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*These procedures are not routinely funded by Commissioners in the North East and Cumbria*
Value Based Clinical Commissioning Policies

Introduction

Across the country most, if not all, CCGs have a set of policies and procedures for limiting the number of low clinical value interventions. The Audit Commission’s report 'Reducing expenditure on low clinical value treatments' analyses variation on approaches to this work. This approach was based on the 'Save to Invest' programme developed by the London Health Observatory incorporating the 'Croydon List' of 34 low priority treatments.

Healthcare commissioners in the North East have adopted a common set of policies since 2010. These were reviewed in and adopted by all CCGs in the North East in January 2013. Revisions to the policy are now managed and co-ordinated by a clinically-led North East Policy Development and Review Group.

Guidance for making referrals

This guide has been developed to assist clinicians answer questions in relation to individual funding requests (IFRs). At the end of this guide you will find quick links to qualifying criteria of individual policies contained within the Value Based Clinical Commissioning Treatment Policies document.

Frequently asked questions

1 Why do we need policies?

NHS resources come under ever greater pressures each year. Ensuring that treatment and care is focused where it can make the biggest difference is a key part of making best use of these resources. This is a key challenge for all NHS organisations, and a prime focus for commissioning among CCGs. These policies help clinicians identify interventions with limited benefit, thereby providing potential for reinvesting elsewhere, where potential benefits are greater.

The alternative to having policies of this kind is to leave each decision to individual GPs, to manage individual dilemmas without guidance and without the context of the health needs of the wider population.

The Academy of Medical Royal Colleges has launched a Choosing Wisely campaign (http://www.choosingwisely.co.uk/) which is aligned to the North East and Cumbria approach to increasing value and improving population health.

At the heart of the Choosing Wisely initiative is a call to both doctors and patients to have a fully informed conversation about the risks and benefits of treatments and procedures. As well

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1 Reducing expenditure on low clinical value treatments. Audit Commission, April 2011... http://www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/lowclinicalvalue/Pages/Default.aspx
as releasing resources for other activities, it says patients should always ask five key questions when seeking treatment. They are:

1. Do I really need this test, treatment or procedure?
2. What are the risks or downsides?
3. What are the possible side effects?
4. Are there simpler, safer options?
5. What will happen if I do nothing?

In a study carried out last year, 82% of doctors said they had prescribed or carried out a treatment which they knew to be unnecessary. The vast majority of this group cited patient pressure or patient expectation as the main reason

2 What do these policies cover?
These cover interventions where there is significant risk that patients undergoing them will gain little health benefit.

The procedures have low rather than no clinical value. Some may be effective, but may have low value because other (medical) treatments could be tried first. Other effective procedures may provide large benefits for some patients but less to those with few symptoms, where risks and benefits are closely balanced. There are interventions which are effective in some but give no clinical value in others.

Finally, there are those interventions that whilst effective, are undertaken for primarily cosmetic reasons, which commissioners often consider as providing low clinical value.

3 Who are they for?
They are to assist clinicians in making referral decisions, where the principal reason for referral is for surgical intervention. They are also to assist providers of treatment and surgical services.

4 How has the list been compiled?
The list of procedures is a historical one, starting with declarations about plastic surgery and IVF, and have grown with greater understanding about health benefits from surgical intervention, publication of authoritative national guidelines and unexplained variations in clinical practice.

The policies have been compiled by a group of clinical decision-makers, GPs, and Public Health specialists, with advice and guidance from clinical specialists and regional networks. The group has used published evidence and guidance, alongside expert opinion to develop and refine this set of policies.

5 How have they been developed?
Every effort has been made to get an up to date view of practice. However, some will contain contentious criteria - for example among eligibility for plastic surgery and IVF.

We aim to take account of the most up to date clinical evidence, legal precedent and gain consensus from local experts before publication. These policies are kept under constant
review to ensure the policies are in-line with evidence and best practice. This process is managed and coordinated across the North East and Cumbria to ensure that there is consistency in the policies and their application.

6 **How often will this policy be reviewed?**
Commissioners plan to review policy content on a bi-annual basis. However, there may be occasions whereby this is more frequent for example upon receipt of new national or local guidance from organisations such as NICE or NTAG.

7 **Can you give any general guidance about what is in the policies?**
Here is some general advice about those policies which are most commonly referred to.

For procedures that are often carried out for cosmetic reasons: breast surgery (reduction or augmentation), benign skin lesions or lipomata, you should consider the extent to which the individual deviates from the normal range, and the impact of any anomaly on function and activities of daily living.

Unhappiness is a common experience among people wanting plastic surgery who do not receive NHS funding. This unhappiness is not, on its own, sufficient to make an individual exceptional.

Much of the varicose vein surgery undertaken in England is for cosmetic reasons, so you should also consider the impact on activities of daily living before referring.

For IVF- there is an age limit for starting treatment that is based on the probability of success. Please alert couples about the lead time to establish infertility (two years) and to undertake relevant investigation and medical treatment. Age and lack of understanding of the pathway are not exceptional reasons for access to IVF.

8 **Is securing funding a guarantee of treatment?**
Approval for NHS funding is NOT the same as a guarantee of treatment. Funding (the role of the commissioner for a whole population) is often requested before specialist assessment. However, the ultimate decision about safety and appropriateness of treatment is a clinical one, which must be discussed with the patient.

9 **What happens when funding is approved?**
It is the applicant i.e. the patient’s clinical representative’s responsibility to refer the patient for treatment. It is expected that this will take place within a maximum period of 12 months. It is expected that any approved treatment will be completed within 12 months, and if a treatment is not completed within this time, a new application for funding would need to be submitted. In the case of ongoing treatments, the approval of such treatments will be for a maximum period of 12 months unless the referring clinician explicitly requests (and justifies) longer-term treatment. Continuing treatments after that time will need a new application for funding and this will be assessed against the policy in place at the time of the new application.

10 **What if funding is declined?**
If there are individual circumstances to be considered, and the decision is to decline funding, you will be sent details of how to appeal.
11 **Who tells the patient if funding is declined?**
We will tell the referring clinician, who remains responsible for ongoing treatment and care. The correspondence lays out this responsibility, and any timescales for action.

12 **What about treatments that have already started under private arrangements?**
If treatments have already been started under private arrangements, the assumption is that a whole package of care has been purchased and its potential complications taken account of. Therefore, it would be unreasonable to expect the NHS to pick up the costs associated with private treatment unless there is a medical emergency, or some other exceptional circumstance. Running out of funds, whilst unfortunate, is not exceptional.

Likewise, if a device has been privately purchased and initiated, the NHS will not pick up the costs of consumables or maintenance, unless the patient meet NHS criteria. For example a patient who has purchased a continuous glucose monitor would be expected to have sufficient funds to purchase consumables for the life of the device.

13 **What about treatments that have been started and completed under private arrangements?**
Funding is not provided retrospectively. If treatment has been completed under private arrangements it is assumed that the patient has sufficient funds to cover this treatment.

14 **What about the continuation of experimental treatments/loaned device trials?**
The continuation of experimental treatments/loaned device trials will not be routinely funded. Initiating patients on treatments without clear evidence of safety, efficacy, effectiveness or cost-effectiveness raises patient expectations that the treatment will be continued. Where treatments are initiated by providers on a loan/ experimental basis this is done at the provider’s own risk. The provider must be clear with the patient about the end point/ exit strategy for the trial and/ or continuing care.

This excludes formal clinical research trials for which there are separate arrangements between funders and providers.

15 **What if I have a patient whose needs are exceptional?**
Exceptionality is defined as:

> ‘The patient or their circumstances are 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.’

We welcome Individual Funding Requests - either for patients who are clearly different from the group of patients covered by the policy - or for those with very unusual conditions or clinical presentations. Please:

- check the policies (see list below),
- use the web based application system to indicate how your patient is exceptional and include all the information requested as clearly and comprehensively as possible to avoid delays in considering the request. Applications must include details of all the conventional treatments undertaken and their impact.
16 What about psychological considerations?
Accounting for psychological factors in arriving at a decision about eligibility for NHS funding is hard to do in a clear and fair way. These considerations have been removed from this policy as psychological distress unfortunately does not constitute clinical exceptional circumstance.

NICE guidance indicates that clinicians should consider the possibility of Body Dysmorphic Syndrome when making referral for plastic surgery (NICE Clinical Guideline 31).

17 Are photographs helpful?
Photographs are not used in consideration of exceptionality - and handling them presents significant risks of compromising confidentiality. Please do NOT submit photographs. Any photographs received will be returned to sender upon receipt and an incident will be logged on Safeguard Incident and Risk Management System (SIRMS).

18 What if GPs make referrals outside the criteria outlined in these policies?
The implication is that there is no guarantee of payment, although the level of detail in these policies is not fully reflected in financial agreements with hospital providers.

19 What if surgeons undertake procedures outside the indications in these policies?
The implication is that there is no guarantee of payment, although legally binding contracts govern financial transactions.

20 What about the smoking status of the patient?
There is clear evidence that stopping smoking prior to surgical interventions improves patient outcomes and recovery. We recommend that patients who smoke should have attempted to stop smoking 8 to 12 weeks before referral to reduce the risk of surgery and the risk of post-surgery complications. Patients should be routinely offered referral to smoking cessation services to reduce these surgical risks and this should be detailed in the application.

21 Describing pain and significant functional impairments/ limitations to activities of daily living endured by patients
Pain has been defined as an “unpleasant sensory and emotional experience arising from actual or potential tissue damage” with clinical pain being “whatever the person says he or she is experiencing whenever he or she says it occurs” and is therefore subjective.³

There is insufficient evidence to use questionnaire derived scores to evidence pain in individuals. Therefore, in lieu of a standard assessment tool, alternative clear and objective evidence must be provided when demonstrating patient pain and significant functional impairments/ limitations to activities of daily living.

