Clinically Effective Commissioning Policy

(formerly Low Priority Procedures (LPPs) and Other Restricted Procedures (ORPs) Policy)

APPROVED BY:	Approved by Quality and Governance Committees September 2018
EFFECTIVE FROM:	September 2018
REVIEW DATE:	September 2020

This policy must be read in conjunction with the following policies:

Individual Funding Requests Policy
Prescribing for Clinical Need Policy

Up-dated December 2017 in line with Tranche 1 of the Sussex and East Surrey STP Clinically Effective Commissioning Programme

Up-dated January 2018 in line with Tranche 2 of the Sussex and East Surrey STP Clinically Effective Commissioning Programme

Up-dated June 2018 in line with Tranche 0 of the Sussex and East Surrey STP Clinically Effective Commissioning Programme

Version Control

Policy Category:		Commissioning
Relevant to:		All staff (including temporary staff contractors and seconded staff)
Version History		
1.	29/01/2015	Ratified by Governing Bodies
1.1.	May 2016	Review by Governance and Policy Officer
1.2.	June 2016	Review by Individual Funding Request Panel Officer
1.3.	January 2017	Review by Director of Performance and Delivery
1.4.	January 2017	Approved by Quality and Governance Committee
2.	January 2017	Ratified by Governing Bodies
2.1.	November 2017	Section 71 – Tonsillectomies amended to reflect updated SIGN guidance
2.2.	December 2017	Amended in line with Tranche 1 of the Sussex and East Surrey STP Clinically Effective Commissioning Programme
2.3.	January 2018	Amended in line with Tranche 2 of the Sussex and East Surrey STP Clinically Effective Commissioning Programme
2.4.		Approved by High Weald Lewes Havens Clinical Effective Committee
2.5. .	24/01/2018	Amended policy approved by Q&G Committees
3.	31/01/2018	Ratified by Governing Bodies
3.1.	June 2018	Amended in line with Trance 0 of the Sussex and East Surrey STP Clinically Effective Commissioning Programme
3.2.	August 2018	Reviewed by Head of Governance and Business Planning
3.3.	September 2018	Reviewed by Chief Operating Officer
4.	19/09/2018	Approved by Quality and Governance Committee

Contents

1. RATIONALE AND SCOPE OF LOW PRIORITY PROCEDURES POLICY.

1.1. The CCGs have designated a number of procedures as low priority for NHS funding.

1.2. The CCGs with the clinicians across our health economies, have considered evidence of clinical effectiveness and experience, information on current activity, resources, costs and provision in order to formulate the following policies.

1.3. The rationale for tightening restrictions on procedures is as follows:

- To allow funding to be concentrated on treatments which result in the most health gain and hence make the best use of limited resources for our population.
- To offer better treatment access to patients with a high clinical priority by reducing referrals / admissions to the waiting lists.

1.4. The NHS as a whole is under significant financial pressure to provide funds for all treatments (or preventative measures) for all patients in its area. The NHS does not have the resources to meet all these demands. Therefore, the CCGs have to make difficult choices about which treatments / services represent the best use of its finite resources and provide the greatest evidence for clinical effectiveness and health gain for our patients.

1.5. In arriving at these decisions on the most appropriate use of resources the CCGs have taken into account the following factors:

a) The extent to which the problem in question is an illness, disease, injury or impairment.
b) The evidence of clinical and cost effectiveness of the treatments.
c) Whether the proposed treatment represents the appropriate clinical strategy to address the problem.
d) Whether the service to address the problem can, and should, be subject to NHS funding.
e) To ensure as far as possible that policies are in keeping with other government guidelines e.g. DVLA.
f) Considering policies made locally, regionally and nationally to reduce differences between commissioners where possible.

1.6. There is no blanket ban on these procedures. There is an established mechanism for dealing with individual funding requests (IFR) / exceptions where it is felt that a possible exception to the policy criteria may exist and require a panel assessment of the individual case being brought forward as an exception. The application form for clinicians wishing to request funding for individuals that are eligible against the definitions of a **"rarity request"** or an **"exceptionality request"** is set out in the Individual Funding Request Policy, available on the EHS CCG and HR CCG staff Intranet at:
www.eastbournehailshamandseafordccg.nhs.uk/intranet/intranet-search/?q=ifr
The IFR application can be sent via secure email to HRCCG.esifrs@nhs.net and **please ensure that the patient's NHS number is included on all correspondence**.

NB: Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG and High Weald Lewes Haven CCG will not pay for these procedures unless prior authorisation is obtained.

