Partners in improving local health

North of England Commissioning Support

Value Based Clinical Commissioning Policies

North East & North Cumbria Clinical Commissioning Groups

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Contents

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'[1] analyses variation on approaches to this work. This approach was based on the 'Save to Invest' programme developed by the London Health Observatory[2] incorporating the 'Croydon List' of 34 low priority treatments.

This policy sets out a consistent approach by CCGs across the North East and North Cumbria to stop variation in access to NHS services and allow fair and equitable treatment for all local patients. Revisions to the policy are now managed and co-ordinated by a clinically-led North East Policy Development and Review Group.

For clarity there are two differing processes in place to apply for NHS funding for these procedures:

VBC Checker – This is a web-based system which enables primary and secondary care clinicians to obtain an instant funding approval where the patient meets the clinical criteria for the procedure. A patient does not need to follow the Individual Funding Request (IFR) process in these circumstances.

Individual Funding Request (IFR) – The IFR process is to be used in circumstances when a patient does not meet the clinical criteria for a procedure as set out in this policy document but can demonstrate exceptionality in accordance with the definition.

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.'*

[1] Reducing expenditure on low clinical value treatments. Audit Commission, April 2011.. https://www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/lowclinicalvalue/Pages/Default.aspx

[2] Save to Invest: Developing criteria-based commissioning for planned health care in London. Malhotra N. Jacobson B. 2007. https://www.lho.org.uk/Download/Public/11334/1/Save%20To%20Invest%20-%20Commissioning%20for%20Equity.pdf

Frequently Asked Questions (General)

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 (https://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 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

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.

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 and are a statement about what the NHS will routinely pay for.

How has the policy been compiled and developed?

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.

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.

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.

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. The ultimate decision about safety and appropriateness of treatment is a clinical one which must be discussed with the patient.

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 unless they meet the NHS criteria for the device.

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.

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.

What if surgeons undertake procedures outside the indications in these policies?

There is no guarantee of payment in accordance with the legally binding contract.

VBC Checker Frequently Asked Questions

What should VBC Checker be used for?

VBC Checker should be used in the first instance for any patients being referred or treated for any procedures documented within this policy

Which part of the policy is governed by the VBC Checker process?

The whole policy document forms part of the VBC Checker requirements. There are no exclusions to this.

Who can make an application for funding through VBC Checker?

VBC Checker is available to use by both primary and secondary care. If the procedure required is known at the point of referral it is expected that the prior approval ticket (PAT) will be generated by the GP. If the GP refers for an opinion and secondary care clinicians advise that a specific procedure is needed, then the PAT should be generated by secondary care.

What happens if the patient does not meet the criteria?

If the patient does not meet the specific policy criteria and the clinician believes that the patient can demonstrate exceptionality, then the Individual Funding Request (IFR) process should be followed.

What if a GP makes a referral outside the criteria outlined in these policies?

Secondary Care have the option to reject the referral back to primary care for completion of the funding approval or complete the PAT themselves. Both options are supported by CCGs.

Individual Funding Request (IFR) Frequently Asked Questions

When should we use the IFR Process?

The IFR process is to be used in circumstances when a patient does not meet the clinical criteria for a procedure as set out in this policy document but can demonstrate exceptionality in accordance with the definition.

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.'*

Can psychological considerations be taken into account within the definition of exceptionality?

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 Guidance 31)

Should photographs be submitted with the IFR?

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).

How can pain and significant functional impairments/ limitations to activities of daily living endured by patients be demonstrated in an IFR case?

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;
- 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.

[3] Fink, R. (2000) Pain assessment: the cornerstone to optimal pain management, Baylor University Medical Centre Proceedings, 13(3): 236-239

Cosmetic Procedures

Treatments or surgery 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 Guidance CG31 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 or Apronectomy
Breast asymmetry
Breast augmentation (Breast enlargement)
Breast prosthesis removal or replacement
Breast reduction
Bunion surgery
Ganglion removal
Gynaecomastia
Inverted nipple correction
Mastopexy
Revision mammoplasty
Blepharoplasty
Pinnaplasty
Repair of lobe of external ear
Septorhinoplasty
Varicose veins
Circumcision
Vaginoplasty, Labial Vulvoplasty and Vulvar lipoplasty
Hirsutism
Removal of tattoos
Resurfacing procedures
Face lift or brow lift
Liposuction
Removal of benign skin lesions
Thigh lift, buttock lift and arm lift
Surgical Treatment for Hair Loss
Oculoplastic Eye Problems
Surgical Fillers

Commissioning Responsibility

The procedures contained within this policy document are the commissioning responsibility of Clinical Commissioning Groups (CCGs). There are a number of procedures / treatments that fall within the commissioning responsibility of NHS England (NHSE), and as such, providers should satisfy themselves that they are following the relevant policy prior to undertaking any interventions. Examples of such procedures that are NHSE commissioning responsibility include:

- Autologous Cartilage Transplantation
- Bone Morphogenetic Protein
- Cervical disc prosthesis
- Fertility preservation for cancer

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

Anal Fissure (Surgery)

Background: An anal fissure is a tear in the lining of the lower rectum (anal canal) that causes pain during bowel movements.

Policy: For referral to secondary care the patient should meet at least one of the following criteria:

- Multiple, off the midline, large or irregular (atypical fissures) as these may be the manifestation of underlying disease

OR

- Children whose anal fissure has not healed after 2 weeks

OR

- Severe pain refractory to conservative therapy and impacting on patient wellbeing

OR

- Persisting anal fissure not healed after 8 weeks of conservative management

OR

- Symptoms suggestive of systemic disease e.g. inflammatory bowel disease

Consider referring an elderly person earlier to exclude an anal or low rectal malignancy.

A 2 week wait referral should be considered for patients aged 50 and over with unexplained rectal bleeding' or 'All ages (<50) with rectal bleeding **and** any of the following unexplained symptoms or findings: abdominal pain/change in bowel habit/weight loss/iron-deficiency anaemia'.

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.

Bariatric surgery

Background: CCGs took over the responsibility of commissioning bariatric surgery for patients (Adults only) from NHS England from 1st April 2017. As such, CCGs adopted the same criteria as previously undertaken by NHSE Commissioning colleagues.

Policy: Surgery will only be considered as a treatment option for adults with morbid obesity providing all of the following criteria are fulfilled:

- The individual is considered morbidly obese – classified as adults with a BMI of 40kg/m2 or more;

OR

- The individual is between 35 kg/m2 and 40kg/m2 in the presence of other significant diseases;

AND

- There must be formalised MDT led processes for the screening of co-morbidities and the detection of other significant diseases. These should include identification, diagnosis, severity / complexity assessment, risk stratification / scoring and appropriate specialist referral for medical management. Such medical evaluation is mandatory prior to entering a surgical pathway.

AND

- Morbid/severe obesity has been present for at least five years.

AND

- The individual has recently received and complied with a specialist obesity service weight loss programme (non-surgical Tier 3 / 4), as described below.

Weight Loss Programmes (non-surgical Tier 3 / 4)

- This will have been for a duration of 12-24 months. For patients with BMI > 50 attending a specialist bariatric service, this period may include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is six months. The specialist obesity weight loss programme and MDT should be decided locally. This will be led by a professional with a specialist interest in obesity and include a physician, specialist dietician, nurse, psychologist and physical exercise therapist, all of whom must also have a specialist interest in obesity. There are different models of local MDT structure.

- Important features are the multidisciplinary, structured and organised approach, lead professional, assessment of evidence that all suitable non-invasive options have been explored and trialled and individualised patient focus and targets. In addition to offering a programme of care, the service will select and refer appropriate patients for consideration for bariatric surgery.

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.

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.

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.

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.

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.

Breast – Prosthesis Removal

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

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:

- 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.

This policy does not apply to breast reconstruction as part of the treatment for breast cancer; or following risk-reducing mastectomy for women with no personal history of breast cancer who meet the criteria detailed in NICE Clinical Guideline CG 164 (2017).

Surgery for primarily cosmetic reasons is not eligible for NHS funding.