This evidence should include documented assessments and/ or patient history, including:

- A description of the pain and which daily activities are no longer achievable;
- Prescribing history;
- Recorded sickness/ absence due to pain/ functional impairment;

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- Evidence from functional tests/investigations, such as gait analysis, physiotherapy/OT assessment;
- History of the pain/impairment and the response to/impact/effect of conventional therapies available.

Significant functional impairment is defined as:

- Symptoms that result in a physical/functional inability to sustain employment/education despite reasonable occupational adjustment, or act as a barrier to employment or undertaking educational responsibilities;
- Symptoms preventing the patient carrying out routine domestic or carer activities;
- Symptoms preventing the patient carrying out self-care or maintaining independent living.

22 Who can make an application for funding under this policy?

Usually a patient's GP will be the person making the application for funding on a patient’s behalf. However, any professionally registered clinician (e.g., surgeon, nurse, therapist, etc.) can make a request for funding when that is in the best interest of the patient (e.g., to speed up an application when they are already seeing a patient, rather than cause delay by sending them back to their GP for an application to be made). Although a clinician might delegate completing the application form to an administrative assistant, they remain responsible for ensuring the correct information is provided so the right decision is made for their patient.

Cosmetic Procedures

Treatments or surgery primarily to achieve a cosmetic outcome are not eligible for NHS funding. A significant degree of exceptionality must be demonstrated before funding can be considered outside of these policies. Specifically, psychological factors are not routinely taken into consideration in determining NHS funding.

Whilst some degree of distress is usual among people who consider aspects of their physical appearance as undesirable, the degree of this will not routinely be taken into account in any funding decision. Further, it is expected clinicians consider the possibility of psychological problems including Body Dysmorphic Syndrome (NICE Clinical Guideline 31), assess for these and ensure appropriate management before considering any referral for plastic surgery.

This guidance applies to many of the following policies, in particular:

- Abdominoplasty
- Breast augmentation (Breast enlargement)
- Breast prosthesis removal or replacement
- Breast reduction
- Gynaecomastia
- Inverted nipple correction
- Mastopexy
- Revision mammoplasty
- Blepharoplasty
- Pinnaplasty
- Repair of lobe of external ear
- Rhinoplasty
- Varicose veins

Circumcision
- Vaginoplasty, Labial Vulvoplasty and Vulvar lipoplasty
- Hirsutism
- Removal of tattoos
- Resurfacing procedures
- Abdominoplasty or Apronectomy
- Face lift or brow lift
- Liposuction
- Removal of benign skin lesions
- Thigh lift, buttock lift and arm lift
- Hair grafting - Male pattern baldness
Abdominoplasty or Apronectomy

**Background:** abdominoplasty (also known as tummy tuck) is a surgical procedure performed to remove excess fat and skin from the mid and lower abdomen. Many people develop loose abdominal skin after pregnancy or substantial weight loss. However, surgery is not part of the usual response to these normal, physiological processes.

**Policy:** Abdominoplasty or Apronectomy will not be routinely funded

*Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p9.*

Autologous Cartilage Transplantation

**Policy:** Autologous cartilage transplantation will not be routinely funded.

Autologous Serum Eye Drops

**Background:** Autologous serum eye drops treat severe keratoconjunctivitis sicca (dry eye). Dry eyes can be helped with intensive treatment with artificial teardrops; however for some patients the symptoms are not completely relieved. The National Blood Service has developed an alternative to these artificial drops. Autologous serum eye drops are a last resort measure where all other conservative interventions have failed.

**Policy:** Autologous serum eye drops will only be funded on a 5 month initial trial basis in accordance with the criteria specified below:

- Patients have been treated unsuccessfully with maximal tolerated conventional and NICE approved therapies (for example, Ciclosporin).

**Note:** Further funding will be subject to the submission of a progress report following a 5 month trial, outlining the improvements in objective measures.

Back Pain – Facet Joint Injections

This commissioning policy statement will be reviewed in the light of new evidence or guidance from NICE (CG88) which is expected in November 2016.

**Background:** This policy relates to recurrent (>6 weeks) and chronic (> 12 months) back pain in the adult population including neck and upper back pain, non-specific lower back pain and radicular pain including sciatica. In areas where the relevant CCGs have adopted the North East Regional Back Pain Pathway (NERBPP), patients presenting with new episodes of persistent back pain will follow the pathway.

**Policy:** Facet Joint Injections for non-specific lower back pain will only be funded in accordance with the criteria specified below:

- The pain has lasted for more than one year (except in case of trauma)

AND
The pain has resulted in moderate to significant impact on daily functioning (assessed using a validated tool such as Oswestry Disability Index)

AND
- All conservative management options (exercise, pharmacotherapy including analgesia and muscle relaxants) have been tried and failed.

AND EITHER
- The patient is part of a comprehensive pain management programme (including physiotherapy, psychological support, medication and patient education)

OR
- The patient is unable to tolerate physiotherapy treatment due to pain, facet joint injection will be followed by return to the physiotherapy programme (minimum 8 weeks)

If facet joint pain is confirmed after a diagnostic local anaesthetic block the patient should be considered for medial branch blocks and then a denervation procedure. There may be a small group of patients unable to tolerate this that might need repeated facet joint injections. A maximum of 2 injections per year will be funded.

Back Pain - Discectomy for Lumbar Spine Prolapse

Policy: Discectomy for lumbar disc prolapse will only be funded in accordance with the criteria specified below:

- Symptoms persist despite some non-operative treatment for at least 6 weeks (e.g. analgesia, physical therapy, bed rest etc.) provided that analgesia is adequate and there is no imminent risk of neurological deficit.

AND
- The patient has had magnetic resonance imaging, showing disc herniation (protrusion, extrusion, or sequestered fragment) at a level and side corresponding to the clinical symptoms;

AND EITHER
- 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° and 70° or positive femoral tension sign);

Back Pain - Injections for Radicular Leg Pain

Policy: 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:

- Symptoms persist despite some non-operative treatment for at least 6 weeks (e.g. analgesia, physical therapy, rest etc.)

AND EITHER
- 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);

Patients may receive up to three injections to diagnose and achieve therapeutic effect. If therapeutic effect is achieved, patient may receive up to six injections in total, minimum 2-3 months apart as part of a comprehensive pain management programme (including physiotherapy, psychological support, medication and patient education).

**Note for ongoing therapy:** Occasionally, injections for radicular leg pain may be the only effective treatment for a cohort of patients. These patients may be considered for prior approval for further epidural or nerve root injections if they:

- demonstrate sustained benefit from the procedure objectively evidenced;
  
  **AND**

- They must have participated in a comprehensive back pain programme including psychology and physiotherapy e.g. Coping with pain course
  
  **AND**

- They must have had a surgical review and must participate in self-directed physiotherapy.

**Blepharoplasty**

**Background:** blepharoplasty is a surgical procedure performed to correct puffy bags below the eyes and droopy upper eyelids. It can improve appearance and widen the field of peripheral vision. It is usually done for cosmetic reasons. Consideration should be given to whether blepharoplasty or brow lift is the more appropriate procedure, particularly in the case of obscured visual fields.

**Policy:** Blepharoplasty will only be funded in accordance with the criteria specified below:

- Impairment of visual fields in the relaxed, non-compensated state
  
  **OR**

- Clinical observation of poor eyelid function leading to discomfort, e.g. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow.

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p9.**

**Bone Morphogenetic Proteins**

**Policy:** Bone morphogenetic protein is funded in line with its licensed indication:

- Non-union of tibia of at least 9 month duration, secondary to trauma
  
  **AND**

- Skeletally mature patient
  
  **AND**

- Previous treatment with autograft has failed or the use of autograft is unfeasible.

**Breast - Asymmetry**

**Policy:** Surgical correction of breast asymmetry will not be routinely funded.
This policy does not apply to breast reconstruction as part of the treatment for breast cancer.

**Surgery for primarily cosmetic reasons is not eligible for NHS funding - see p9.**

**Breast - Augmentation**

This policy does not apply to breast reconstruction following mastectomy for treating breast cancer.

**Policy: Breast augmentation will not be routinely funded.**

**Surgery for primarily cosmetic reasons is not eligible for NHS funding - see p9.**

**Breast – Inverted Nipple Correction**

**Background:** the term inverted nipple refers to a nipple that is tucked into the breast instead of sticking out or being flat. It can be unilateral or bilateral. It may cause functional and psychological disturbance. Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded.

**Policy: Surgery for the correction of inverted nipple for cosmetic reasons will not be funded.**

**Surgery for primarily cosmetic reasons is not eligible for NHS funding - see p9.**

**Breast – Mastopexy**

**Background:** breasts begin to sag and droop with age as a natural process. Pregnancy, lactation and substantial weight loss may escalate this process. This is sometimes complicated by the presence of a prosthesis which becomes separated from the main breast tissue leading to “double bubble” appearance.

This policy does not apply to breast reconstruction as part of the treatment for breast cancer.

**Policy: Mastopexy will not be routinely funded.**

**Surgery for primarily cosmetic reasons is not eligible for NHS funding - see p9.**

**Breast – Prosthesis Removal**

**Background:** breast prosthesis may have to be removed after some complications such as leakage of silicone gel or physical intolerance.

This policy does not apply to breast reconstruction as part of the treatment for breast cancer.