1.7. This Policy does **not** cover:

- The use of medicines and related products except where they are an integral part of a Low Priority Procedure. The East Sussex Area Prescribing Committee is responsible for the prioritisation of drugs and related products via the East Sussex Health Economy Formulary. For information on medicines and products considered less suitable for prescribing, please see the Prescribing for Clinical Need Policy, available on the staff Intranet at: www.eastbournehailshamandseafordccg.nhs.uk/intranet/intranet-search/?q=Clinical+Need+
- Procedures directly funded by NHS England (NHSE), an IFR request form can be downloaded at www.england.nhs.uk/publication/specialised-services-individual-funding-requests/
- The costs of an NHS patient who transfers to a provider for private treatment.

1.8. The CCG **does not routinely fund** Interventional Procedures Guidance exceptions as listed on the NICE website. A list is regularly updated by NICE, please visit the NICE website for up-to-date information.

1.9. This Policy also includes other procedures which are funded by the CCG but where restrictions apply.

1.10. **Clinical Trials,** Where there is a possibility that there may be impacts on NHS funded care following the cessation of a trial or a patient's completion of a trial, clinicians are advised to discuss this with the CCGs at the earliest opportunity. Such requests will be considered within the context of the CCG's Area Prescribing Policy.

2. REVIEW.

2.1. This policy will be the subject of review in the light of experience, national guidelines and emerging clinical evidence. The implementation of this policy will be audited on a two-yearly basis, or when changes in legislation dictate.

2.2. This version of the policy includes Tranches 0, 1 and 2 of the work by the Sussex and East Surrey Sustainability and Transformation Partnership (STP) to review and standardise clinical thresholds and policies to bring a uniform approach to policy review and implementation across the STP to remove unwarranted variation and apply sound clinical decision making.

2.3. Further tranches are likely to propose changes to the existing policy. The proposals will, similarly, be subject to approval by all Sussex CCGs. They will be submitted through our CCG's Quality and Governance Committees for scrutiny and approval, which will be subject to ratification by the CCG Governing Bodies.

3. EQUALITY STATEMENT.

3.1. In applying this policy, the CCG will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups, in particular on the grounds of the following characteristics protected by the Equality Act (2010); age, disability, sex,

gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic.

3.2. As statutory bodies the Sussex CCGs (the CCGs) are required to make clear and transparent decisions about the availability of medicines and treatments. The NHS Constitution makes clear that patients have:

> "*the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you."*

3.3. The policies within this document have been formulated through a clear process and are based on evidence of clinical effectiveness and value for money. The intention is to have equitably applied clinically based policies which are transparent.

3.4. In addition the CCGs Code of Conduct positively promotes standards of behaviour by stating that "Individuals must not do anything, in carrying out their CCG activities, to breach their equality duties" and that CCG members behaviours should evidence "Promoting equality and diversity in the treatment of staff, patients, their families and carers, and the community, and in the design and delivery of services for which they are responsible".

Appendix A: Low Priority Procedures and Other Restricted Procedures.

In exceptional circumstances, funding for the procedures listed may be approved on an individual basis, via the agreed CCG mechanism as described in paragraph 1.6 of the policy.

1. **Abdominoplasty / Apronectomy.** **Updated September 2018**
   This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

2. **Acupuncture.** **Updated September 2018**
   Acupuncture is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

3. **Acne Scarring.** **Updated September 2018**
   This is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

4. **Aromatherapy.** **Updated September 2018**
   This therapy is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

5. **Arthroscopy of the Knee** **updated January 2018 and September 2018**
   This policy covers the use of knee arthroscopy as a **surgical treatment**

   Knee Arthroscopy for chronic osteo-arthritis **is not routinely funded.**

   Arthroscopy of the knee **can be undertaken** where there is reasonable evidence as shown by MRI or other procedures / examination that treatment is needed for one or more of the following:
   - Removal of loose body.
   - Meniscal surgery (repair or resection).
   - Ligament reconstruction / repair (including lateral relapse).
   - Synovectomy.
   - Treatment of articular defects e.g. micro-fracture.

   It does not cover arthroscopy recommended by an orthopaedic specialist in those under 18 years of age or in adults following:
   - Acute injury with suspected internal joint derangement.
   - Septic arthritis.
   - Suspected malignancy.

   Funding **will NOT** be approved for:
   - Arthroscopic lavage and debridement as part of treatment for osteoarthritis (NICE Interventional Procedure Guidance 230).
   - Use as a primary diagnostic tool.