Breast - Revisions of Breast Reconstruction Surgery and Repeated Courses of Nipple Tattooing

Background: Breast reconstruction is surgery to make a new breast after removal of the breast or part of the breast due to cancer. The aim is to make a breast of similar size and shape to the original breast. Breast reconstruction can be done at the same time as the cancer surgery (immediate reconstruction), or after cancer surgery (delayed reconstruction) and may involve the use of implants to achieve the desired effect. Nipple tattooing is also a recognised procedure in relation to breast reconstruction surgery following treatment for breast cancer in order to improve the appearance of the breast.

Policy: A full course of treatment will be funded for patients undergoing either immediate or delayed breast reconstruction surgery, to include all aspects of the reconstruction. This includes the provision of implant(s) for the reconstruction, and one course of treatment for Nipple Tattooing.

Revisions of reconstruction surgery for purely cosmetic reasons and further courses of Nipple Tattooing will not be funded.

Please Note: Breast Reconstruction Surgery Post Mastectomy does NOT require Prior Approval

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, 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/m^2.

AND

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

Surgery for primarily cosmetic reasons is not eligible for NHS funding.

Repeat surgeries will <u>not</u> be routinely commissioned.

Bunions / Minor Foot Problems

Background: Degeneration of the small joints of the toes and feet is a common problem. It is often caused by inappropriate footwear. It can usually be managed conservatively by changing footwear. Surgery is sometimes sought to avoid the need to change footwear or for cosmetic purposes.

Policy: Referral for surgery for minor foot problems will only be considered when the following criteria are met:

- The patient has been referred to a podiatrist and conservative management has failed (Including avoiding high heels, exercises, applying ice, non-surgical treatment)

AND

- The patient suffers from severe deformity that causes significant functional impairment (including inability to fit adequate footwear)

OR

- The patient suffers from severe pain that causes significant functional impairment

OR

- There is recurrent or chronic ulceration due to the deformity

OR

- There is recurrent or chronic bursitis or tendinitis at the first metatarsal head due to the deformity.

Exclusions: If the patient has diabetic peripheral neuropathy or suspected osteomyelitis and a foot lesion may lead to amputation of a toe or foot, there is no restriction and prompt referral using appropriate local pathways is required. This policy does not apply to surgery to correct deformity

due to acute trauma.

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:

There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link: https://www.evidence.nhs.uk/Search?q=.

AND EITHER

- Severe symptoms that significantly interfere with daily activities (see FAQ) persist or recur after at least 3 months of conservative therapy, including 8 weeks of nocturnal splinting and local corticosteroid injections if clinically appropriate.

OR

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

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 there is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the

patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link:
https://www.evidence.nhs.uk/Search?q=

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 for both Adults and Children 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
- Leukoplakia (suspicion of cancer)

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.

Continuous Glucose Monitoring

Background: Continuous Glucose Monitoring (CGM) is a device including a sensor self-inserted subcutaneously, which records blood glucose levels through the day and night. This can help individuals with variable and unpredictable glucose levels achieve safer and more stable overall control, improve metabolic control, reduce hypoglycaemia episodes and improve quality of life.

Policy: Continuous Blood Glucose Monitors for Type 1 Diabetes will only be funded in accordance with the criteria specified below, and where requests are made by a Consultant Diabetologist :

- Disabling hypoglycaemia despite optimal self-management supported by a secondary care specialist team

OR

- Inability to recognise hypoglycaemia due to age or communicate about, symptoms of hypoglycaemia (for example, because of cognitive or neurological disabilities)

OR

- Dangerously erratic glucose levels leading to decompensated high glucose levels and diabetic ketoacidioosis

OR

- For pregnant women with labile blood glucose or dangerous hypoglycaemia

OR

- Transition from paediatric care where patients are already using CGM and having demonstrated significant clinical benefit justifying ongoing provision

OR

- Children and young people who undertake high levels of physical activity at a regional, national, or international level, that despite optimal management and education is leading to suboptimal diabetes control

All initial requests are made on the basis of a short term (maximum 6 months) trial of continuous monitoring.

Where there have been successful results of the trial, a further request for long term funding should be made.

Continuous Glucose Monitoring should be discontinued after a six month trial if no improvement is demonstrated.

Dilatation and Curettage (D&C) for treatment of Heavy Menstrual Bleeding

Background: Dilatation and curettage (D&C) is a procedure performed under general anaesthetic in which the lining of the uterus (the endometrium) is biopsied or removed by scraping (curettage).

NICE Clinical Guideline [CG44] Published date: January 2007. Last updated: August 2016
Heavy menstrual bleeding assessment and management states: D&C should **not** be used as a therapeutic treatment.

Policy: Dilatation and curettage (**D&C) is NOT routinely commissioned as a therapeutic treatment for heavy menstrual bleeding or any other uterine bleeding disorder**. **Procedures for diagnostic purposes as part of the investigation for menorrhagia will be funded.**

Dupuytren's Contracture – Referral for Secondary Care Opinion

Policy: Referral for Secondary Care Opinion of Dupuytren's contracture will only be funded in accordance with the criteria specified below:

- Flexion deformity >30° at the MCP Joint or PIP Joint

OR

- Rapidly progressive disease

AND

- Contracture interferes with lifestyle and/or occupation

NB: If the above criteria are fulfilled and PAT obtained, the specialist will not need to obtain a further PAT for surgery

Dupuytren's Contracture – Collagenase Clostridium Histolyticum (CCH) Injections

Policy: Collagenase Clostridium Histolyticum (CCH) Injections is recommended as an option for treating Dupuytren's contracture with a palpable cord in adults only if all of the following apply:

- There is evidence of moderate disease that includes:
    - Contracture interferes with lifestyle and/or occupation

AND

- Metacarpophalangeal joint contracture of 30° to 60°

AND

- Proximal interphalangeal joint contracture of less than 30° or first web contracture

AND

- Up to 2 affected joints

AND

- Percutaneous needle fasciotomy (PNF) is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon

AND

- The choice of treatment (CCH or limited fasciectomy) is made on an individual basis after discussion between the responsible hand surgeon and the patient about the risks and benefits of the treatments available

AND

- One injection is given per treatment session by a hand surgeon in an outpatient setting

Dupuytren's Contracture - Radiotherapy

Policy: Radiotherapy for Dupuytren's contracture is not routinely funded.

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)

Extracorpreal Shockwave for MSK conditions

Background: Extracorporeal Shockwave Therapy or ESWT is a treatment that can be used in physical therapy, orthopaedics, urology and cardiology. The shockwaves are abrupt, high amplitude pulses of mechanical energy, similar to soundwaves, generated by an electromagnetic coil or a spark in water. Similar technology using focused higher energies is used to break up

kidney and gallstones, and is termed lithotripsy. “Extracorporeal” means that the shockwaves are generated externally to the body and transmitted from a pad through the skin.

Policy: Extracorporeal Shockwave Therapy is not routinely funded for musculoskeletal conditions.

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.

Flash Glucose Monitoring

Background: Flash Glucose Monitoring (for example, Freestyle Libre® devices) are classified as a red device and therefore can only be initiated and prescribed by specialist secondary care clinicians.

Consumables for this device should be prescribed for a period of time aligned to a patients required routine outpatient appointments. Additional outpatient appointments should not be made purely for

the purpose of obtaining repeat prescription for associated consumables. In these circumstances CCG will not pay for additional outpatient appointments.

In circumstances where a patient has bought their own device or has been provided with the device as part of a clinical trial, consumables will only be funded when prior approval has been obtained demonstrating that the patient meets the criteria.

Consumable costs will be reconciled using the routine reconciliation process associated with VBC data on the basis of 100% compliance. The cost of any consumables for this product which have been prescribed without prior funding approval will not be reimbursed by CCGs to providers.

Policy: Flash Glucose Monitoring (for example, Freestyle Libre® devices) **should only be used for people with Type 1 diabetes, aged four and above, attending specialist Type 1 care using multiple daily injections or insulin pump therapy, who have been assessed by the specialist clinician and deemed to meet one or more of the below requirements.**

- Patients who undertake intensive monitoring >8 times daily

OR

- Those who meet the current NICE criteria for insulin pump therapy (HbA1c>8.5% (69.4mmol/mol) or disabling hypoglycemia as described in NICE TA151) where a successful trial of Flash Glucose Monitoring may avoid the need for pump therapy.