**Policy: The removal of breast implants for any of the following in patients who have undergone cosmetic augmentation mammoplasty that was performed either in the NHS or privately will be funded for the following indications:**

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- Breast disease
- Implants complicated by recurrent infections
- Implants with capsule formation that is associated with severe pain
- Implants with capsule formation that interferes with mammography
- Intra or extra capsular rupture of silicone gel filled implants.

**Breast Prosthesis replacement will not routinely be funded.**

**Surgery for primarily cosmetic reasons is not eligible for NHS funding - see p9.**

**Breast – Reduction**

**Background:** excessively large breasts can cause physical and psychological problems. Breast reduction procedures involve removing excess breast tissue to reduce size and improve shape.

As excess weight is likely to exacerbate symptoms associated with large breasts, it is assumed that patients going forward for surgery will be near normal weight.

Assessing eligibility for surgery is problematic not least because there are several recognised approaches to measuring bra size [http://www.wikihow.com/Measure-Your-Bra-Size](http://www.wikihow.com/Measure-Your-Bra-Size), some of which relate to historical manufacturing standards.

The following approach to calculating cup size is recommended for standardisation (extracted from Modern Sizing section of above reference): subtract band size (below the breast) from the bust size (at the widest point). The difference between the two numbers determines cup size:

- Less than 1 inch difference = AA
- 1 inch difference = A
- 2 inches = B
- 3 inches = C
- 4 inches = D
- 5 inches = DD
- 6 inches = DDD (E in UK sizing)
- 7 inches = DDDD/F (F in UK sizing)
- 8 inches = G/H (FF in UK sizing)
- 9 inches = I/J (G in UK sizing)
- 10 inches = J (GG in UK sizing)

This policy does not apply to breast reconstruction as part of the treatment for breast cancer.

**Policy: Breast reduction will only be funded in accordance with the criteria specified below.**

For women:
• With documented evidence of significant chronic or repeated neck ache or, backache that has not responded to conservative management and breast reduction is likely to significantly reduce the level of pain.

AND
• wearing a professionally fitted brassiere has not relieved the symptoms;

AND
• has a preoperative body mass index (BMI) of less than 27.0 kg/m².

• Has a minimum cup size of >=E (6 inches difference as measured above)

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p9.**

**Repeat surgeries will not be routinely commissioned.**

**Bunions**

**Policy:** Surgery to treat bunions will only be funded in accordance with the criteria specified below:

• There is ulceration over the bunion

OR

• Conservative methods of management have failed including

  • Avoiding high heel shoes and wearing wide fitting leather shoes which stretch

  • Applying ice and elevating painful and swollen bunions

  • Non-surgical treatments such as bunion pads, splints, insoles or shields available from community pharmacies

  • Specialist podiatry/biomechanical referral (where available)

AND

• The patient suffers from significant functional impairment (please refer to FAQs):

AND

• Functional impairment is caused by either severe deformity (overriding toes) or significant pain.

**Carpal Tunnel Surgery**

**Background:** Evidence from observational studies shows that symptoms resolve spontaneously in some people: good prognostic indicators are short duration of symptoms, a young age, and carpal tunnel syndrome due to pregnancy.

There is good evidence that surgical treatment relieves the symptoms of carpal tunnel syndrome (CTS) more effectively than splinting. However splinting is effective in about 50% of people in the short term. Carpal tunnel surgery is a low priority procedure for patients with intermittent or mild to moderate symptoms.
**Referral guidance:** Consider referral for electromyography and nerve conduction studies if the diagnosis is uncertain.

**Policy: Carpal tunnel surgery will be funded if the following criteria are met:**

- Confirmation that the referrer and the patient have discussed the NHS Rightcare Shared Decision-Making tool on carpal tunnel syndrome [http://sdm.rightcare.nhs.uk/pda/carpal-tunnel-syndrome/introduction/](http://sdm.rightcare.nhs.uk/pda/carpal-tunnel-syndrome/introduction/)

**AND**

- Symptoms persist or recur after at least 3 months of conservative therapy, including 8 weeks of nocturnal splinting and local corticosteroid injections if clinically appropriate.

**AND EITHER**

- There is neurological deficit, for example sensory blunting, thenar muscle wasting or motor weakness

**OR**

- There are severe symptoms that significantly interfere with daily activities (see FAQs)

**Cervical Spinal Disc Prosthesis**

**Policy:** Cervical spinal disc prosthesis is not routinely funded for degenerative cervical disc disease

**Cholecystectomy (for asymptomatic gall stones)**

**Background:** Cholecystectomy is the surgical removal of the gall bladder. Prophylactic cholecystectomy is not indicated in most patients with asymptomatic gallstones. Possible exceptions include patients who are at increased risk for gallbladder carcinoma or gallstone complications, in which prophylactic cholecystectomy or incidental cholecystectomy at the time of another abdominal operation can be considered. Although patients with diabetes mellitus may have an increased risk of complications, the magnitude of the risk does not warrant prophylactic cholecystectomy.

**Policy:** Cholecystectomy for asymptomatic gall stones will only be funded in exceptional clinical circumstances through an Individual Funding Request. Bile duct clearance and laparoscopic cholecystectomy will be funded for both symptomatic and asymptomatic stones in the common bile duct.

**Note:** The referrer should include evidence that the risk and benefits have been discussed with the patient using the NHS Rightcare Shared Decision-Making tool [http://sdm.rightcare.nhs.uk/pda/gallstones/introduction/](http://sdm.rightcare.nhs.uk/pda/gallstones/introduction/)

**Circumcision**

**Background:** Circumcision is a surgical procedure that involves partial or complete removal of the foreskin of the penis. It is an effective procedure and confers benefit for a range of medical indications.

**Policy:** Circumcision is not funded for social, cultural or religious reasons. Circumcision
will only be funded for specific medical reasons in accordance with the criteria specified below.

Medical reasons for funding circumcision include:

- Carcinoma of the penis.
- Pathological phimosis: the commonest cause is lichen sclerosus – balanitis xerotica obliterans (BXO) is an old fashioned descriptive term
- Recurrent episodes of balanoposthitis

Relative indications for circumcision or other foreskin surgery:

- Prevention of urinary tract infection in patients with an abnormal urinary tract
- Recurrent paraphimosis
- Traumatic (e.g. zipper injury)
- Tight foreskin causing pain on arousal/interfering with physical function
- Congenital abnormalities.

### Complementary and Alternative Medicines

**Background:** Complementary and alternative medicines (CAMs) are treatments that fall outside of mainstream healthcare. These medicines and treatments range from acupuncture, massage and homeopathy to aromatherapy, meditation transcutaneous electrical nerve stimulation (TENS) and colonic irrigation.

**Policy:** Complementary and alternative therapies, outside of existing CCG commissioned services and pathways, will not be routinely funded.

### Dupuytren’s Contracture

**Policy:** Surgery of Dupuytrens contracture will only be funded in accordance with the criteria specified below:

- Flexion deformity >30° at the MCPJoint or PIPJoint
  - OR
  - Rapidly progressive disease
  - OR
  - Contracture interferes with lifestyle and/or occupation

### Collagenase injections

- Limited to one joint or cord
AND
- Flexion contracture is greater than 40º from the horizontal plane

Radiotherapy for Dupuytren's contracture is not routinely funded.

**Excimer Laser for Cases with Poor Refraction After Corneal Transplant or Cataract Surgery**

**Background:** This is a last resort measure where all other conservative and surgical interventions have failed.

**Policy:** This procedure will only be funded if all other conservative and surgical interventions have failed.

**Exogen Ultrasound Bone Healing**

**Policy:** Exogen ultrasound for bone healing only be funded in accordance with the criteria specified below:
- Where there is a long bone fracture with non-union (failure to heal after 9 months)

**Extracorporeal Shock Wave Therapy for Plantar Fasciitis**

**Policy:** Extracorporeal shock-wave therapy for plantar fasciitis is not routinely funded.

**Face Lift or Brow Lift**

**Background:** These surgical procedures are performed to lift the loose skin of the face and forehead to get a firm and smoother appearance of the face. These procedures will not be funded to treat the natural processes of ageing or to achieve a cosmetic outcome.

**Policy:** Face lift or brow lift will only be funded in accordance with the criteria specified below.

These procedures will only be considered for treatment of the functional impairments arising from:
- Congenital facial abnormalities
- Facial palsy (congenital or acquired paralysis)
- As part of the treatment of specific conditions affecting the facial skin eg. Cutis laxa, pseudoxanthoma elasticum, neurofibromatosis
- To correct the functional consequences of trauma
- To correct functional consequences of deformity following surgery
- In some cases of impaired visual fields, where it may be a more appropriate primary procedure than blepharoplasty
Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p9.

Fertility Preservation for Cancer Patients

Best practice recommends that the consideration of the potential impact of the cancer treatment on fertility is one of the issues that should be discussed before that treatment is started. In some cases the individual's fertility will return after the cancer treatment is completed but in other cases fertility never returns, or is severely impaired.

Preservation of fertility involves some form of freezing, technically called cryopreservation. The methods used in this service involve the cryopreservation of semen, oocytes and embryos. The service does not cover the storage of ovarian or testicular tissue.

Policy: Fertility preservation will be funded through requests from adult and paediatric oncology teams in accordance with the criteria specified below:

**Men:** The service should be offered to men and adolescent boys who are preparing for medical treatment for cancer that is likely to make them infertile. Adolescent boys who may also be capable of producing mature sperm and therefore benefiting from semen storage should be known to those treating their cancer and specialist advice and counselling should be available.