6. Blepharoplasty (eyelid surgery) updated December 2017

The CCG will consider funding if there is **evidence of impairment of visual fields** in the relaxed, non-compensated state.

All applications should be submitted with copies of both taped and non-taped in the form of:

either

- The 120 point Humphrey screening test results.

or

- The Superior 36 screening test.

This procedure will not be funded for cosmetic reasons.

NB: The CCG supports the correction of ectropion and entropion where clinically indicated**.**

Facial Reconstruction and treatment of cancers is out of scope of this policy.

7. Body Contour Procedures. Updated September 2018

This is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

8. Botulinum Toxin Injections

The CCG supports the use of botulinum toxin injections for the treatment of the following conditions:

- Blepharospasm.
- Cervical dystonia.
- Hemifacial spasm.
- Urinary frequency (NICE Clinical Guidance 171 and NICE Clinical Guidance 148).
- Migraine. (NICE Technology Appraisal Guidance 260).
- Hyperhidrosis affecting the axillae when all conservative treatments have been tried without success. (NICE Hyperhidrosis clinical knowledge summary).

Botulinum toxin injections for other conditions will not be funded.

9. Brachioplasty / Upper Arm Lift. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

10. Breast Surgery

10.1. Breast Augmentation / Reduction / Mammoplasty. Updated December 2017

Funding for this procedure requires prior approval. A funding application for breast reduction will be considered an option for patients who fulfil **all** the following criteria:

- Documented on-going physical symptoms of back, neck and/or shoulder pain due to large breasts (plus documented evidence for treatment of pain).
- Requires more than 500g tissue to be removed from each breast (to be assessed by the surgeon).
- BMI<26kg/m^2.
- Non-smoker.
- Breast development is complete (documented for at least 18 months).

10.2. Revision of Breast Augmentation / Mammoplasty updated December 2017 and September 2018

Revision of breast augmentation is **not routinely funded** for any patient group.

Replacement of breast implants is **not routinely funded** within the local NHS for any patient group, this includes following removal of breast implants where it is considered clinically necessary and available on the local NHS.

The CCG **will consider** a funding application for the removal of breast Implant(s) where it is clinically indicated but will not routinely fund replacement implants.

The above statement applies to both patients who underwent their original breast augmentation privately and those who received it on the NHS.

These recommendations **do not apply to the following**:

- Patients undergoing breast reconstruction as part of treatment for breast cancer.
- Patients with PIP implants for whom national guidance applies.
- Patients undergoing gender reassignment surgery or Sex reassignment surgery services commissioned by NHS England offer surgical procedures (which may include breast augmentation and/or breast removal) as part of the gender dysphoria treatment pathway. Queries or requests in this regard should be directed to NHS England.

Where implants have been fitted in the private sector it is not an NHS responsibility and /or priority to remove and replace implants. The NHS is not responsible for follow up cosmetic breast surgery following an earlier privately funded augmentation. Patients are required to refer to their breast implant provider for removal.

10.3. Correction of Gynaecomastia. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

10.4. Mastopexy. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

10.5. Nipple Eversion / Inversion. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

11. Brow Lift

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

12. Brow Ptosis updated January 2018

Scope of Policy is **only** for age 18 and above. **Policy Covers both Brow Ptosis and Dermatochalasis.**

Blepharoplasty, brow lift and ptosis correction will be funded by CCG for dermatochalasis, brow ptosis and blepharoptosis if the following criteria apply:

Functional impairment and significant symptoms where **all** of the following must be met:

- Patient must constantly raise eyebrows to see.

and

- In the resting position (with eyebrows not raised) eyelids cause significant visual field obstruction leading to functional impairment as evidenced by one of:
  - the 120 point Humphrey screening test,
  - the superior 36 screening test,
  - impairment of 30% of upper vision.

and

- Validated visual QOL tool as part of assessment process.

Please note that the following indications for eye lid surgery **are out of scope of this policy** as they are routinely provided under contract:

- Reconstructive surgery.
- Trauma.
- Dysthyroid eye disease.
- Third nerve palsy.
- Myasthenia gravis.
- Myopathy.
- Post-cancer reconstruction.
- Entropion and ectropion correction.