OR

- Those who have recently developed impaired awareness of hypoglycaemia. It is noted that for persistent hypoglycaemia unawareness, NICE recommend continuous glucose monitoring with alarms

OR

- Patient has had frequent admissions (>2 per year) with DKA or hypoglycaemia

OR

- Those who require third parties to carry out monitoring and where conventional blood testing is not possible

In addition, all patients (or carers) must be willing to undertake training in the use of Flash Glucose Monitoring devices (for example, Freestyle Libre® devices) and commit to on-going regular follow-up and monitoring (including remote follow-up where this is offered).

Flash Glucose Monitoring devices **should be discontinued after a six month trial if no improvement is demonstrated in one or more of the following areas:**

1. Reductions in severe/non-severe hypoglycaemia
2. Reversal of impaired awareness of hypoglycaemia
3. Episodes of diabetic ketoacidosis
4. Admissions to hospital
5. Changes in HbA1c
6. Testing strip usage
7. Quality of Life changes using validated rating scales.
8. Commitment to regular scans and their use in self-management.

Functional Electrical Stimulation

Background: Functional electrical stimulation (FES) is a treatment that uses the application of small electrical charges to improve mobility. It is particularly used as a treatment for drop foot. Drop foot is caused by disruption in the nerve pathway to and from the brain, rather than in nerves within the leg muscles.

Non-Implantable Devices:

Policy: Functional Electrical Stimulation for drop foot is routinely commissioned with the non-implantable device, in line with NICE IPG278, providing normal arrangements are in place for clinical governance, consent and audit, and provided ALL of the following criteria are met:

- Drop foot is impeding gait and in whom the use of all orthotics (AFO) has proven to be unsuccessful following specialist assessment;

AND

- The patient has demonstrable functional improvement from an individual trial of FES;

AND

- The intervention is recommended by a multidisciplinary team specialised in rehabilitation.

Implantable Devices:

Policy: The wireless or implantable device is NOT routinely commissioned. Funding will only be considered where there are exceptional clinical circumstances. The clinician needs to submit an application to the Individual Funding Request Panel.

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)

Gastric Neuromodulation

Background: Gastric neuromodulation (GNM) has been advocated for the treatment of drug refractory gastroparesis or persistent nausea and vomiting in the absence of a mechanical bowel obstruction. There is, however, little in the way of objective data to support its use, particularly with regards to its effects on gastric emptying

Policy: Gastric Neuromodulation for gastroparesis is NOT routinely commissioned.

All requests for this treatment must be sent to the IFR Panel for consideration.

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[4] with 40% presenting as emergencies[5]. 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 (NB: Policy only applies to Adults):

- 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

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link: https://www.evidence.nhs.uk/Search?q=.

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

[5] McIntosh A, Hutchinson A, Roberts A and Withers H. Evidence-based management of groin hernia in primary care—a systematic review. Family Practice 2000; 17: 442–447.

Grommets (and other ventilation devices) 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 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. There should be evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link: https://www.evidence.nhs.uk/Search?q=.

Referral for a Specialist opinion when:

- Persistence of bilateral otitis media with effusion (OME) and hearing loss over 3 months

OR

- If hearing loss of any level is associated with a significant impact on the child's developmental, social, or educational status.

OR

- If hearing loss is severe.

OR

- The hearing loss persists on two documented occasions (usually following repeat testing after 6–12 weeks).

OR

- The tympanic membrane is structurally abnormal (or there are other features suggesting an alternative diagnosis).

OR

- There is a persistent, foul-smelling discharge suggestive of a possible cholesteatoma.

OR

- The child has Down's syndrome or has a cleft palate.

OR

- The child has recurrent acute otitis media (defined as three or more episodes in 6 months, or

four or more episodes in 12 months with at least one episode in the past 6 months) in whom conservative measures have been ineffective.

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

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link: https://www.evidence.nhs.uk/Search?q=.

AND EITHER

- 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).

OR

- 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.

OR

- The ventilation tube is inserted for the diagnosis of underlying sensori-neural hearing loss

OR

- The treatment of recurrent acute otitis media (defined as three or more episodes in 6 months, or four or more episodes in 12 months with at least one episode in the past 6 months) in whom conservative measures have been ineffective

OR

- The treatment of chronic retraction of the tympanic membrane

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.

Haemorrhoidectomy (Surgical)

Background: From the Banov et al paper 1985, grading of haemorrhoids is as follows:

- Grade I: The haemorrhoids do not prolapse.
- Grade II: The haemorrhoids prolapse upon defecation but spontaneously reduce.
- Grade III: The haemorrhoids prolapse upon defecation and must be manually reduced.
- Grade IV: The haemorrhoids are prolapsed and cannot be manually reduced.

Policy: Haemorrhoidectomy will be funded in the following circumstances:

- Grade I or II haemorrhoids with severe symptoms which include bleeding, faecal soiling, itching or pain which have failed to respond to conservative management for 3 months, where banding or Haemorrhoidal Arterial Ligation (HAL) is inappropriate.

OR

- Grade III or IV haemorrhoids (i.e. prolapsed) where banding or Haemorrhoidal Arterial Ligation (HAL) is inappropriate.

OR

- Symptoms suggestive of systemic disease e.g. inflammatory bowel disease

NB: Fast track referral - In patients aged 50 and over with unexplained rectal bleeding' or 'All ages (<50) with rectal bleeding **and** any of the following unexplained symptoms or findings: abdominal pain/change in bowel habit/weight loss/iron-deficiency anaemia'.

Please note that perianal haematoma is not classified as haemorrhoidectomy and will require separate management.

All other circumstances require prior approval.

Hip Arthroscopy

Background: Hip arthroscopy refers to the viewing of the interior of the acetabulofemoral (hip) joint through an arthroscope and the treatment of hip pathology through a minimally invasive approach.

Policy: Hip Arthroscopy will only be commissioned (from surgeons with specialist expertise in this type of surgery) in line with the requirements stipulated by NICE IPG 408 and only for patients who fulfil ALL of the following criteria:

- A definite diagnosis of hip impingement syndrome / femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans

AND

- An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist

AND

- The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly compromised functioning for at least 6 months

AND

- The symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy

If the patient does not meet all the criteria described above but the Specialist still recommends this treatment, an Individual Funding Request should be submitted for consideration.

Hip Arthroscopy is **NOT** routinely funded for patients where any of the following apply:

- Advanced osteoarthritis or severe cartilage injury
- A hip joint space on plain radiograph that is less than 2mm wide anywhere
- Candidates for total hip replacement
- Hip dysplasia
- Generalised joint laxity especially in diseases connected with hypermobility of the joints
- Osteogenesis imperfecta (brittle bone disease)

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 appropriate to age, co-morbidity, pain severity or disability
    - Access to facilitated interventions to achieve weight loss if the patient is overweight or obese.

AND

- The patient has moderate to severe persistent joint pain that is refractory to non-surgical treatment, and may include 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

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link: https://www.evidence.nhs.uk/Search?q=.

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

Revision Surgery for Hip replacements is not currently included within the scope of this policy.

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.

Hyperhidrosis - Referral

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. Depending on the severity of the hyperhidrosis, it can be managed in primary or secondary care.

Primary care: lifestyle management, such as regular night-time antiperspirant use (up to 20% aluminium chloride hexahydrate available OTC), avoiding tight clothing and manmade fabrics,

wearing white or black clothing to minimize the signs of sweating, dress shields to absorb excess sweat, and avoiding stimuli such as caffeine, spicy foods or crowded areas. Underlying anxiety should be treated.

More patient information and support is available from Hyperhidrosis UK. http://hyperhidrosisuk.org/

Policy: Referral for Hyperhidrosis will only be funded in accordance with the criteria below:

- The search for an underlying cause has been exhausted

AND
- Hyperhidrosis Disease Severity Scale (HDSS) 3 or 4.