**Women:** The service should be offered to women of reproductive age (including adolescent girls) who are preparing for medical treatment for cancer that is likely to make them infertile if:

- they are well enough to undergo ovarian stimulation and egg collection
  - *AND*
- this will not worsen their condition
  - *AND*
- enough time is available before the start of their cancer treatment.

Staff must be aware of and take account of the child protection law for anyone under the age of 18.

The service will store cryopreserved material for an initial period of 10 years. The service will offer men the option to continue the storage of cryopreserved sperm beyond the 10 years if they remain at risk of significant infertility.

Ganglia

**Background:** Ganglia are benign fluid filled, firm and rubbery lumps attached to the adjacent underlying joint capsule, ligament, tendon or tendon sheath. They occur most commonly around the wrist, but also around fingers, ankles and the top of the foot. They are usually painless and completely harmless. Many resolve spontaneously especially in children (up to 80%). Reassurance should be the first therapeutic intervention. Aspiration alone can be successful but recurrence rates are up to 70%. Surgical excision is the most invasive therapy but recurrence rates up to 40% have been reported. Complications of surgical excision include scar sensitivity, joint stiffness and distal numbness.

**Referral guidance:** Include reference to the degree of pain and restriction of normal activities
caused by the ganglion.

Policy: Surgical treatment for ganglia will only be funded in accordance with the criteria specified below.

- There is significant pain and/or a significant functional impairment affecting activities of daily living (see FAQs)

Groin Hernia

Background: An inguinal hernia is the most common hernia (about 70% of all hernias). Femoral hernias account for less than 10% of all groin hernias. However, they frequently become incarcerated or strangulated due to the small size of this space through which they protrude and hence present as emergencies in most cases with 40% presenting as emergencies. The incidence of femoral hernias is higher in women than men. In general, women have an increased risk of emergency procedure from groin hernias compared to men.

Policy: Referral to secondary care and subsequent surgical treatment will be provided where patients meet one or more of the following criteria:

- History of incarceration, difficulty in reducing the hernia, OR
- Increased risk of strangulation (high risk in female patients) OR
- Inguino-scrotal hernia OR
- Progressive increase in size of hernia (month-on-month) OR
- Significant pain or discomfort sufficient to cause significant functional impairment (see FAQs)

AND

- The referrer should include evidence that the risk and benefits have been discussed with the patient using the NHS Rightcare Shared Decision-Making tool http://sdm.rightcare.nhs.uk/pda/inguinal-hernia/

Grommets in Children

Background: Otitis media with effusion (OME) has a good prognosis. It is a self-limiting condition and 90% of children will have complete resolution within 1 year. Active observation for at least 3 months (watchful waiting) rarely results in long-term complications. There is no proven benefit from treatment with any medication or complementary or alternative treatments. Insertion of ventilation tubes, or grommets, is the most common surgical treatment. Evidence suggests that the benefit of grommets on children’s hearing gradually decreases in first year of

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4 https://www.hernia.org/types/femoral-hernia/

insertion.

The procedure improves hearing in the short term (up to 12 months after surgery) but has not been shown to improve language or speech development. Parents/ cares should have the risks and benefits of treatment clearly discussed with them. Use the NHS Rightcare Shared Decision Making tool on glue ear [http://sdm.rightcare.nhs.uk/pda/glue-ear/]

**Referral for a Specialist opinion when:**

- Persistence of bilateral otitis media with effusion (OME) and hearing loss over 3 months
- If hearing loss of any level is associated with a significant impact on the child’s developmental, social, or educational status.
- If hearing loss is severe.
- The hearing loss persists on two documented occasions (usually following repeat testing after 6–12 weeks).
- The tympanic membrane is structurally abnormal (or there are other features suggesting an alternative diagnosis).
- There is a persistent, foul-smelling discharge suggestive of a possible cholesteatoma. (Referral should be urgent within 2 weeks).
- The child has Down's syndrome or has a cleft palate.

**Ventilation tube (grommet) insertion will be funded in accordance with NICE guidance:**

- There is evidence that the risks and benefits of treatments options have been clearly discussed with the parent/ carer using the NHS Rightcare Shared Decision Making tool [http://sdm.rightcare.nhs.uk/pda/glue-ear/]
- Children with persistent bilateral OME documented over a period of 3 months with a hearing level in the better ear of 25–30 dBHL or worse, when averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available).
- Exceptionally in children with persistent bilateral OME with a hearing loss less 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.

**Note:** Adjuvant adenoidecetomy is not recommended in the absence of persistent and/or frequent upper respiratory tract symptoms.

**Gynaecomastia**

**Background:** Gynaecomastia is benign enlargement of the male breast. Most cases are idiopathic. For others endocrinological disorders and certain drugs such as oestrogens,
gonadotrophins, digoxin, spironolactone, cimetidine and proton pump inhibitors could be the primary cause. Obesity can also give the appearance of breast development as part of the wide distribution of excess adipose tissue. Early onset gynaecomastia is often tender but this usually resolves in 3 to 4 months.

Full assessment of men with gynaecomastia should be undertaken, including screening for endocrinological and drug related causes and necessary treatment is given prior to request for NHS funding. It is important to exclude inappropriate use of anabolic steroids or cannabis.

**Policy: Surgery to correct gynaecomastia will not be routinely funded.**

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p9**

**Hair Grafting – Male Pattern Baldness and Hair Transplantation**

**Background:** male pattern baldness is a common type of hair loss and for many men it is a normal process at whatever age it occurs. Almost all men have some baldness in their 60s. Hair grafting is mostly done for aesthetic reasons.

**Policy: Hair grafting for male pattern baldness will not be funded. Hair transplantation will not normally be funded**

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p9**

**Hip Prostheses and Resurfacing**

**Policy:** Prostheses for total hip replacement and resurfacing arthroplasty will only be funded where the prosthesis to be used has a rate (or projected rate) of revision of 5% or less at 10 years (ODEP 10A* rating, or A* rating at less than 10 years).

**Hip Replacement Surgery**

**Policy:** Hip replacement surgery will only be funded in accordance with the criteria specified below:

- The patient has accessed core (non-surgical) treatment options for at least 3 months as part of their management plan:
  - Access to appropriate information as an ongoing, integral part of the management plan rather than a single event at time of presentation
  - Access to activity and exercise including aerobic fitness and local muscle strengthening irrespective of age, co-morbidity, pain severity or disability
  - Access to facilitated interventions to achieve weight loss if the patient is overweight or obese. Use the NHS Rightcare Shared Decision-making tool on weight loss.
    http://sdm.rightcare.nhs.uk/pda/obesity/introduction/

**AND**

- The patient has moderate to severe persistent joint pain that is refractory to non-surgical treatment, including joint injections and recommended use of non-steroidal anti-inflammatory and other analgesics and has a substantial impact on their quality of life.
AND

- There is clinically significant moderate to severe functional limitation which is refractory to use of walking aids and other forms of physical therapies and results in diminished quality of life (see FAQs)

AND

- Evidence that the risks and benefits of treatments options have been clearly discussed with the patient using the NHS Rightcare Shared Decision Making tool http://sdm.rightcare.nhs.uk/pda/osteoarthritis-of-the-hip/introduction/

Note: referral for joint surgery should be considered before there is prolonged and established functional limitation and significant pain.

Hirsutism

Background: Laser treatment is increasingly being used as a cosmetic intervention to remove body hair. Patients with excessive body hair are described as having hirsutism. Hair depilation (for the management of hypertrichosis) involves permanent removal/reduction of hair from face, neck, legs, armpits and other areas of body usually for cosmetic reasons. Hair depilation is most effectively achieved by laser treatment.

Policy: Hair depilation will only be funded in accordance with the criteria specified below.

One course of treatment will be funded for those patients:

- Who are undergoing treatment for pilonidal sinuses to reduce recurrence

Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p9

Hyperhidrosis Treatment with Botulinium Toxin

Background: Hyperhidrosis is a condition characterised by excessive sweating, and can be generalised or focal. Generalised hyperhidrosis involves the entire body, and is usually part of an underlying condition, most often an infectious, endocrine or neurological disorder. Focal hyperhidrosis is an idiopathic disorder of excessive sweating that mainly affects the axillae, the palms, the soles of the feet, armpits and the face of otherwise healthy people. The principal management strategies for hyperhidrosis are medical http://cks.nice.org.uk/hyperhidrosis#!scenario.

Botulinum Toxin is only licensed for the treatment of severe axillary hyperhidrosis and its cost effectiveness compared to other treatment options is yet to be established.

Policy: Botulinum Toxin will only be funded in the management of severe axillary hyperhidrosis in accordance with the criteria below:

- The search for an underlying cause has been exhausted

AND

- Advice on lifestyle management has been followed (use an antiperspirant frequently, Avoid
tight clothing and manmade fabrics, wear white or black clothing to minimize the signs of sweating, consider dress shields to absorb excess sweat)

AND

- 20% aluminium chloride hexahydrate has failed or is contraindicated

AND

- Any underlying anxiety has been identified and managed

AND

- In the opinion of an experienced dermatologist, other treatment options have been exhausted

**Hysterectomy for Heavy Menstrual Bleeding**

Hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding.

**Policy:** For women diagnosed with heavy menstrual bleeding (menorrhagia), with or without fibroids, hysterectomy will not be commissioned unless ALL of the following criteria are met:

- Recommendations for the medical treatment of heavy menstrual bleeding (and/or symptomatic large or multiple fibroids) set out in NICE Clinical Guideline No. 44 for Heavy Menstrual Bleeding (https://www.nice.org.uk/guidance/cg44) have failed, or are contraindicated. This includes the use of a progestogen-releasing intrauterine device (levonorgestrel releasing systems - LNG-IUS).