13. Bunions – updated December 2017 and September 2018

The CCG will fund surgery for Hallux Valgus when:

- The patient experiences persistent significant pain and functional impairment that is interfering with the activities of daily living.

and

- **All** appropriate conservative measures have been tried over a six-month period and failed to relieve symptoms, including up to six months of evidence-based non-surgical treatments. Conservative management techniques include:

- Avoiding high heel shoes and wearing wide fitting leather shoes which stretch.
- Exercises specifically designed to alleviate the effects of a Hallux Valgus and keep it flexible.
- Applying ice and elevating painful and swollen Hallux Valgus.
- Use of Hallux Valgus pads, splints, insoles or shields.

and

- The patient understands that they will be out of sedentary work for 2-6 weeks and physical work for 2-3 months and they will be unable to drive until advised by their surgeon.

The CCG will not fund surgery for cosmetic reasons for Asymptomatic Hallux Valgus

14. Buttock Lift. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

15. Calf Implants. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

16. Carpal Tunnel Decompression added January 2018 and updated September 2018

Carpal Tunnel surgery will be funded by the CCG and the patient may be referred for surgery by the referring clinician if the below criteria have been met:

1. **One of the following:**
   - Acute, severe symptoms, that interfere with daily life due to pain or sensory loss which persist after conservative therapy having tried a local corticosteroid injection by a trained, competent practitioner, and nocturnal splinting for 8 weeks for acute severe symptoms.
     or
   - Mild to moderate symptoms including pain or sensory loss, which persist for at least 3 months after conservative therapy having tried local corticosteroid injection (if appropriate) and nocturnal splinting (used for at least 8 weeks).
     or
   - Positive diagnostic nerve conduction study
     or
   - Presence of muscle wasting.

2. **And** shared decision making is adopted and the patient wants surgery.

17. Cataract added January 2018

Adults with a visual acuity of 6/12 or better (with the aid of glasses or contact lenses if worn) in the cataract affected eye are considered a low priority for cataract surgery.

Referrals from GP/ community services should only be made after an assessment of the patient's visual acuity and consideration of the patients reported effect of glare on their ability to manage activities of daily living.

Surgery for cataract will be funded by CCGs based on the following indications:

- Best corrected visual acuity must be **worse than 6/12 in the cataract affected eye**

and / or

- Where glare affects the patient's ability to manage their activities of **daily living** rather than visual acuity alone. Consider the impact any deficit is having on their lifestyle, is their livelihood compromised, can they live independently. (V/A = 6/12 or worse with QOL Questionnaire)

and

- Patient's willingness to have cataract surgery;
- The referring optometrist or GP has discussed the risks and benefits and ensured the patient understands and is willing to undergo surgery prior to referral.
- Patient Decision Aids (PDA) need to be explicit - there is a national PDA for Cataracts which needs to be used.

QOL assessment to be completed in primary care (Optometrist)

VA needs to be done in secondary care due to quality of machines in community / primary

Second Eye Surgery:
Patients should only undergo surgery of the second eye when that cataract affected eye meets the thresholds of worse than 6/12 visual acuity or glare affects their ability to manage their activities of daily living.

Exceptions
Cataract surgery can continue to be performed for medical reasons such as:

- Acute glaucoma.
- Diabetes.
- Patients with severe anisometropia who wear glasses.

The clinical reason for the surgery should be clearly documented.

Cataracts in children is not in scope of this policy

18. Cerebellar Stimulator Implants. New section September 2018

Enquiries and applications should be directed to NHS England.

19. Chalazia updated December 2017 and September 2018
This procedure is not routinely funded.

The CCG will fund excision of Chalazia when **all** of the following criteria are met:

- The chalazia has been present for more than 6 months.
- It is situated on the upper eyelid.
- It is causing blurring of vision.

NB: In common with all types of lesions, the CCG will fund removal where malignancy is suspected.

20. Chemical Peels. Updated September 2018
This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

21. Chinese Medicines. Updated September 2018
These therapies are not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

22. Chiropractic Therapy. Updated September 2018
This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

23. Circumcision updated December 2017 and September 2018
CCG will fund circumcision surgery for the following indications:

- Suspected cancer or balanitis xerotica obliterans (lichen sclerosus).
- Congenital urological abnormalities when skin is required for grafting.
- Symptomatic cases of paraphimosis.
- Symptomatic cases of minor hypospadias.
- Recurrent balanoposthitis resistant to antibiotic treatment.
- The nature of the phimosis severely interferes with sexual function.
- Traumatic (e.g. zipper injury).