AND
- Trial of lifestyle management for a minimum of 2 months.

AND
- The patient has medical complications of hyperhidrosis (i.e. skin macerations and secondary infections).

References:

http://cks.nice.org.uk/hyperhidrosis#!scenario

http://www.bad.org.uk/

http://hyperhidrosisuk.org/

Hyperhidrosis – Thoracic Sympathectomy (Endoscopic or Open)

Policy: Thoracic Sympathectomy (Endoscopic or Open) for the treatment of hyperhidrosis is not routinely funded.

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 https://cks.nice.org.uk/hyperhidrosis

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

AND

- The patient is 17 years or older

There must be a minimum of 6 months duration between Botulin Toxin injections.

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, or has been declined by the woman. 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, or has been declined by the woman.

AND

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

AND

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may

include the NHS Rightcare Shared Decision Making tool.

Ilizarov Technique

Background: The Ilizarov apparatus is a type of external fixation used in orthopaedic surgery to lengthen or reshape limb bones; to treat complex and/or open bone fracture; and in cases of infected non-union of bones that are not amenable with other techniques.

Policy: **Ilizarov technique is commissioned for routine elective use in orthopaedics in individual carefully selected cases, where there is agreement by a local orthopaedic MDT that of all available treatments, Ilizarov/TSF is the best clinical option for the patient in terms of a favourable functional limb outcome (bone and functional outcomes are not always the same). Ideally, the MDT should comprise at least two consultant Orthopaedic surgeons, with input from specialist nursing, physiotherapy and musculoskeletal radiology.**

Please note; this does not apply to emergency care.

Invitro Fertilisation (IVF) and Intracytlopasmic 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:

Ref	Eligibility criteria for treatment	Definition	Additional Notes
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 intrauterine insemination), offer 3 full cycles of IVF, with or without 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
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 intrauterine insemination), offer 1 full	**1 full cycle of IVF** (Including associated frozen/thaw transfers) provided that all other criteria are met.

Ref	Eligibility criteria for treatment	Definition	Additional Notes
		cycle of IVF, with or without ICSI, provided all the following 4 criteria are fulfilled: • 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	**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 *AND* • anti-Müllerian hormone of more than or equal to 5.4 pmol/l.
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

Ref	Eligibility criteria for treatment	Definition	Additional Notes
			likely to improve their chance of conception
5.	**Male Body Mass Index (BMI)**	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	Men who have a BMI of 30 or over should be informed that they are likely to have reduced fertility
6.	**Existing children**	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.	This criterion includes adopted children, but excludes fostered children.
7.	**Smoking Status**	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.	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.
8.	**Same sex couples and single women**	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.	Treatment is offered to couples irrespective of sexual orientation. The NHS does not fund donor insemination to establish fertility in same sex couples.
9.	**Previous Sterilisation**	No previous sterilisation history in either partner. This applies to all treatments including those using gonadotrophins for fertility	

Ref	Eligibility criteria for treatment	Definition	Additional Notes
		treatment including ovulation induction and induction of spermatogenesis, and for donor insemination.	
10.	**Length of time resident in catchment area**	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.	This excludes short term students who are otherwise eligible for NHS treatment.
11.	**Residence in UK**	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.	

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 appropriate to age, co-morbidity, pain severity or disability
    - Access to facilitated interventions to achieve weight loss if the patient is overweight or obese.

AND

- The patient has moderate to severe persistent joint pain that is refractory to non-surgical treatment and may include 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

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link: https://www.evidence.nhs.uk/Search?q=.

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

Revision Surgery for Knee replacements is not currently included within the scope of this policy.

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.

Low (lumbar) Back Pain and Sciatica (radicular pain)

This policy has been revised in the light of NICE guideline NG59 and the National Back Pain and Radicular Pain Pathway (NBPRPP). The policy applies to all patients who experience either new episodes or chronic persistent and unremitting symptoms of low back pain and sciatica.

The policy covers treatment procedures for the lumbar spine. It does not cover:

- non-lumbar regions of the spine, and
- serious spinal pathology and the potentially serious neurological sequelae of sciatica (progressive neurological deficit and Cauda Equina Syndrome)

The precise form and content of comprehensive non-surgical treatments including Combined Physical and Psychological Programmes (CPPP) may vary according to Clinical Commissioning Group (CCG), the extent to which the NBPRPP has been implemented, and the individual needs of the patient.

Low Back Pain - Spinal injections

Therapeutic spinal injections are not routinely funded for the treatment of non-specific low back pain.

Spinal injections include:

- Facet joint injections
- Medial branch blocks
- Intradiscal therapy
- Prolotherapy
- Trigger Point Injections

Medial branch blocks for diagnostic purposes prior to radiofrequency denervation will be funded only once for one particular level or side.

Low Back Pain - Radiofrequency denervation (rhizolysis)

Radiofrequency denervation for chronic non-specific low back pain will only be funded in accordance with the criteria below:

- Comprehensive non-surgical treatment including CPPP where available, or where not available, analgesia, physiotherapy, and modified activity has not been successful

AND

- The main source of pain is thought to come from structures supplied by the medial branch nerve

AND

- Moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral

AND

- Positive response to a diagnostic medial branch block

AND

- Where a patient has had a previous rhizolysis then the interval should be a minimum of 16 months

Low Back Pain - Epidural and nerve root injections

Epidural and nerve root injections are not routinely funded for the treatment of non-specific low back pain.

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:

- The patient has radicular leg pain (below the knee for lower lumbar herniation, into the anterior thigh for upper lumbar herniation) consistent with the level of spinal involvement

OR

- There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30° and 70° or positive femoral tension sign)

AND

- Comprehensive non-surgical treatment, including CPPP where available, or where not available, analgesia, physiotherapy, and modified activity has not been successful

Note: Nerve root injections should only be performed under imaging. Under these circumstances, a total of up to two injections will be funded per episode.

The interval between two injections must be at least 6 months.

Epidural injections are not recommended or funded for neurogenic claudication caused by central spinal canal stenosis.

Nerve root injections for diagnostic purposes will be funded where Prior Approval is in place.

Low Back Pain - Spinal decompression and discectomy (lumbar)

Spinal decompression (laminectomy) and discectomy will only be funded for patients with sciatica (radicular pain) in accordance with the following criteria:

- Magnetic resonance imaging shows compression of the neural elements consistent with the clinical symptoms

AND

- Radicular pain (below the knee for lower lumbar herniations, into the anterior thigh for upper lumbar herniations) and neurological deficit consistent with the level of spinal involvement

OR

- There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30° and 70° or positive femoral tension sign)

AND

- Symptoms persist despite non-operative treatment for at least 6 weeks (e.g. analgesia, physiotherapy, modified activity, etc.) provided that analgesia is adequate and there is no significant neurological deficit.

Low Back Pain - Spinal fusion

Spinal Fusions will only be funded for patients in accordance with the following criteria:

- Failed Conservative Treatment for at least 3 months (including targeted physiotherapy and appropriate analgesia)

AND

- Discussion and Agreement at Regional Spinal MDT

AND

- Symptomatic Instability (spondylolisthesis)

OR

- Destabilising Decompression

OR

- Revision of Non-Union (previous attempted fusion)

OR

- Revision discectomy

This policy excludes patients where there is evidence of Trauma, Tumour, Infection, Degenerative Scoliosis, or Progressive neurological deficit - including cord or cauda equine compression.

Low Back Pain - Lumbar Disc replacement

Policy: Lumbar disc replacement will not routinely be funded for patients with low back pain.

Minor Skin Lesions

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

OR

- there is impairment of visual fields

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.

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.

Oculoplastic Eye Problems - Surgery for Minor Eyelid Lesions

Background: Minor eyelid lesions include eyelid papillomas or skin tags, cysts of moll, cysts of zeis, chalazia/Meibomium cysts.

Policy: Surgery or treatment for minor eyelid lesions will only be funded in accordance with criteria 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

OR

- There is significant impact on vision affecting functionality

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.