AND

- Uterine endometrial ablation methods have failed or are not clinically appropriate.

AND

- The woman has been fully informed of the implications of surgery, and does not wish to retain her uterus and fertility.

AND

- Evidence that the risks and benefits of treatments options have been clearly discussed with the patient using the NHS Rightcare Shared Decision Making tool http://sdm.rightcare.nhs.uk/pda/menorrhagia/

**Invitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI)**

This policy describes the eligibility criteria for NHS funded infertility treatment including:

- In vitro fertilisation (IVF)

- Intracytoplasmic sperm injection (ICSI)

This policy does not apply to the investigation and assessment of infertility in general.

**Background:** The Clinical Guideline on *fertility assessment and treatment* was published by NICE in February 2013 (NICE CG156, 2013) and covers all clinical procedures/pathways relating to fertility assessment and treatment.

This document provides a single infertility specific commissioning policy for the NHS with the aim to
ensure consistency in the application of the guideline across the North East region.

Over 80% of couples in the general population will conceive within 1 year if:

- the woman is aged under 40 years
  AND
- they do not use contraception and have regular sexual intercourse (every 2 – 3 days).

Of those who do not conceive in the first year, about half will do so in the second year (cumulative pregnancy rate over 90%). [NICE 2004, amended 2013].

The estimated prevalence of infertility is one in seven couples in the UK. A typical Clinical Commissioning Group can expect about 230 new consultant referrals (couples) per 250,000 head of population per year (NICE CG11, 2004).

All couples are eligible for consultation and advice from the specialist service.

**Definition of infertility:** A woman of reproductive age who has not conceived after 1 year of unprotected vaginal sexual intercourse, in the absence of any known cause of infertility, should be offered further clinical assessment and investigation along with her partner. IVF will only be funded after at least 2 years of unexplained infertility.

Offer an earlier referral for specialist consultation to discuss the options for attempting conception, further assessment and appropriate treatment where:

- the woman is aged 36 years or over
- there is a known clinical cause of infertility or a history of predisposing factors for infertility.

**Definition of a full cycle:** This term is used to define a full IVF treatment, which should include 1 episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryo(s).

Additional background notes to accompany this policy are available on request.

**Policy:** Funding for egg donation and/or surrogacy is not routinely funded. IVF treatment involving a privately arranged surrogate is undertaken at the discretion of the provider. IVF treatment will be funded in accordance with the criteria specified below:
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<th>Ref</th>
<th>Eligibility criteria for treatment</th>
<th>Definition</th>
<th>Additional Notes</th>
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</table>
| 1.  | Female Age – under 40 years      | In women aged under 40 years who have not conceived after 2 years of regular unprotected intercourse or 12 cycles of artificial insemination using partner’s sperm or 6 cycles of donor sperm (where six or more are by intracytoplasmic sperm injection (ICSI). If the woman reaches the age of 40 during treatment, complete the current full cycle but do not offer further full cycles. For people with unexplained infertility, mild endometriosis or 'mild male factor infertility', who are having regular unprotected sexual intercourse: do not routinely offer intrauterine insemination, either with or without ovarian stimulation (exceptional circumstances include, for example, when people have social, cultural or religious objections to IVF) advise them to try to conceive for a total of 2 years before IVF will be considered. | 3 full cycles of IVF  
Inform people that normally a full cycle of IVF treatment, with or without ICSI should comprise 1 episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryo(s)  
The age limit also applies to all treatments including those using gonadotrophins for fertility treatment including ovulation induction and for donor insemination.  
Access to three cycles is not an automatic right – the outcome of any previous cycle will be taken into account. Treatment must be medically indicated at the start of each cycle.  
As IVF success rates decline significantly after 3 cycles, previous cycles received irrespective as to whether they were funded by the NHS or privately will be taken into account.  
If patients have funded 3 or more IVF cycles privately they will not be entitled to any NHS funded cycles.  
If patients have funded 2 cycles privately they will be entitled to 1 NHS cycle.  
If patients have funded 1 cycle privately they will be entitled to 2 NHS cycles. |
<p>| 2.  | Female Age – 40 to 42 years       | In women aged 40–42 years who have not conceived after 2 years of regular unprotected intercourse or 12 cycles of artificial insemination using partner’s sperm or 6 cycles of donor sperm (where 6 or more are by intracytoplasmic sperm injection), offer 1 full cycle of IVF (Including associated frozen/thaw transfers) provided that all other criteria are met. | 1 full cycle of IVF |</p>
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|     | cycle of IVF, with or without ICSI, provided all the following 4 criteria are fulfilled: | | Ovarian reserve testing  
The aim is to select those with at least 10% chance of successful treatment. The criteria remain under review. At present use the following criteria to predict the likely ovarian response to gonadotrophin stimulation in women who are eligible for IVF treatment.  
- total antral follicle count of more than or equal to 4  
- anti-Müllerian hormone of more than or equal to 5.4 pmol/l. |
|     | - They have never previously had IVF treatment  
AND  
- There is evidence of good ovarian reserve as identified by a specialist clinician  
AND  
- There has been a discussion of the additional implications of IVF and pregnancy at this age  
AND  
- Specialist clinical opinion that there is no likelihood of pregnancy with expectant management e.g. confirmed tubal blockage (absolute infertility) | | |
|     | Treatment must start before the woman’s 43rd birthday | | |
| 3.  | Minimum length of unexplained infertility | 2 years of regular unprotected intercourse and unexplained infertility at time of treatment. | Unexplained infertility is a diagnosis made by exclusion in couples who have not conceived and in whom standard investigations including semen analysis, tubal patency tests and assessment of ovulation have not detected any abnormality. |
| 4.  | Female Body Mass Index (BMI) | BMI greater than 19.0 and lower than or equal to 30.0 at the start of treatment. This applies to all treatments including those using gonadotrophins for fertility treatment including ovulation induction and for donor insemination. | This criterion reflects the increased efficacy of infertility treatment in this weight range. Women with a BMI of 30 or above should be informed that:  
- They are likely to take longer to conceive  
- If they are not ovulating then losing weight is likely to increase their chance of conception  
Women who have a BMI less than 19 and who have irregular menstruation or are not menstruating should be advised that increasing body weight is |
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<tr>
<td>5.</td>
<td><strong>Male Body Mass Index (BMI)</strong></td>
<td>If the male partner has mild male factor infertility which, after clinical assessment could be improved should weight be reduced, then the male partner should be re-assessed for fertility once weight has reduced to a BMI of 30 or below</td>
<td>Men who have a BMI of 30 or over should be informed that they are likely to have reduced fertility</td>
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<td>6.</td>
<td><strong>Existing children</strong></td>
<td>Treatment will only be offered to couples where neither partner has any living children from current or previous relationship. This applies to all treatments including those using gonadotrophins for fertility treatment including ovulation induction and for donor insemination.</td>
<td>This criterion includes adopted children, but excludes fostered children.</td>
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<td>7.</td>
<td><strong>Smoking Status</strong></td>
<td>Both partners should be non-smokers when referred for IVF. This is part of primary care general assessment procedures. Assessment of smoking status will be through the use of carbon monoxide monitors in primary care or stop smoking services. This applies to all treatments including those using gonadotrophins for fertility treatment including ovulation induction and for donor insemination.</td>
<td>Women who smoke should be informed that this is likely to reduce their fertility. Women who smoke should be offered a referral to a smoking cessation programme to support their efforts to stop smoking. Women should be informed that passive smoking is likely to affect their chance of conceiving. Men who smoke should be informed that there is an association between smoking and reduced semen quality.</td>
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<td>8.</td>
<td><strong>Same sex couples and single women</strong></td>
<td>Treatment will only be offered where the partner wishing to become pregnant is sub-fertile. Documentary evidence for subfertility is either no live birth following donor insemination from an accredited sperm bank for at least six cycles over two years or absolute infertility documented after clinical investigation.</td>
<td>Treatment is offered to couples irrespective of sexual orientation. The NHS does not fund donor insemination to establish fertility in same sex couples.</td>
</tr>
<tr>
<td>9.</td>
<td><strong>Previous Sterilisation</strong></td>
<td>No previous sterilisation history in either partner. This applies to all treatments including those using gonadotrophins for fertility.</td>
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<tr>
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<td>treatment including ovulation induction and induction of spermatogenesis, and for donor insemination.</td>
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<tr>
<td>10.</td>
<td>Length of time resident in catchment area</td>
<td>Both partners should be patients registered for one year with a GP practice that is itself a member of one of the Clinical Commissioning Groups subscribing to these policies. This applies to all treatments including those using gonadotrophins for fertility treatment including ovulation induction and for donor insemination.</td>
<td>This excludes short term students who are otherwise eligible for NHS treatment.</td>
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<tr>
<td>11.</td>
<td>Residence in UK</td>
<td>Must be eligible for free hospital treatment in line with the Overseas Visitors Charging Regulations. This applies to all treatments including those using gonadotrophins for fertility treatment including ovulation induction and for donor insemination.</td>
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**Knee Arthroscopy**

**Policy:** Knee arthroscopy will only be funded in accordance with the criteria specified below:

- Clinical examination (or MRI scan) 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.

In exceptional cases, intractable knee pain considered likely to benefit from arthroscopic treatment according to assessment by a Consultant Knee Surgeon.

There is continuing diagnostic uncertainty following MRI, such that a Consultant Knee Surgeon recommends diagnostic arthroscopy.

**Arthroscopy is not commissioned:**

- For diagnostic purposes only (noting the exception above);

- To provide arthroscopic washout alone as a treatment for chronic knee pain due to osteoarthritis. This procedure may be appropriate in conditions such as septic arthritis.