24. Clinical Ecology. Updated September 2018
This is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

25. Cochlear Implant
Enquiries and applications should be directed to NHS England..

26. Dental Extraction of Non-Impacted Teeth
Enquiries and applications should be directed to NHS England.

27. Dental Implants
Enquiries and applications should be directed to NHS England.

28. Dermabrasion of Skin. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

29. Detoxification – unplanned admission. New section September 2018

Unplanned admission for detoxification is not routinely funded by the CCG.

30. Dilation and Curettage updated December 2017 and September 2018

The CCG will fund Dilatation and Curettage (D&C) for heavy menstrual bleeding (HMB) if **one** of the following criteria, in accordance with NICE criteria, is met:

- As an investigation for structural and histological abnormalities where ultrasound has been used as a first line diagnostic tool and where the outcomes are inconclusive.
- Where dilatation is required for non-hysteroscopic ablative procedures, hysteroscopy should be used immediately prior to the procedure to ensure correct placement of the device.
- The patient has had outpatient negative pressure endometrial sampling (e.g. Pipelle TM sampling) with an unsatisfactory result.
- The patient has had a hysteroscopy and endometrial biopsy with an unsatisfactory histological result.
- Transvaginal ultrasound has demonstrated focal pathology and facilities for a hysteroscopy with targeted biopsy are unavailable.

The CCG will not commission D&C for therapeutic intervention for HMB.

The CCG will not commission D&C as a diagnostic tool for HMB in isolation.

31. Dupuytren's Disease updated January 2018

Surgical correction or CCH Injection for Dupuytrens Contracture will be funded if **criteria 1 and 2** are met:

1. **One** of the following:
   - There is a fixed flexion in one or more joints 30 degrees of greater at MPJ or PIPJ.
   - A contracture affecting fixed flexion / loss of extension exceeding 10 degrees at the interphalangeal joint (a positive Hueston's tabletop test).
   - Younger patients with disease affecting 2 or more digits and loss of extension exceeding 30 degrees or more.

2. **All** of the following criteria:
   - Patients are aware of the implications of the surgical procedure.
     - 50% recurrence rate within 3-5 years.
     - longer term recurrence rate with CCH has not been determined.
     - complications of the procedure. (Average success rate of CCH injection used for moderate severe group is about 63 %.).
   - Patient wants surgery or CCH injection after Shared decision making aids used.

If an exact measurement is not possible then clinical assessment should evaluate the extent of the disease and severity / deformity and assess limitation in hand function.

32. Electrolysis. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

33. Electronic Spinal Implants

There is no strong evidence to indicate that electronic spinal implants are clinically effective when used to treat chronic pain. Therefore, they are not routinely funded by the CCG.

Failed Back Surgery Syndrome and Chronic Regional Pain Syndrome (CRPS) type 1, more trials are needed to confirm whether spinal cord stimulation is an effective treatment for certain types of chronic pain. In addition, there needs to be a debate about trial designs that will provide the best evidence for assessing this type of intervention.

This conclusion was based on 2 RCTs (n = 81). One of the included studies looked at Failed Back Surgery syndrome, the other at CRPS type 1. All other studies on spinal cord stimulation were case series (and excluded from this review), so there is little evidence that spinal cord stimulation is effective when chronic pain is due to other causes.

NICE Technology Appraisal Guidance 159 states that spinal cord stimulators fall outside the remit of interventional procedure guidance.

34. Endoscopic Thoracic Sympathectomy for Facial Blushing. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

35. Excimir Laser Surgery for Short Sight / Long Sight of Astigmatism. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

36. Excision of Redundant Skin or Fat. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

37. EXOGEN Ultrasound Bone Healing System. New section September 2018

Not routinely funded unless criteria met in line with NICE MTG12 – “EXOGEN ultrasound bone healing system for long bone fractures with non-union or delayed healing”.

Medical technologies guidance [MTG12] Published date: January 2013

"NICE has said that EXOGEN can be used to treat non-union fractures of long bones (such as the tibia or femur, long bones in the leg). Non-union means that the fracture hasn't healed after 9 months. Healthcare teams may want to use the EXOGEN ultrasound bone healing system because the evidence shows high rates of fracture healing when it is used and it can save money, by avoiding surgery, compared with current treatment for non-union fractures."
www.nice.org.uk/guidance/mtg12

38. Face Lift. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

39. Facial Skin Procedure. New section September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

40. Female Genital Prolapse added January 2018. Updated September 2018

Asymptomatic patients should not be referred to secondary care. Surgery is not routinely funded for asymptomatic patients or those with mild symptoms.

Recurrent prolapse is out of scope of this policy.