Oculoplastic Eye Problems - Ectropion

Background: Ectropion is a condition, typically a consequence of advanced age, in which the eyelid is turned outwards away from the eyeball.

Policy: Surgery for Ectropia will only be funded in accordance with the criteria below:

- Conservative management has been exhausted and there is evidence of significant impairment of the punctum

AND

- There is recurrent infection in surrounding skin

OR

- There is significant impact on vision affecting functionality

OR

- In order to have safer intraocular procedures / so the patient can undergo another intraocular procedure.

Surgery for primarily cosmetic reasons is not eligible for NHS funding.

Oculoplastic Eye Problems - Entropion

Background: An entropion occurs where an eyelid turns inwards towards the eye. This causes the eyelashes to rub against the front of the eye (the cornea). The lower eyelid is most commonly affected.

Policy: Surgery for Entropia will only be funded in accordance with the criteria below:

- There entropion is symptomatic causing ocular irritation, foreign body sensation, blepharospasm, tearing and redness and there is risk of corneal damage

OR

- There is significant impact on vision affecting functionality

OR

- In order to have safer intraocular procedures / so the patient can undergo another intraocular procedure.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Oculoplastic Eye Problems - Blepharitis

Background: Blepharitis is a common condition where the edges of the eyelids (eyelid margins) become red and swollen (inflamed). This condition often runs a protracted course and its containment will largely depend on the patient understanding the nature of the problem and what the management issues are. **Lid hygiene** is the mainstay of treatment and may be sufficient to control simple low-grade blepharitis.

Policy: Referral to secondary care for Blepharitis is NOT routinely commissioned. Referral will only be funded in accordance with criteria below:

- Associated cellulitis

OR

- Corneal involvement

OR

- There is well documented evidence of significant pain (see FAQs)

OR

- There is significant impact on vision affecting functionality

Consider Referring patients with persistent unilateral blepharitis which may be a presentation of Meibomian gland carcinoma

Paediatric Foot Problems

Background: Whilst minor foot or gait problems are relatively common presentations in children, referral directly for surgery is rarely needed. Referral for prophylactic or cosmetic reasons for minor foot problems should not be considered in children.

Policy: Referral of children to orthopaedic surgery for minor foot problems should only be considered in the following circumstances:

- Metatarsus varus (also known as metatarsus adductus or “in-toeing”) has been diagnosed clinically;

AND

- associated developmental dysplasia of the hips is suspected;

OR

- Child is ≥ 5 years of age and intoeing is still evident despite community podiatry review

OR

- Curly toes have been diagnosed clinically;

AND

- Severe deformity is present (as is shown by either deformity of the growing nail of the toe or pressure on the adjacent toe or corn formation on the dorsum of the toe.)

OR

- There is significant pain unmanageable by community podiatry services

Exclusions: The treatment of children with acute foot trauma or with neurodevelopmental problems or other complex conditions affecting the feet is not covered by this policy. This policy also does not apply when a foot or gait problem is considered to need further investigation by a paediatrician to determine its cause.

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 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.

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.

Resperate Device for Hypertension

Background: Resperate is a portable electronic device that promotes slow, deep breathing. Resperate is approved by the Food and Drug administration for reducing stress and lowering blood pressure.

Policy: Resperate device for hypertension is not routinely commissioned owing to inadequate evidence of long term benefit over other relaxation techniques.

As such, clinicians should not routinely prescribe or recommend this product to patients either as monotherapy or an adjunct to pharmacological management because there is limited clinical evidence of effectiveness.

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.

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.

Sacral Nerve Stimulation for Bladder Symptoms

Background: Sacral nerve stimulation, also termed sacral neuromodulation, is a type of medical electrical stimulation therapy.

It typically involves the implantation of a programmable stimulator subcutaneously, which delivers low amplitude electrical stimulation via a lead to the sacral nerve, usually accessed via the S3 foramen.

In line with NICE recommendations this policy has separate eligibility criteria and care pathways for men and women.

Policy: Women

SNS for urinary incontinence or urgency-frequency syndrome in women will only be funded in accordance with the criteria below:

- Symptoms are refractory to lifestyle modification (caffeine reduction, modification of fluid intake, weight loss if BMI >30)

AND

- Symptoms are refractory to behavioural interventions: a minimum of 6 weeks of bladder retraining OR 3 months of pelvic floor muscle training (in mixed UI only, where there is some stress incontinence as well as OAB)

AND

- Symptoms are refractory to 4 weeks of anticholinergic medication to a maximal tolerated dose (a number of drugs may be tried in accordance with NICE CG171) [OR Mirabegron, in people for whom anticholinergic drugs are contraindicated or clinically ineffective or have unacceptable side effects (NICE TA290)]

AND

- The woman has been referred to secondary care, reviewed by an MDT and a diagnosis of detrusor over activity has been confirmed by urodynamic assessment

AND

- Symptoms are refractory to injections of Botulinum Toxin Type A into the bladder wall unless the patient is unwilling or unable to perform clean intermittent catheterisation.

Policy: Men

SNS for men with overactive bladder (OAB) caused by detrusor over activity will only be funded in accordance with the criteria below:

- Symptoms are refractory to conservative management lifestyle advice, advice on fluid intake, supervised bladder training and use of containment products (pads, sheaths, etc.)

AND

- Symptoms are refractory to 4-6 weeks of anticholinergic medication [OR Mirabegron, in people for whom anticholinergic drugs are contraindicated or clinically ineffective, or have unacceptable side effects (NICE TA290)]

AND

- The man has been referred to secondary care for specialist assessment and a diagnosis of detrusor over activity has been confirmed

AND

- Symptoms are refractory to injections of Botulinum Toxin Type A into the bladder wall unless the patient is unwilling or unable to perform clean intermittent catheterisation.

Before a permanent SNS device is fitted, ALL prospective patients must have been approved for and have undergone a positive trial period (2-3 weeks) of temporary stimulation resulting in a 50% or greater improvement in voiding function based on the results of a voiding diary.

SNS will not be funded for patients with:

- Stress incontinence, the most common type of urinary dysfunction
- Urinary retention due to obstruction (e.g. from benign prostatic hypertrophy, cancer, or urethral stricture)
- Urge incontinence due to psychological or neurological conditions, such as diabetes with peripheral nerve involvement, MS, stroke or spinal cord injury (see NICE CG 148).

Septorhinoplasty, Rhinoplasty, and Septoplasty for nasal deformities

Background: Septorhinoplasty, Rhinoplasty, and Septoplasty for nasal deformities are surgical procedures performed on the nose to change its size or shape or both. People usually ask for this procedure to improve self-image. The policy applies to all three procedures of Septorhinoplasty, Rhinoplasty, and Septoplasty.

Policy: Rhinoplasty, Septoplasty, or Septorhinoplasty for nasal deformities will only be funded in accordance with the criteria specified below:

- Where conservative treatment has been exhausted;

AND

- Problems caused by obstruction of the nasal airway

OR

- Objective nasal deformity caused by direct trauma and the treatment is required at the time of, or soon after the acute episode and before permanent healing has occurred.

OR

- 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.

Surgery for Refractive Error (including Excimer Laser following corneal transplant or cataract surgery)

Background: Refractive eye surgery is any eye surgery used to improve the refractive state of the eye and decrease or eliminate dependency on glasses or contact lenses. This can include various methods of surgical remodelling of the cornea or cataract surgery. The most common methods today use excimer lasers to reshape the curvature of the cornea. Successful refractive eye surgery can reduce or cure common vision disorders such as myopia, hyperopia and astigmatism, as well as degenerative disorders like keratoconus.

Excimer Laser for poor refraction after corneal transplant or cataract surgery is a last resort measure where all other conservative and surgical interventions have failed.

Policy: Surgery for refractive error is only commissioned in the following circumstances;

- Where poor refraction after corneal transplant or cataract surgery is demonstrated;

AND

- Where all other conservative and surgical interventions have failed.

Surgical Fillers

Background: Surgical Fillers are widely used in cosmetic surgery, for the treatment of wrinkles and skin aging, to improve the appearance of scars and for augmenting the volume of soft tissue such as in the lips.