This policy restriction does not apply where there is an urgent need for investigation/treatment.
Knee Replacement Surgery

Policy: Knee replacement surgery will only be funded in accordance with the criteria specified below:

- The person has been offered the core (non-surgical) treatment options for at least 3 months as part of their management plan:
  - Access to appropriate information as an ongoing, integral part of the management plan rather than a single event at time of presentation
  - Access to activity and exercise including aerobic fitness and local muscle strengthening irrespective of age, co-morbidity, pain severity or disability
  - Access to facilitated interventions to achieve weight loss if the patient is overweight or obese. Use the NHS Rightcare Shared Decision Making Tool on weight loss [http://sdm.rightcare.nhs.uk/pda/obesity/introduction/](http://sdm.rightcare.nhs.uk/pda/obesity/introduction/)

AND

- The patient has moderate to severe persistent joint pain that is refractory to non-surgical treatment, including joint injections and recommended use of non-steroidal anti-inflammatories and other analgesics and has a substantial impact on their quality of life.

AND

- There is clinically significant moderate to severe functional limitation which is refractory to use of walking aids and other forms of physical therapies and results in diminished quality of life (see FAQs)

AND

- Evidence that the risks and benefits of treatments options have been clearly discussed with the patient using the NHS Rightcare Shared Decision Making tool [http://sdm.rightcare.nhs.uk/pda/osteoarthritis-of-the-knee/](http://sdm.rightcare.nhs.uk/pda/osteoarthritis-of-the-knee/)

Note: referral for joint surgery should be considered before there is prolonged and established functional limitation and significant pain.

Liposuction

Background: Liposuction (also known as liposculpture), is a surgical procedure performed to improve body shape by removing unwanted fat from areas of the body such as abdomen, hips, thighs, calves, ankles, upper arms, chin, neck and back. Liposuction is sometimes done as an adjunct to other surgical procedures.

Policy: Liposuction simply to correct the distribution of fat will not be funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p9.

Pinnaplasty

Background: Pinnaplasty is performed for the correction of prominent ears or bat ears. Prominent ears are a condition where one's ears stick out more than normal.
Correction is considered to be a primarily a cosmetic procedure. Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p 8.

The exception to this policy is procedures (remodelling of external ear lobe) in children with congenital abnormalities of the ear to improve hearing as this is covered by Specialised commissioning and should be managed through the specialised commissioning route. Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p 8.

**Policy:** Pinnaplasty will not routinely be funded.

**Removal of Benign Skin Lesions Including Scars**

**Background:** Benign skin lesions (across the body including eyelids) include a wide range of skin disorders such as sebaceous cyst, dermoid cyst, lipoma(ta), skin tags (including anal skin tags), , milia, molluscum contagiosum, seborrhoeic keratoses (basal cell papillomata), spider naevus (telangiectasia), viral warts (excluding in immunocompromised patients), sebaceous cysts, thread veins, xanthelasma, dermatofibromas, benign pigmented moles, comedones and corn/callous.

Disfiguring scars and keloid or hypertrophic scars (including acne scarring), whether arising from prior injury or surgery, are also included in the scope of this policy.

Mostly these are removed on purely cosmetic grounds. The risks of surgical scarring must be balanced against the appearance of the lesion. Patients with multiple subcutaneous lipomata may need a biopsy to exclude neurofibromatosis.

**Policy:** Removal, cryotherapy or treatment (in secondary care) of benign skin lesions will only be funded in accordance with the criteria specified below:

- There is well documented evidence of significant pain (see FAQs)
- OR
- recurrent infection
- OR
- recurrent bleeding
- OR
- is subject to unavoidable recurrent trauma leading to bleeding

Where the lump is rapidly growing, abnormally located and/or is displaying features suspicious of malignancy, specialist assessment should be sought using the 2 week wait pathway.

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p9**

**Note:** If an IFR is obtained for the treatment of a keloid or hypertrophic scar, the number of treatments with intralesional triamcinolone will be limited to 3.

**Removal of Tattoos**

A tattoo is defined as a form of body modification, made by inserting indelible ink into the dermis layer of the skin to change the pigment.
Policy: Tattoo removal will not be routinely funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding - see p9

Repair of Lobe of External Ear

Background: The external ear lobe can split partially or completely as result of trauma or wearing ear rings. Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk.

Policy: Repair of lobe of external ear will only be funded in accordance with the criteria specified below.

- If the totally split ear lobe is a result of direct trauma and the treatment is required at the time of, or soon after the acute episode and before permanent healing has occurred.

Surgery for primarily cosmetic reasons is not eligible for NHS funding - see p9

Resurfacing Procedures: Dermabrasion, Chemical Peels and Laser Treatment

Background: Dermabrasion involves removing the top layer of the skin with an aim to make it look smoother and healthier. Scarring and permanent discolouration of skin are the rare complications. This policy includes all laser skin treatments, for example for Rhinophyma or Rosacea.

Policy: Resurfacing procedures will not be routinely funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding - see p9

Reversal of Female Sterilisation

Background: Reversal of sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes.

Sterilisation procedure is available on the NHS and couples seeking sterilisation should be fully advised and counselled (in accordance with RCOG guidelines) that the procedure is intended to be permanent.

Policy: Reversal of sterilisation will not be routinely funded.

Reversal of Male Sterilisation

Background: Reversal of male sterilisation is a surgical procedure that involves the reconstruction of the vas deferens.

Sterilisation procedure is available on the NHS and couples seeking sterilisation should be fully advised and counselled (in accordance with RCOG guidelines) that the procedure is intended to be permanent.
Policy: Reversal of sterilisation will not be routinely funded.

**Rhinoplasty**

**Background:** rhinoplasty is a surgical procedure performed on the nose to change its size or shape or both. People usually ask for this procedure to improve self-image.

**Policy:** Rhinoplasty will only be funded in accordance with the criteria specified below:

- Problems caused by obstruction of the nasal airway
- Correction of complex congenital conditions to improve function e.g. cleft lip and palate.

*Surgery for primarily cosmetic reasons is not eligible for NHS funding - see p9*

**Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat**

**Background:** These surgical procedures are performed to remove loose skin or excess fat to reshape body contours. As the patient groups seeking such procedures are similar to those seeking abdominoplasty (see above), the functional disturbance of skin excess in these sites tends to be less and so surgery is less likely to be indicated except for appearance, in which case it should not be available on the NHS.

**Policy:** These procedures will not be routinely funded.

*Surgery for primarily cosmetic reasons is not eligible for NHS funding - see p9*

**Tonsillectomy**

**Background:** Tonsillectomy is one of the most common surgical procedures in the UK. There is good evidence for the effectiveness of tonsillectomy in children but only limited evidence in adults.

**Policy:** Tonsillectomy will only be funded in accordance with the criteria specified below.

For recurrent acute sore throat in adults and children in the following circumstances:

- The sore throats are due to tonsillitis;
- The episodes of sore throat are disabling and prevent normal functioning
- Seven or more well documented, clinically significant, adequately treated episodes of sore throat in the previous year;
- Five or more such episode have occurred in each of the previous two years
- Three or more such episodes have occurred in each of the previous three years

This policy does not apply to suspected malignancy, management of acute quinsy, bleeding or
deep neck infection or OSAS in children.

There is no restriction on funding for tonsillectomy to treat adult obstructive sleep apnoea with tonsillar enlargement (if trials of continuous positive airway pressure (CPAP) and the use of mandibular advancement devices are unavailable or unsuccessful).

Tonsillectomy for the treatment of halitosis associated with tonsilloliths will not be routinely funded.

**Trigger Finger**

**Policy:** Surgery for trigger finger will only be funded in accordance with the criteria specified below:

- The patient has co-morbidities associated with an increased risk of trigger finger (e.g. rheumatoid arthritis or diabetes mellitus) and the patient’s symptoms have not improved with at least 4 months of conservative treatment (e.g. NSAIDs, splintage, physiotherapy).
  OR
- The patient’s symptoms have not resolved despite at least one steroid injection in the last 4 months.
  OR
- The specialist opinion is that surgery is needed promptly to prevent the development of flexion contractures.

**Vaginoplasty, Labial Vulvoplasty and Vulvar Lipoplasty**

Surgery for Vaginoplasty, Labial Vulvoplasty and Vulvar lipoplasty are all cosmetic procedures. This policy does not cover vaginal repair following delivery and is part of obstetric or gynaecological treatment. Clinicians should refer to the following guidance from the Royal College of Obstetricians and Gynaecologists: [Joint RCOG BritSPAG release - vaginoplasty](#)

**Policy:** Vaginoplasty will not routinely be funded.

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p9**

**Varicose Veins in the Leg**

**Background:** Varicose veins are dilated, often palpable subcutaneous veins with reversed blood flow. They are most commonly found in the legs. Estimates of the prevalence of varicose veins vary. Visible varicose veins in the lower limbs are estimated to affect at least a third of the population. Risk factors for developing varicose veins are unclear, although prevalence rises with age and they often develop during pregnancy.

In some people varicose veins are asymptomatic or cause only mild symptoms, but in others they cause pain, aching or itching and can have a significant effect on their quality of life. Varicose veins may become more severe over time and can lead to complications such as changes in skin pigmentation, bleeding or venous ulceration. It is not known which people will develop more severe disease but it is estimated that 3–6% of people who have varicose veins in their lifetime will develop venous ulcers.
Referral to a vascular service guidance\(^1\) : Refer people with bleeding varicose veins to a vascular service\(^6\) immediately.

