire and Seisdon Peninsula CCG, and Cannock Chase CCG) now direct requests for procedures of "low clinical value" as determined by the CCGs to their IFR team. As a result, the number of IFRs in the three CCGs rose from 416 in 2014-15 to 7000 in 2016-17.

Hips and knees

Between 2013-14 and 2016-17 the number of IFRs for hip and knee surgery rose from 49 (0.2% (49/22 669 of the total number of IFRs with available data)) to 899 (3% (899/30 166)), indicating that these procedures are becoming increasingly difficult to obtain on the NHS.

In Buckinghamshire, two CCGs, Aylesbury Vale and Chiltern, recently issued guidance stating that all referrals for hip and knee surgery should go through an IFR process (see left).

Service commissioners say that such policies reduce clinical variation and are guided by evidence. But though evidence now advises against some specific procedures such as knee arthroscopy for patients with degenerative knee disease, surgeons argue that policies such as Buckinghamshire's are too draconian and are denying patients treatment that could benefit them.

Stephen Cannon, vice president of the Royal College of Surgeons, said, "Hip and knee replacements are some of the most clinically effective and economical treatments available on the NHS. Unfortunately, patients needing hip and knee surgery have misguidedly become soft targets for NHS savings."

A GP's VIEW—"IT IS VERY DISCONCERTING FOR THE PATIENT"

CCGs in the north east of England had some of the highest numbers of IFRs last year and some of the highest year on year increases in requests received.

Neil Morris, medical director of Newcastle Gateshead CCG, said that the rise had largely been driven by giving more guidance to clinicians on when to refer for so called limited value procedures. He said that it was necessary for the CCG to have "an honest discussion" with doctors and patients over which treatments to prioritise, given financial pressures.

George Rae, a GP in Whitley Bay and chief executive officer of Newcastle and North Tyneside Local Medical Committee, told *The BMJ* that he had made more IFRs in the past few months and was getting more refusals.

"One of my IFR [patients] had knee problems. They had had a meniscus partially shaved, which resolved the problem five years ago. The patient came to me and said, "It is exactly the same on the other knee as I had five years ago. I was helped: I did it through the IFR." As the GP, I did x ray the knee first, because [the CCG] would return it if I didn't do that. It wasn't anything to do with joint degeneration. I did the IFR, and what happens? They refused to do it. So what does the patient do? Either they put up with their symptoms, or they have to go privately. I don't think that's fair."

THE 10 MOST COMMONLY REQUESTED TREATMENT AREAS THROUGH IFRs IN 2016-17

Excision of skin—6079 requests

Cosmetic and aesthetic surgery—4426

Varicose vein surgery—2058

Plastic surgery—1889

Fertility treatment—1151

Mental health—1150

Cataract removal—1034

Carpal tunnel surgery—952

Hip and knee surgery—899

Breast surgery—786

Source: IFRs made to 155 CCGs

A patient's view—"The process doesn't make sense to me"

I had a lot of pain in my joints and really big problems with fatigue. It can be really challenging day to day

HELEN COLE, from west London, was given a diagnosis of rheumatoid arthritis 11 years ago. For the past two years Cole has been treated successfully with rituximab after she was switched from other tumour necrosis factor inhibitors that were not working. But to receive rituximab her consultant has to submit an IFR every six months and wait for a panel to approve it. All the requests have been approved so far, but Cole said that the uncertainty over whether her treatment could continue was "stressful," while delays in getting the drug meant there have been gaps in her treatment that have left her in pain.

"Last time was the longest wait for me—10 weeks. That's a long time to be living with a flare, and the potential joint damage. I had a lot of pain in my joints and really big problems with fatigue. It can be really challenging day to day," she told *The BMJ*.

Cole is critical of the IFR process as it requires her to reach a certain level of pain before being judged eligible to receive funding for treatment.

"The process doesn't make sense to me. The whole point of treating a disease like rheumatoid arthritis is to try to keep it under control at all times, stop it from flaring, and stop permanent long term damage to joints. But you almost have to flare to get the funding.

"This treatment works. There isn't anything else they could give me. It just seems like a waste of the rheumatologist's and the panel's time. I'm sure there is an unbelievable amount of paperwork behind the request."

"It is assumed these policies have been put in place to reduce the number of hip and knee replacements performed and thereby save money. Patients needing surgery will cost the NHS more, in physiotherapy, pain medication, and other support, while they wait to find out if they can be referred," said Cannon.

Cataracts

As commissioning budgets have become increasingly stretched in recent years, some CCGs have restricted access to cataract surgery by imposing thresholds for referral that are based on visual acuity.

The BMJ's investigation found that the total number of IFRs for cataract removal in England rose from 359 (1.6% (359/22 669 of the total number of requests with available data)) in 2013-14 to 1034 (3.4% (1034/30 166)) in 2016-17.

These requests were concentrated in three CCGs in Staffordshire, which in 2015-16 increased the remit of its IFR department to include so called procedures of low clinical value, including cataract surgery.

Mike Burdon, president of the Royal College of Ophthalmologists, said that asking doctors to submit IFRs for cataract surgery amounted to inappropriate rationing.

"There should not be any impediment to access for what is a highly effective procedure that can seriously transform quality of life," he said. "My concern is that there is no longer equality of access to cataract surgical care across the country."

Mental health

The data show a consistently high number of mental healthcare requests through IFR between 2013-14 and 2016-17. This is despite a government push to improve access to mental health treatments over this period.

In some areas of the country mental healthcare was the most commonly requested treatment area under IFR last year. This included Wakefield CCG, which processed 122 requests for mental health services such as autism diagnosis, treatment for attention-deficit/hyperactivity disorder, psychiatry, and counselling in 2016-17, but approved only eight.

"Many requests that were declined were signposted to make a referral into a suitable service already available," said a spokeswoman for Wakefield CCG.

These procedures are becoming increasingly difficult to obtain on the NHS

The spokeswoman added that the rise in the number of IFRs was due to "increased understanding and awareness" of mental health conditions among patients. But she insisted that patients had "timely and necessary access" to psychological therapies and that the CCG had responded to demand by commissioning a new diagnostic and treatment service for autism.

Gareth Iacobucci, *The BMJ*

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Find the full version with references at http://dx.doi.org/10.1136/bmj.j3190

bmj.com Visit the online version to find out what the top three IFR requests were in your area last year