Policy: Surgical fillers for the treatment of wrinkles and skin ageing will not be routinely funded

This commissioning position applies to the use of both natural (e.g. fat, dermis) and synthetic fillers (temporary or permanent) including hyaluronic acid fillers and collagen. Please note, the treatment of complications arising from the cosmetic use of surgical fillers in private practice is not routinely funded.

Surgical Treatment for Hair Loss

Background: Hair loss and hypotrichosis for men and women have many causes including androgenetic alopecia, fungal infection, trauma (e.g., due to (trichotillomania), radiotherapy, chemotherapy, nutritional deficiencies (e.g., iron deficiency), and autoimmune diseases (e.g., alopecia areata). 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. Treatment of hair loss can include hair transplantation or hair grafting, the 'Interlace' hair system, or Dermatography (tattooing).

Policy: Surgical Treatment for hair loss will not be routinely funded.

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.

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 for adults or children in accordance with the criteria specified below:

- The sore throats are due to tonsillitis;

AND

- The episodes of sore throat are disabling and prevent normal functioning

AND

- Seven or more well documented, clinically significant, adequately treated episodes of sore throat in the previous year;

OR

- Five or more such episode treated with antibiotics, have occurred in each of the preceding two years

OR

- Three or more such episodes have occurred in each of the preceding three years

OR

- There is a suspicion of malignancy

This policy does not apply to suspected malignancy, management of acute recurrent quinsy (peritonsillar abscess), tonsil bleeding or deep neck infection or OSAS in children. These diagnosis will be funded.

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.

This policy applies to adults only.

Vaginoplasty, Labial Vulvoplasty and Vulvar Lipoplasty

Background: 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 Gyaencologists : https://www.rcog.org.uk/en/news/joint-rcogbritspag-release-issues-surrounding-women-and-girls-undergoing-female-genital-cosmetic-surgery-explored/

Policy: Vaginoplasty will not routinely be funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding.

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

[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.*

- 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 actives 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)

OR

- Recurrent superficial thrombophlebitis where there is significant pain and disability

OR

- Progressive skin changes that suggest potential ulceration due to venous insufficiency

OR

- Significant haemorrhage from a ruptured superficial varicosity

OR

- 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.

Vasectomy under General Anaesthetic

Background: Vasectomy is a surgical procedure for male sterilization or permanent contraception. During the procedure, the male vas deferens are severed and then tied or sealed in a manner so as to prevent sperm from entering into the seminal stream (ejaculate) and thereby prevent fertilization.

Policy: **Vasectomy under general anaesthetic will not be routinely funded.**

Document History

Revision date	Summary of Changes
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

	the removal of the criterion for patients to have tried at least 6 months of conservative management, for lack of an evidence base
BMI criterion for safe surgery	Consideration of evidence base for this criterion- all weight related eligibility criteria reviewed
Tonsillectomy	Complete new criterion based policy(s) based on RCS guidance (section on sleep disordered breathing in adults remains
Fertility treatment	Policy revised in light of NICE guidelines- age limit raised (in restricted circumstances) but priority for families where both parents are childless remains 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.
Hyperhidrosis	Added link to CKS best practice guidance Added criteria based on CKS medical management of hyperhidrosis
Hirsuitism	Eligibility for treatment restricted, no longer available routinely for those with excessive facial hair
Excimer laser for corneal erosions	Specialised service commissioned by NHS England, policy removed
Ophthalmology- correction of refractive error	Policy removed as not in Cumbria policy and not considered as a priority- NE and Cumbria policies now consistent
Rhinophyma	Included Cumbria policy
Vulvoplasty	Clarification that this is not usually funded
Keloid scarring	Included Cumbria policy within Benign skin lesions policy
Breast asymmetry	Default to breast reduction- as in Cumbria policy- new policy guidance and clearer criteria- as distinct from breast augmentation policy
Breast prosthesis removal or replacement	NHS funding position on part payment clarified
Gynaecomastia	Changed default to not routinely funded- primary consideration is already of exceptionality
Pre-implantation genetic diagnosis	specialised service commissioned by NHS England, policy removed
Reversal of male sterilisation	Clarification that this is not normally funded
Reversal of female sterilisation	Clarification that this is not normally funded
Collagen cross-linking for corneal irregularities including keratoconus	specialised service commissioned by NHS England, policy removed
September 2014	
Carpal tunnel syndrome	Inclusion of shared decision making in the criteria. *http://arms.evidence.nhs.uk/resources/hub/1057569/attachment*
Breast augmentation (Breast enlargement)	Delete 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.
Breast asymmetry	Delete 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.*
Breast prosthesis removal	Limit the funding to criteria to prosthesis removal to make safe only. Replacements will not be 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.*
Breast reduction	Change the wording for the severity of functional problems
Gynaecomastia	Clarification on the place of mastectomy for painful gynaecomastia Rationale: *This is based on advice from surgical colleagues taking into account the lack of evidence for the effectiveness of surgical treatment for painful gynaecomestia.*
Mastopexy	Delete 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.*
Revision mammoplasty	Policy deleted as covered by other policies.
Blepharoplasty	Clarification of wording to emphasise that surgery will only be funded for functional problems and not for cosmetic issues.
Apicectomy	Removed. NHS England commissioning responsibility
Dental implants	Removed. NHS England commissioning responsibility
Orthodontic treatments for essentially cosmetic nature	Removed. NHS England commissioning responsibility
Varicose veins in the legs	Revised wording of criteria around significant discomfort and quality of life as indication for referral and surgical treatment in line with NICE guidance.
Resurfacing procedures: Dermabrasion, chemical peels and laser treatment	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.*
Abdominoplasty or Apronectomy	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.
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 lesions	Include cryotherapy as removal option. Added more specific criteria to clarify clinical condition of the lesion.

Tonsillectomy	Clarification added that Tonsillectomy for the treatment of halitosis associated with tonsilloliths will not be routinely funded.
December 2015	
Autologous Cartilage Transplantation	New policy inclusion to clarify that treatment is not routinely funded
Bunions	New policy inclusion.
Discectomy for Lumbar Spine Prolapse	New policy inclusion
Dupuytrens Contracture	New policy inclusion
Hip Prosthesis and Resurfacing	New policy inclusion
Facet Joint Injection	New policy inclusion
Epidural Injections for Lumbar Back Pain	New policy inclusion
Exogen Ultrasound Bone Healing	New policy inclusion
Knee Arthroscopy	New policy inclusion
Trigger Finger	New policy inclusion
Cervical Spinal Disc Prosthesis	New policy inclusion to clarify that treatment is not routinely funded
Extracorporeal Shock-wave Therapy for Planta Fasciitis	New policy inclusion to clarify that treatment is not routinely funded
Bone Morphogenetic Proteins	New policy inclusion
In vitro fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI).	Clarity added that funding is not routinely provided for egg donation or surrogacy.
Breast Reduction	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.
June 2016	
Frequently Asked Questions	Clarity added that psychological distress does not constitute exceptionality
Carpal Tunnel Syndrome	Title amended to Carpal Tunnel Surgery

Breast Prosthesis Removal	Clarity added that Breast Prosthesis replacement will not routinely be funded
Tonsillectomy	Clarity added around exclusions to policy
Rhinoplasty	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.
Hip Prosthesis	Clarity added that this is a quality statement around prosthesis.
Circumcision	Clarity added to the medical indications for treatment.
November 2016	
Frequently Asked Questions	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.
Cosmetic Treatments	Clarity added that funding will not be provided for treatments that are requested to achieve a cosmetic outcome.
Autologus Serum Eye Drops	Clarity added that funding will only be provided on a trial basis.
Back Pain	Inclusion of New Policy
Breast Prosthesis	Title changed to Breast Prosthesis Removal. Replacement removed from title.
Breast Reduction	Clarity added that repeat surgery will not be funded.
Carpal Tunnel	Link to shared decision making tool added.
Cholecystectomy	Link to shared decision making tool added.
Circumcision	Clarification of wording to emphasis that surgery will only be carried out for functional issues.
Complementary Therapies	Inclusion of new policy
Discectomy	Re-termed as Back Pain – Discectomy
Epidural Injections	Removed as covered within Back Pain Policy
Face or Brow Lift	Clarity added the funded will only be considered based on functional impairments
Facet Joint injections	Removed as covered within Back Pain Policy