CCGs will fund surgery for Female Genital / Pelvic Organ Prolapse for patients who meet the following criteria:

- Symptomatic pelvic organ prolapse (e.g. overactive bladder, incomplete emptying of bladder, feel lump / see lump, dragging sensation, sexual dysfunction)

and

- The patient has undergone a minimum of 6 months supervised lifestyle and specialist management (usually in the acute Trust), which should include:
  - A programme of supervised physiotherapy and pelvic floor exercises / muscle training (PFMT).
  - Weight loss if the patient's body mass index is 30 kg/m^2 or greater.
  - Managing chronic cough.
  - Received smoking caseation advice.
  - Avoiding constipation.
  - Avoiding heavy lifting and high-impact exercise.

41. Female Sterilisation updated December 2017. Updated September 2018

Sterilisation will not be available on non-medical grounds unless the patient has had at least 12 months' trial using Long Acting Reversible Contraception (LARC) and found it unsuitable.

The CCG will fund this procedure if **one** of the following applies:

- Where sterilisation is to take place at the time of another procedure such as caesarean section.

or

- Where there is a clinical contraindication to the use of a LARC.

or

- Where there are severe side effects with the use of LARC.

or

- Where there is an absolute clinical contraindication to pregnancy. These include;
  - young patient (under 45 years of age) undergoing endometrial ablation for heavy periods,
  - patient with severe diabetes.
  - patient with severe heart disease.

and

- Patients should be informed that vasectomy carries a lower failure rate in terms of post-procedure pregnancies and that there is less risk related to the procedure.

  Prior to referral and performance of the surgery the required consenting and counselling process as per RCOG guidelines must be followed.

- www.rcog.org.uk/globalassets/documents/guidelines/clinical-governance-advice/cga6.pdf
- www.fsrh.org/standards-and-guidance/documents/clinical-standards-consent-july2014/

42. Female Sterilisation – reversal. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

43. Foetal Alcohol Spectrum Disorder. New section September 2018

This procedure is not routinely funded by the CCGs. Assessment for, and diagnosis of, Foetal Alcohol Spectrum Disorder should be undertaken by local specialists; referrals to the National Foetal Alcohol Spectrum Disorder Clinic for specialist assessment will not be routinely funded.

Please contact the relevant CCG for information on referral pathways / local arrangements.

44. Functional Electrical Stimulation. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

45. Gallstones updated December 2017

The CCG will **not** routinely fund surgery for asymptomatic Gall Stones.

The CCG **will only support** the funding of cholecystectomy in asymptomatic gallstones if **one or more of the following criteria** are met:

- High risk of gall bladder cancer, e.g. gall bladder polyps ≥1cm, porcelain gall bladder, strong family history (parent, child or sibling with gallbladder cancer).
- Transplant recipient (pre or post-transplant).

- Diagnosis of chronic haemolytic syndrome by a secondary care specialist.
- Increased risk of complications from gallstones, e.g. presence of stones in the common bile duct, stones larger than 2cm or smaller than 3mm with a patent cystic duct, presence of multiple stones.
- Confirmed episode of gall stone induced pancreatitis or obstructive jaundice.

The CCG **will not normally support the funding** of cholecystectomy for patients in the following scenarios:

- **Asymptomatic gallstones** in patients undergoing **bariatric surgery**, unless intra-operatively the gall bladder is found to be abnormal or the presence of calculi are very apparent. In such cases it is worth considering concurrent cholecystectomy.
- **All** patients with **asymptomatic gallstones who do not meet any of the above criteria**.

46. Ganglion - Wrist and Foot updated January 2018

This Policy covers ganglions and **excludes** mucoid cysts.

This procedure is **not routinely** funded **except** when criteria 1 **or** 2 are met **and also** criteria 3.

1. **All** the following:
   - When the patient experiences persistent significant pain **or** functional impairment, attributed to ganglion that is interfering with the activities of daily living.

   and
   - The patient has had it explained that these may resolve and given opportunity for this to happen.

   and
   - Local protective padding has been tried and shoe wear changed (foot and ankle cases) to avoid pressure on the ganglion over a 6-month period and failed to relieve symptoms.

2. **Either** of the following:
   - Where there is a higher risk of ulceration over the ganglion arising from weight-bearing or shoe pressure especially where there are potential complications arising from co-morbidities; for example, neuropathy and diabetes.

     or
   - There is evidence of nerve or blood vessel compression.

3. Shared decision making is in place incorporating a full understanding of the risk and benefits, expected outcomes and requirement for aftercare.