Referral guidance: Refer people to a vascular service\(^1\) if they have any of the following:

- History of bleeding from a varicosity which are at risk of bleeding again
- Ulceration which is progressive and/or causing significant pain despite treatment
- Active or healed ulceration and/or progressive skin changes that may benefit from surgery
- Recurrent superficial thrombophlebitis
- Significant pain attributable to varicose veins having a severe impact on quality of life and interfering with activities of daily living (see FAQ).

Assessment and treatment in a vascular service\(^1\)

Assessment: Use duplex ultrasound to confirm the diagnosis of varicose veins and the extent of truncal reflux, and to plan treatment for people with suspected primary or recurrent varicose veins.

Interventional treatment: For people with confirmed varicose veins and truncal reflux:

- Offer endothermal ablation and Endovenous laser treatment of the long saphenous vein
- If endothermal ablation is unsuitable, offer ultrasound-guided foam sclerotherapy
- If ultrasound-guided foam sclerotherapy is unsuitable, offer surgery.

If incompetent varicose tributaries are to be treated, consider treating them at the same time.

Non-interventional treatment: Compression hosiery to treat varicose veins is not recommended unless interventional treatment is unsuitable for clinical reasons or patient choice.

Policy: Interventional treatments for varicose veins outlined above will only be funded in accordance with the criteria specified below.

- Persistent ulceration that is progressive or causing significant pain (see FAQs)
- Recurrent superficial thrombophlebitis where there is significant pain and disability
- Progressive skin changes that suggest potential ulceration due to venous insufficiency
- Significant haemorrhage from a ruptured superficial varicosity

\(^{6}\) A team of healthcare professionals who have the skills to undertake a full clinical and duplex ultrasound assessment and provide a full range of treatment.
● Patients with significant pain attributable to chronic venous insufficiency which is having a significant impact on quality of life and interfering with activities of daily living (see FAQs)

Patients whose primary concern is cosmetic will not be funded for surgical treatment.

**Surgery for primarily cosmetic reasons is not eligible for NHS funding - see page 8.**
<table>
<thead>
<tr>
<th>Revision date</th>
<th>Summary of Changes</th>
</tr>
</thead>
</table>
| May 2012      | Removed the policy on Gender Reassignment surgery in Adults as this is included in Specialised Services Commissioning for Mental Health Services.  
                Removed the reference to Gender Reassignment in the policy on the treatment of hirsutism.  
                Modified the criteria for orthodontic treatment in line with DH guidance.  
                Clarification of the criteria for mastopexy.  
                Clarification of the criteria for Pre-implantation Genetic Diagnosis.                                                                                                                                                                                                 |
| August 2012   | BMI criteria specified to one decimal point.  
                BMI added as a criterion for mastopexy- as excess weight is likely to be a contributing to the magnitude of the problems experienced.  
                BMI added as a criterion for thigh lift- as excess weight is likely to be a contributing to the magnitude of the problems experienced.  
                Excimer laser laser for refractive error limited to patients when all other conservative interventions have failed. This moves the policy in line with prevailing clinical practice  
                Clarification is offered on the rationale for age limits for pinnaplasty.  
                Laser treatment for hirsutism limited to face and neck only- bringing the wording of the policy in line with decision precedents.                                                                                                                                 |
| December 2012 | Cosmetic surgery – inclusion of a general statement applying to a number of procedures.  
                Breast augmentation replacement needing a new funding application.  
                Breast reduction – clarifying the degree of neck ache, back ache and intertrigo; rewording the assessment of breast size.  
                Gynaecomastia – endocrine problems treated before referral  
                Pinnaplasty – removed age criteria.  
                Repair of ear lobe - clarifying the timing of surgery following trauma.  
                Varicose veins – inclusion of progressive skin changes due to venous insufficiency.  
                Resurfacing procedures – clarification of criteria  
                Removal of benign skin lesions – one change in the order of the wording.                                                                                                                                                                                            |
| September 2013| Varicose veins  
                Policy reviewed in light NICE guideline (CG168) published in July 2013 and discussed with chair of the cardiovascular network. Recommended interventions include the newer treatments: endothermal (radiofrequency) ablation endovenous laser treatment of the long saphenous vein and ultrasound-guided foam sclerotherapy. The policy now refers to Interventional rather than surgical treatment |
<table>
<thead>
<tr>
<th>Procedure/Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value Based Clinical Commissioning Policy</td>
<td></td>
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<tr>
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<tr>
<td><strong>BMI criterion for safe surgery</strong></td>
<td>the removal of the criterion for patients to have tried at least 6 months of conservative management, for lack of an evidence base</td>
</tr>
<tr>
<td><strong>Tonsillectomy</strong></td>
<td>Consideration of evidence base for this criterion - all weight related eligibility criteria reviewed</td>
</tr>
<tr>
<td><strong>Fertility treatment</strong></td>
<td>Complete new criterion based policy(s) based on RCS guidance (section on sleep disordered breathing in adults remains)</td>
</tr>
<tr>
<td><strong>Fertility treatment</strong></td>
<td>Policy revised in light of NICE guidelines - age limit raised (in restricted circumstances) but priority for families where both parents are childless remains</td>
</tr>
<tr>
<td><strong>Fertility treatment</strong></td>
<td>The policy covers eligibility for fertility treatments as covered in NICE guidelines. There are further elements of guidance that require consideration, particularly embryo transfer and fertility preservation. Further analysis on these topics is available on request.</td>
</tr>
<tr>
<td><strong>Hyperhidrosis</strong></td>
<td>Added link to CKS best practice guidance</td>
</tr>
<tr>
<td><strong>Hyperhidrosis</strong></td>
<td>Added criteria based on CKS medical management of hyperhidrosis</td>
</tr>
<tr>
<td><strong>Hirsuitism</strong></td>
<td>Eligibility for treatment restricted, no longer available routinely for those with excessive facial hair</td>
</tr>
<tr>
<td><strong>Excimer laser for corneal erosions</strong></td>
<td>Specialised service commissioned by NHS England, policy removed</td>
</tr>
<tr>
<td><strong>Ophthalmology - correction of refractive error</strong></td>
<td>Policy removed as not in Cumbria policy and not considered as a priority - NE and Cumbria policies now consistent</td>
</tr>
<tr>
<td><strong>Rhinophyma</strong></td>
<td>Included Cumbria policy</td>
</tr>
<tr>
<td><strong>Vulvoplasty</strong></td>
<td>Clarification that this is not usually funded</td>
</tr>
<tr>
<td><strong>Keloid scarring</strong></td>
<td>Included Cumbria policy within Benign skin lesions policy</td>
</tr>
<tr>
<td><strong>Breast asymmetry</strong></td>
<td>Default to breast reduction - as in Cumbria policy - new policy guidance and clearer criteria - as distinct from breast augmentation policy</td>
</tr>
<tr>
<td><strong>Breast prosthesis removal or replacement</strong></td>
<td>NHS funding position on part payment clarified</td>
</tr>
<tr>
<td><strong>Gynaecomastia</strong></td>
<td>Changed default to not routinely funded - primary consideration is already of exceptionality</td>
</tr>
<tr>
<td><strong>Pre-implantation genetic diagnosis</strong></td>
<td>specialised service commissioned by NHS England, policy removed</td>
</tr>
<tr>
<td><strong>Reversal of male sterilisation</strong></td>
<td>Clarification that this is not normally funded</td>
</tr>
<tr>
<td><strong>Reversal of female sterilisation</strong></td>
<td>Clarification that this is not normally funded</td>
</tr>
<tr>
<td><strong>Collagen cross-linking for corneal irregularities</strong></td>
<td>specialised service commissioned by NHS England, policy removed</td>
</tr>
<tr>
<td><strong>September 2014</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Carpal tunnel syndrome</strong></td>
<td>Inclusion of shared decision making in the criteria.</td>
</tr>
<tr>
<td><strong>Breast augmentation (Breast enlargement)</strong></td>
<td>Delete specific criteria to emphasise this is not normally funded. Rationale: There appears to be little clinical support to undertake this treatment</td>
</tr>
<tr>
<td>Procedure</td>
<td>Action</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Breast asymmetry</td>
<td>Delete specific criteria to emphasise this is not normally funded.</td>
</tr>
<tr>
<td>Breast prosthesis removal</td>
<td>Limit the funding to criteria to prosthesis removal to make safe only.</td>
</tr>
<tr>
<td>Breast reduction</td>
<td>Change the wording for the severity of functional problems</td>
</tr>
<tr>
<td>Gynaecomastia</td>
<td>Clarification on the place of mastectomy for painful gynaecomastia</td>
</tr>
<tr>
<td>Mastopexy</td>
<td>Delete specific criteria to emphasise this is not normally funded.</td>
</tr>
<tr>
<td>Revision mammoplasty</td>
<td>Policy deleted as covered by other policies.</td>
</tr>
<tr>
<td>Blepharoplasty</td>
<td>Clarification of wording to emphasise that surgery will only be funded for functional problems and not for cosmetic issues.</td>
</tr>
<tr>
<td>Apicectomy</td>
<td>Removed. NHS England commissioning responsibility</td>
</tr>
<tr>
<td>Dental implants</td>
<td>Removed. NHS England commissioning responsibility</td>
</tr>
<tr>
<td>Orthodontic treatments for essentially cosmetic nature</td>
<td>Removed. NHS England commissioning responsibility</td>
</tr>
<tr>
<td>Varicose veins in the legs</td>
<td>Revised wording of criteria around significant discomfort and quality of life as indication for referral and surgical treatment in line with NICE guidance.</td>
</tr>
<tr>
<td>Resurfacing procedures:</td>
<td>Remove specific criteria to emphasise this is not normally funded.</td>
</tr>
<tr>
<td>Dermabrasion, chemical peels</td>
<td></td>
</tr>
<tr>
<td>and laser treatment</td>
<td></td>
</tr>
<tr>
<td>Abdominoplasty or Apronectomy</td>
<td>Remove specific criteria to emphasise this is not normally funded.</td>
</tr>
<tr>
<td><strong>Value Based Clinical Commissioning Policy</strong></td>
<td></td>
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<tr>
<td>---------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>April 2017</strong></td>
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</tr>
<tr>
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<td></td>
</tr>
</tbody>
</table>