Ganglia	Amalgamation of criterion
Groin Hernia	Inclusion of new policy
Grommets in Children	Inclusion of new policy
Hip Replacement Surgery	Inclusion of new policy
Hysterectomy for Heavy Menstrual Bleeding	Inclusion of new policy
IVF	Clarity added around surrogacy pathways
Knee Replacement Surgery	Inclusion of new policy
Lipomata	Treatment type removed as captured within removal of benign skin lesion policy.
Removal of Tattoo	Definition of a tattoo added for clarity and that funding will not routinely be provided.
Removal of Benign Skin Lesion	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.
Resurfacing Procedures	Examples provided over treatments within the scope of the policy
Tonsillectomy	Clarity added to detail the previous history of the patient
Vaginoplasty	Link added to the RCOG guidelines on this treatment
June 2017	
Carpal Tunnel	Amendment to wording from AND to OR to reflect criteria requirement
Hip Replacement Surgery	Amendment to criteria wording to reflect “may include” joint injections as non-surgical treatment.
Knee replacement Surgery	Amendment to criteria wording to reflect “may include” joint injections as non-surgical treatment.

September 2017		
Policy Area	**Notes**	**Contributors**
Various	Re-wording of the Shared Decision Making statements throughout the policy, replacing the *mandated* use of	Clinical leads for NE&C and Deputy Medical Director North Tees FT

	the NHS Rightcare SDM tool with the following statement: 'There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision Making tool. Patient decision making aids are available to search through the following link: https://www.evidence.nhs.uk/Search?q=.'	
Cosmetic Surgery	Addition of procedures to this statement of clarity	Clinical Leads for North Durham CCG, South Tyneside CCG, HRW CCG, and Public Health Darlington
Autologous Cartilage Transplantation	Removal of policy due to NHSE Commissioning responsibility.	NE&C Clinical Leads and NHSE Commissioners
Back Pain – Facet Joint Injections	Removal of policy – replaced by Low (lumbar) Back Pain and Sciatica Policy	NE&C Clinical Leads and Deputy Medical Director North Tees FT
Back Pain - Discectomy for Lumbar Spine Prolapse	Removal of policy – replaced by Low (lumbar) Back Pain and Sciatica Policy	NE&C Clinical Leads and Deputy Medical Director North Tees FT
Back Pain - Injections for Radicular Leg Pain	Removal of policy – replaced by Low (lumbar) Back Pain and Sciatica Policy	NE&C Clinical Leads and Deputy Medical Director North Tees FT
Bariatric Surgery	Inclusion of policy relating to Bariatric Surgery following change in commissioning responsibility from NHSE. No change to previous NHSE policy.	NE&C Clinical Leads and NHSE Commissioners
Bone Morphogenetic Protein	Removal of policy due to NHSE Commissioning responsibility.	NE&C Clinical Leads and NHSE Commissioners
Cervical disc prosthesis	Removal of policy due to NHSE Commissioning responsibility.	NE&C Clinical Leads and NHSE Commissioners
Circumcision	Clarification that the policy applies to both Adults and Children	Clinical Leads for North Durham CCG, South Tyneside CCG, HRW CCG, and Public Health Darlington
Dupuytren's contracture	Update to Policy based on revised NICE Guidelines (NICE TA 459):	NE&C Clinical Leads and Public Health Durham

	Policy for Collagenase Injections updated	
Excimer Laser treatment for poor refraction following corneal transplant or cataract surgery	Removal of policy as this is now incorporated under a new policy addition – Surgery for Refractive Error (including Excimer Laser treatment for poor refraction following corneal transplant or cataract surgery)	NE&C Clinical Leads
Fertility preservation for cancer	Removal of policy due to NHSE Commissioning responsibility.	NE&C Clinical Leads and NHSE Commissioners
Functional Electrical Stimulation	Inclusion of new policy	Clinical Leads for North Durham CCG, South Tyneside CCG, HRW CCG, and Public Health Darlington
Gastric Neuromodulation	Inclusion of new policy	Clinical Leads for North Durham CCG, South Tyneside CCG, HRW CCG, and Public Health Darlington
Grommets in Children	Title of policy to be amended to; 'Grommets (and other ventilation devices) in children' Removal of the words 'Referral should be urgent within 2 weeks' as it is a chronic condition and is not urgent. Additional criteria to be added under the section 'Referral for a Specialist Opinion when', as follows; *OR* The child has recurrent acute otitis media (defined as three or more episodes in 6 months, or four or more episodes in 12 months with at least one episode in the past 6 months) in whom conservative measures have been ineffective. Additional criteria added to the policy in relation to the insertion of ventilation tubes as follows;	Clinical input from Newcastle Hospitals ENT Consultants Clinical Leads for North Durham CCG, Newcastle Gateshead CCG.

	OR The ventilation tube is inserted for the diagnosis of underlying sensor-neural hearing loss *OR* The treatment of recurrent acute otitis media (defined as three or more episodes in 6 months, or four or more episodes in 12 months with at least one episode in the past 6 months) in whom conservative measures have been ineffective. *OR* The treatment of chronic retraction of the tympanic membrane. Removal of 'Adjuvant adenoidectomy is not recommended in the absence of persistent and/or frequent upper respiratory tract symptoms'.	
Hip Replacement	Clarity added around access to activity and exercise being 'appropriate to age'	Orthopaedic Consultants CDDFT
Hyperhidrosis Treatment with Botulinium Toxin	Clarification that treatment is only applicable to patients 17 years or over	Clinical Lead for Northumberland CCG and Newcastle Hospitals Dermatology Consultant
Hysterectomy for Heavy Menstrual Bleeding	Clarification added to the policy to ensure patient choice is secured as part of criteria	Clinical Leads for North Durham CCG and CDDFT Obstetrics and Gynae Consultants
Knee Replacement	Clarity added around access to activity and exercise being 'appropriate to age'	Orthopaedic Consultants CDDFT
Low (lumbar) back pain and sciatica (radicular pain)	Inclusion of new policy	NE&C Clinical Leads and Deputy Medical Director North Tees FT
Low Back Pain - Spinal injections	Inclusion of new policy	NE&C Clinical Leads and Deputy Medical Director North Tees FT

Low Back Pain - Radiofrequency denervation (rhizolysis)	Inclusion of new policy	NE&C Clinical Leads and Deputy Medical Director North Tees FT
Low Back Pain - Epidural and nerve root injections	Inclusion of new policy	NE&C Clinical Leads and Deputy Medical Director North Tees FT
Low Back Pain - Spinal decompression and discectomy (lumbar)	Inclusion of new policy	NE&C Clinical Leads and Deputy Medical Director North Tees FT
Low Back Pain - Spinal fusion	Inclusion of new policy	NE&C Clinical Leads and Deputy Medical Director North Tees FT
Low Back Pain - Lumbar Disc replacement	Inclusion of new policy	NE&C Clinical Leads and Deputy Medical Director North Tees FT
Resperate device for hypertension	Inclusion of new policy	Clinical Leads for North Durham CCG, South Tyneside CCG, HRW CCG, and Public Health Darlington
Removal of Benign Skin Lesions	Policy title changed to 'Minor Skin Lesions' and additional criteria to add 'impairment of visual field'.	NE&C Clinical Leads and input from NuTH Consultants
Rhinoplasty	Title of policy to be amended to; Septorhinoplasty Addition to the policy to include Septoplasty for nasal deformities and additional criteria linked to nasal deformity	Clinical Leads for North Durham CCG, South Tyneside CCG, HRW CCG, and Public Health Darlington
Surgery for Refractive Error (including Excimer Laser following corneal transplant or cataract surgery	Inclusion of new policy for overall refractive error, but incorporating the previous position on Excimer Laser treatment for poor refraction following corneal transplant or cataract surgery	Clinical Leads for North Durham CCG, South Tyneside CCG, HRW CCG, and Public Health Darlington
Tonsillectomy	Clarity added to the criteria to note that episodes of tonsillitis must have been adequately treated and must have occurred in each of the relevant preceding periods. Additional criteria added to clarify that where there is a suspicion of malignancy, funding will be approved.	Clinical input from Newcastle Hospitals ENT Consultants Clinical Leads for North Durham CCG, Newcastle Gateshead CCG.