47. Gender Reassignment

Enquiries and applications should be directed to NHS England..

48. Glaucoma Procedure – Endocyclophotocoagulation

As there are no current national recommendations for this procedure the CCG will not fund this treatment. It is expected that patients with raised intra-ocular pressure will be treated as per NICE guideline and pathway for Glaucoma.

49. Grommets and Ventilation Tubes (insertion / removal) policy for children under 12 years of age updated January 2018 and September 2018

(Note: There is a separate policy for children more than12 years and adults)

The CCG will fund grommets in children who are likely to benefit and meet **any** of the following eligibility criteria:

1. Children with demonstrable conductive hearing loss, with hearing in the better ear of 25 dBHL or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available), (evidenced by two hearing tests done minimum 3 months apart) in the presence of middle ear fluid **and one** of the following:
- Speech delay;
- Difficulties at school related to hearing;
- Behavioural difficulties related to hearing

2. Recurrent infections.
3. Sensory neural hearing loss with supra-imposed either fluctuating or persistent conductive loss.
4. Severe tympanic membrane retraction.
5. A second disability such as Down's Syndrome or Cleft Palate.

50. Grommets in older children (12 and above) and adults (ventilation tubes). Updated September 2018

(Note: There is a separate policy for children under 12.)

This procedure is not routinely funded for people over the age of 12 except under the following conditions:

- A middle ear effusion causing measured conductive hearing loss, with hearing in the better ear of 25 dBHL or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available), for a minimum of 6 months (documented by two hearing tests done 6 months apart) (earlier intervention may be justified in certain situations like flying and where ability to work is impacted) and is resistant to medical treatments.

AND

- The patient must be experiencing disability due to deafness; **OR**
- Persistent Eustachian tube dysfunction resulting in pain (e.g. whilst flying and where ability to work is impacted); **OR**
- As one possible treatment for Meniere's disease; OR
- Severe retraction of the tympanic membrane if the clinician feels this may be reversible and reversing it may help avoid erosion of the ossicular chain or the development of cholesteatoma;

Grommet insertion as part of a procedure for the diagnosis or management of head and neck cancer and/or its complications is not in scope of this policy

Balloon dilatation will only be considered as part of a research trial.

51. Haemorrhoids added 17January 2018, updated September 2018

Surgery will be commissioned for symptomatic:

- Grade III and IV haemorrhoids.
- Grade I or II haemorrhoids if they are large, symptomatic, and have not responded to the following non-surgical or out-patient treatments:
  - Diet modification to relieve constipation.
  - Topical applications.
  - Stool softeners and laxatives.
  - Rubber band ligation.
  - Sclerosant injections.
  - Infrared coagulation.

Surgical treatment options include:

- Surgical excision (haemorrhoidectomy).
- Stapled haemorrhoidopexy.
- Haemorrhoidal artery ligation.

Removal of skin tags is not routinely commissioned.

Removal of haemorrhoids as part of other surgeries or before other anal surgeries is permitted.

The grading system described by Goligher (Goligher JC. Advances in Proctology Practitioner 1964; 193:526-32), is the most commonly used and is based on objective findings and history:

- Grade I: No prolapse, vascular cushions in the anal canal visualized by endoscopy.
- Grade II: Prolapse during defecation, but spontaneous reduction.
- Grade III: Prolapse during defecation, which need manually reduction.
- Grade IV: Persistent prolapse irrespective attempt to reduce the prolapse.

52. Hair Transplant / Graft / Replacement / Interlace hair. Updated September 2018

These procedures are not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

Hallux Valgus – see Bunions

53. Herbal Remedies. Updated September 2018

This is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

54. Hernia Surgery updated January 2018 and September 2018

The scope of this Policy is for age **18** and above only. Recurrent hernia is not in scope of this policy.

Inguinal hernia repair will only be funded for patients with **one or more** of the following:

- History of incarceration or difficulty reducing hernia.

- Pain / symptoms interfering with activities of daily living or Threatened strangulation.
- Pain during strenuous activity.
- Inguino-scrotal hernia.
- Significantly increasing in size (assessed by GP follow up or reported history).

Umbilical hernia repair will only be funded for patients with **one or more** of the following:

- Pain / symptoms interfering with activities of daily living.
- Threatened strangulation.
- Significantly increasing in size (assessed by GP follow up or reported history).

Incisional hernia repair will only be funded for patients with **both** of the following:

- Pain / symptoms interfering with activities of daily living AND Conservative management e.g. weight loss, has been tried first where appropriate.
- Threatened strangulation.