- **Removal of benign skin lesions including scars**
  - Deleted the criteria of prominent facial lesion
  - Added repeated infection

- **Thigh lift, buttock lift and arm lift, excision of redundant skin or fat**
  - Remove specific criteria to emphasise this is not normally funded.
  - Rationale: *There appears to be little clinical support to undertake this treatment and there is varied interpretation of criteria. By removing the criteria we are making a consistent statement that the NHS will no longer fund cosmetic surgery. Where applications are submitted emphasis will need to be made on clinical exceptionality.*

- **Infertility Treatment**
  - Clarifying the scope of the policy to IVF and ICSI
  - Females aged 40 to 42 treatment to start before 43rd birthday
  - Same sex couples to include single women
  - For same sex couples clarification around the evidence of infertility based on documentary proof of artificial insemination provided by a reputable centre of at least six cycles over 2 years
  - Clarification of the minimum time of unexplained infertility for IVF.

- **Fertility preservation**
  - This is a new policy developed in response to NICE guidance and endorsed by the North CCG forum.

**November 2015**

- **Breast - Asymmetry**
  - Clarification added that this policy does not apply to breast reconstruction as part of the treatment for breast cancer.

- **Breast - Mastopexy**
  - Clarification added that this policy does not apply to breast reconstruction as part of the treatment for breast cancer.

- **Breast – Prosthesis removal and/or replacement**
  - Clarification added that this policy does not apply to breast reconstruction as part of the treatment for breast cancer.
  - Removal of specific criteria to emphasise that removal of implants is only undertaken for clinical reasons.

- **Breast - Reduction**
  - Removal of criteria detailing documented evidence of intractable intertrigo that has not responded to conservative treatment to ensure consistency across this policy.

- **Cholecystectomy**
  - Criteria amended to include section on bile duct clearance.

- **Circumcision**
  - Clarification added that Circumcision is not funded for social, cultural or religious reasons

- **Infertility Treatment**
  - Title changed to In vitro fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI).
  - Clarification added that this policy does not apply to the investigation and assessment of infertility in general.

- **Pinnaplasty**
  - Removal of narrative detailing the psychological issues faced.

- **Removal of benign skin**
  - Include cryotherapy as removal option.
  - Added more specific criteria to clarify clinical condition of the lesion.
<table>
<thead>
<tr>
<th>Lesions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tonsillectomy</td>
<td>Clarification added that Tonsillectomy for the treatment of halitosis associated with tonsilloliths will not be routinely funded.</td>
</tr>
</tbody>
</table>

### December 2015

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autologous Cartilage Transplantation</td>
<td>New policy inclusion to clarify that treatment is not routinely funded</td>
</tr>
<tr>
<td>Bunions</td>
<td>New policy inclusion</td>
</tr>
<tr>
<td>Discectomy for Lumbar Spine Prolapse</td>
<td>New policy inclusion</td>
</tr>
<tr>
<td>Dupuytrens Contracture</td>
<td>New policy inclusion</td>
</tr>
<tr>
<td>Hip Prosthesis and Resurfacing</td>
<td>New policy inclusion</td>
</tr>
<tr>
<td>Facet Joint Injection</td>
<td>New policy inclusion</td>
</tr>
<tr>
<td>Epidural Injections for Lumbar Back Pain</td>
<td>New policy inclusion</td>
</tr>
<tr>
<td>Exogen Ultrasound Bone Healing</td>
<td>New policy inclusion</td>
</tr>
<tr>
<td>Knee Arthroscopy</td>
<td>New policy inclusion</td>
</tr>
<tr>
<td>Trigger Finger</td>
<td>New policy inclusion</td>
</tr>
<tr>
<td>Cervical Spinal Disc Prosthesis</td>
<td>New policy inclusion to clarify that treatment is not routinely funded</td>
</tr>
<tr>
<td>Extracorporeal Shock-wave Therapy for Planta Fasciitis</td>
<td>New policy inclusion to clarify that treatment is not routinely funded</td>
</tr>
<tr>
<td>Bone Morphogenetic Proteins</td>
<td>New policy inclusion</td>
</tr>
<tr>
<td>In vitro fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI)</td>
<td>Clarity added that funding is not routinely provided for egg donation or surrogacy.</td>
</tr>
<tr>
<td>Breast Reduction</td>
<td>Removal of narrative advising that 500gms of tissue is to be removed as this detail is not always possible to confirm at the time of assessment. Clarity of cup sizing threshold added.</td>
</tr>
</tbody>
</table>

### June 2016

<p>| Frequently Asked Questions                   | Clarification added that psychological distress does not constitute exceptionality                     |</p>
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carpal Tunnel Syndrome</td>
<td>Title amended to Carpal Tunnel Surgery</td>
</tr>
<tr>
<td>Breast Prosthesis Removal</td>
<td>Clarity added that Breast Prosthesis replacement will not routinely be funded</td>
</tr>
<tr>
<td>Tonsillectomy</td>
<td>Clarity added around exclusions to policy</td>
</tr>
<tr>
<td>Rhinoplasty</td>
<td>Removal of criterion indicating that funding can be approved for deformity caused by direct trauma as this is outside of the policy as reduction of facial bones would need to be completed within two weeks of acute trauma and is not defined as rhinoplasty.</td>
</tr>
<tr>
<td>Hip Prosthesis</td>
<td>Clarity added that this is a quality statement around prosthesis.</td>
</tr>
<tr>
<td>Circumcision</td>
<td>Clarity added to the medical indications for treatment.</td>
</tr>
<tr>
<td>November 2016</td>
<td></td>
</tr>
<tr>
<td>Frequently Asked Questions</td>
<td>Clarity added to existing FAQ as well as the addition of new FAQs to provide referrers with additional understanding/clarity around the application and funding processes.</td>
</tr>
<tr>
<td>Cosmetic Treatments</td>
<td>Clarity added that funding will not be provided for treatments that are requested to achieve a cosmetic outcome.</td>
</tr>
<tr>
<td>Autologus Serum Eye Drops</td>
<td>Clarity added that funding will only be provided on a trial basis.</td>
</tr>
<tr>
<td>Back Pain</td>
<td>Inclusion of New Policy</td>
</tr>
<tr>
<td>Breast Prosthesis</td>
<td>Title changed to Breast Prosthesis Removal. Replacement removed from title.</td>
</tr>
<tr>
<td>Breast Reduction</td>
<td>Clarity added that repeat surgery will not be funded.</td>
</tr>
<tr>
<td>Carpal Tunnel</td>
<td>Link to shared decision making tool added.</td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>Link to shared decision making tool added.</td>
</tr>
<tr>
<td>Circumcision</td>
<td>Clarification of wording to emphasis that surgery will only be carried out for functional issues.</td>
</tr>
<tr>
<td>Complementary Therapies</td>
<td>Inclusion of new policy</td>
</tr>
<tr>
<td>Discectomy</td>
<td>Re-termed as Back Pain – Discectomy</td>
</tr>
<tr>
<td>Epidural Injections</td>
<td>Removed as covered within Back Pain Policy</td>
</tr>
<tr>
<td>Face or Brow Lift</td>
<td>Clarity added the funded will only be considered based on functional impairments</td>
</tr>
<tr>
<td>Procedure</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Facet Joint injections</td>
<td>Removed as covered within Back Pain Policy</td>
</tr>
<tr>
<td>Ganglia</td>
<td>Amalgamation of criterion</td>
</tr>
<tr>
<td>Groin Hernia</td>
<td>Inclusion of new policy</td>
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<tr>
<td>Grommets in Children</td>
<td>Inclusion of new policy</td>
</tr>
<tr>
<td>Hip Replacement Surgery</td>
<td>Inclusion of new policy</td>
</tr>
<tr>
<td>Hysterectomy for Heavy Menstrual Bleeding</td>
<td>Inclusion of new policy</td>
</tr>
<tr>
<td>IVF</td>
<td>Clarity added around surrogacy pathways</td>
</tr>
<tr>
<td>Knee Replacement Surgery</td>
<td>Inclusion of new policy</td>
</tr>
<tr>
<td>Lipomata</td>
<td>Treatment type removed as captured within removal of benign skin lesion policy.</td>
</tr>
<tr>
<td>Removal of Tattoo</td>
<td>Definition of a tattoo added for clarity and that funding will not routinely be provided.</td>
</tr>
<tr>
<td>Removal of Benign Skin Lesion</td>
<td>Clarity added to confirm that this policy covers lesions on the eye lid; criterion amended to clarify that suspected malignancy does not fall within the scope of this policy.</td>
</tr>
<tr>
<td>Resurfacing Procedures</td>
<td>Examples provided over treatments within the scope of the policy</td>
</tr>
<tr>
<td>Tonsillectomy</td>
<td>Clarity added to detail the previous history of the patient</td>
</tr>
<tr>
<td>Vaginoplasty</td>
<td>Link added to the RCOG guidelines on this treatment</td>
</tr>
</tbody>
</table>