February 2018 – For Implementation from 1st April 2018		
Policy Area	**Notes**	**Contributors**
Anal Fissure (Surgery)	Inclusion of new policy.	NE&C CCG Clinical Leads and Clinical Teams from Gateshead Health FT and Newcastle Hospitals FT
Bariatric Surgery	Removal of the word 'local' to clarify that patient's still need to attend one of the regions specialist weight loss programmes. Clarification that the policy only refers to Adults. Paediatrics continues to be NHSE commissioning responsibility.	NE&C Clinical Leads and NHSE Commissioners
Bunions	Merged with new Policy addition – Bunions / Minor Foot Problems	NE&C CCG Clinical Leads
Circumcision	Additional criteria added to policy to allow procedure for Leukoplakia - suspicion of cancer.	NE&C CCG Clinical Leads
Dialation and Curettage for treatment of heavy menstural bleeding.	Inclusion of new policy.	NE&C CCG Clinical Leads and Clinical Teams from Gateshead Health FT
Extracorpreal Shockwave for MSK conditions	Inclusion of new policy	NE&C CCG Clinical Leads
Freestyle Libre Flash Glucose Monitoring	Policy included within VBCC Policy document based on the notification distributed to Providers during 2017 and to correlate with criteria already established through VBC Checker.	NE&C CCG Clinical Leads
Groin Hernia	Clarity added to policy to state that this applies to adults only	NE&C CCG Clinical Leads
Haemorroidectomy (Surgical)	Inclusion of new policy.	NE&C CCG Clinical Leads and Clinical Teams from Gateshead Health FT and Newcastle Hospitals FT
Hair Grafting – Male pattern baldness and hair transplantation	Policy amended to clarify that surgical treatment of hair loss is not routinely funded. Title of policy to be updated to 'Surgical Treatment for Hair Loss'	NE&C CCG Clinical Leads and Clinical Teams from Newcastle Hospitals FT and North Durham CCG
Hip Arthroscopy	Inclusion of new policy.	NE&C CCG Clinical Leads

Hyperhidrosis - Referral	Inclusion of new policy.	NE&C CCG Clinical Leads and Clinical Teams from Newcastle Hospitals FT and North Durham CCG
Hyperhidrosis – Thoracic Sympathectomy (Endoscopic or Open)	Inclusion of new policy.	NE&C CCG Clinical Leads and Clinical Teams from Newcastle Hospitals FT and North Durham CCG
Iljzarov Technique	Inclusion of new policy.	NE&C Clinical Leads and Consultant Orthopaedic Surgeons at North Tees FT and CDDFT.
Low Back Pain – Epidural and Nerve Root Injections	Clarity added to policy to note that nerve root injections for diagnostic purposes is acceptable where a PAT is present.	NE&C Clinical Leads and NHSE Commissioners
Low Back Pain – Spinal decompression and discectomy (lumbar)	Revision to policy to add criteria stating 'Magnetic resonance imaging shows compression of the neural elements consistent with the clinical symptoms'	NE&C Clinical Leads and NuTH Spinal Consultants
Oculoplastic Eye Problems – Surgery for Minor Eyelid Lesions; Ectropion; Entropion; Blepharitis.	Inclusion of new policies.	NE&C CCG Clinical Leads and Clinical Teams from Newcastle Hospitals FT, South Tees FT and North Durham CCG
Paediatric Foot Problems	Inclusion of new policy.	NE&C CCG Clinical Leads
Sacral Nerve Stimulation for Bladder Symptoms	Inclusion of new policy.	NE&C CCG Clinical Leads and Clinical Teams from Newcastle Hospitals FT
Surgical Fillers	Inclusion of new policy	NE&C CCG Clinical Leads and Clinical Teams from Newcastle Hospitals FT and South Tees FT
Tonsillectomy	Clarity added to note that the policy does not apply to recurrent quinsy, ie: surgery for this diagnosis is acceptable.	NE&C CCG Clinical Leads and Clinical Teams from Newcastle Hospitals FT
Trigger Finger	Clarity added that the policy covers adults only	NE&C CCG Clinical Leads and Clinical Teams from Newcastle Hospitals FT
Vasectomy under general Anaesthetic	Inclusion of new policy.	NE&C CCG Clinical Leads

September 2018 – For Implementation from 1st November 2018		
Breast - Revisions of Breast Reconstruction Surgery and Repeated Courses of Nipple Tattooing	Nipple Tattooing added under a separate policy under the title of 'Revisions of Breast Reconstruction Surgery and Repeated Courses of Nipple Tattooing', in order to provide clarity around all elements of the breast reconstruction process.	NE&C CCG Clinical Leads and Clinical Teams from Newcastle Hospitals FT & Gateshead FT
Septorhinoplasty for nasal deformities	The title of the policy is now amended to be clear that it applies to all three procedures. The title will read as follows; 'Septorhinoplasty, Rhinoplasty, and Septoplasty for nasal deformities' Clarity also added to the background information, and the policy description, that the policy relates to all three procedures.	NE&C CCG Clinical Leads
Dupuytren's Contracture - Surgery	Dupuytren's Contracture – Surgery; title of policy to be amended to 'Dupuytren's Contracture – Referral for Secondary Care Opinion'. Criteria for obtaining prior funding approval to now read that patients need to have rapidly progressive disease AND interferes with lifestyle. Clarity added to the policy that if a primary care clinician refers for a specialist opinion and includes the PAT, then the specialist does not need to obtain a further PAT if their decision is to treat via surgery.	NE&C CCG Clinical Leads
Dupuytren's Contracture – Collagenase clostridium histolyticum (CCH) Injections	Criteria for obtaining prior funding approval to now read that patients need to have rapidly progressive disease AND interferes with lifestyle.	NE&C CCG Clinical Leads

Low Back Pain – Spinal Fusion	Spinal Fusions whilst previously not routinely commissioned will now be recognised as a commissioned procedure where a specific set of criteria are met, as detailed within the policy.	NE&C CCG Clinical Leads and Clinical Teams from Newcastle Hospitals FT
Low Back Pain – Radiofrequency denervation (Rhizolysis)	Criteria around non-surgical treatment including CPPP made more explicit and to address where a pain programme is not available. Criteria relating to the intervals between treatment provided has been updated to 16 months.	NE&C CCG Clinical Leads and Clinical Teams from Newcastle Hospitals FT
Continuous Glucose Monitoring	Inclusion of new policy	NE&C CCG Clinical Leads, NTAG Guidance, and Northern England Clinical Networks published guidance.
Low Back Pain – Epidural and Nerve Root Injections	Criteria around non-surgical treatment including CPPP made more explicit and to address where a pain programme is not available.	NE&C CCG Clinical Leads and Clinical Teams from Newcastle Hospitals FT
Freestyle Libre Flash Glucose Monitoring	Policy title to be amended to simply read - 'Flash Glucose Monitoring' Background information and policy wording also amended where necessary to be consistent with the new title of the policy	NE&C CCG Clinical Leads
Oculoplastic Eye Problems – Surgery for Minor Eyelid Lesions	The final bullet point within the policy criteria stating 'A suspicion of basal cell Carcinoma', has now been removed.	NE&C CCG Clinical Leads
Hip Replacement Surgery	Statement to be added to the end of the policy text to read that revision surgery for Hip replacements is not currently included within the scope of this policy.	NE&C CCG Clinical Leads

Knee Replacement Surgery	Statement to be added to the end of the policy text to read that revision surgery for Knee replacements is not currently included within the scope of this policy.	NE&C CCG Clinical Leads