Hernia repair using Strattice Mesh will not be funded for hernia repair surgery.

Femoral. All suspected femoral hernias are approved for a referral to secondary care.

55. Hirsutism Treatments. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

56. Homoeopathy. Updated September 2018

This is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

57. Hydrotherapy

This is not routinely funded by the CCG **unless** it is part of an established care package. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

58. Hyperbaric Oxygen Therapy for Wound Healing

Enquiries and applications should be directed to NHS England.

59. Hyperhidrosis Therapy. New section September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

60. Hypnotherapy. Updated September 2018

This is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

61. Hysterectomy for Heavy Menstrual Bleeding added 17January 2018, updated September 2018

The CCG will not routinely fund laparoscopic hysterectomy or open hysterectomy for dysfunctional uterine bleeding.

The CCG will fund the procedure if the **following criteria** are met:

1. **At least two** of the recommended drug treatments have failed, are not appropriate or are contra-indicated in line with the National Institute for Health and Clinical Excellence, 2015 NICE Clinical Guideline 44
    a) There has been an unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena®) for at least 12 months has failed to relieve symptoms unless it is medically inappropriate, declined by the patient or contraindicated.
    b) Tranexamic acid or NSAIDS or combined oral contraceptives.
    c) Norethisterone (15 mg) daily from days 5 to 26 of the menstrual cycle, or injected long- acting progestogens
2. Surgical treatments such as endometrial ablation or myomectomy have failed to relieve symptoms, or are not appropriate, or are contra-indicated, or have been declined by the patient.

62. Impacted Third Molar

Enquiries and applications should be directed to NHS England.

63. Indwelling Pleural Catheter for Treatment of Malignant Pleural Effusions in Community Setting. New section September 2018

Enquiries and applications should be directed to NHS England..

64. Keloidectomy. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

65. Labial Reduction / Labiaplasty. New section September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

66. Laser Therapy / Laser Treatment / Tunable Dye Laser for aesthetic reasons. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

67. Liposuction. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

68. Lower Back Pain (Non-Specific) – Surgical Procedures

The CCG will not routinely fund spinal injections or disc replacement for low back pain and will only fund other surgical procedures in line with the

recommendations in NICE Clinical Guideline 59.

69. Manual Lymphatic Drainage. Updated September 2018

This is not routinely funded by the CCG **unless** it is part of an established care package. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

70. Massage. Updated September 2018

This is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

71. Minor Irregularities of Aesthetic Significance. Updated September 2018

These procedures are not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

72. Minor Skin Lesions updated January 2018 and September 2018

This procedure is not routinely funded on cosmetic grounds alone.

Removal of benign skin lesions is available as a treatment option for patients where the lesion is associated with **any one** of the following:

- Suspicion of malignancy.
- Recurrent infection, discharge or spontaneous bleeding.
- Pain **or** impact on quality of life (DLQI score more than 10).
- Obstruction of an orifice to the extent that function is, or is likely to become, impaired.
- Pressure symptoms, e.g. on an organ, nerve or tissue.

The policy applies to all minor skin lesions including, but not limited to:

- Skin tags.
- Sebaceous cysts.
- Milia.
- Asymptomatic seborrheic keratosis.
- Warts of hands and feet (except if immunosuppressed).
- Skin tags (including anal / rectal).
- Corns / callous.
- Physiological androgenetic alopecia (male pattern baldness).
- Asymptomatic dermatofibromata.
- Asymptomatic fungal infections of toe nails.
- Comedones.
- Asymptomatic lipomata.
- Asymptomatic epidermal cysts (sebaceous cysts).
- Molluscum contagiosum.
- Mild or moderate non scarring acne vulgaris which has not been treated with 6 months of systemic therapy.
- Xanthelasma.
- Any other minor skin lesions.

Below is the link to the **DLQI** test tool and instructions: sites.cardiff.ac.uk/dermatology/quality-of-life/dermatology-quality-of-life-index-dlqi/dlqi-instructions-for-use-and-scoring/

73. Neck Lift. **Updated September 2018**
This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

74. Neurology – Cerebellar Stimulator Implants. **New section added September 2018**
Enquiries and applications should be directed to NHS England..

75. Neurology – Spinal Cord Stimulation for Ischaemic Pain. **New section added September 2018**
Enquiries and applications should be directed to NHS England..

76. Neurology – Neurosurgery for Cerebral Metastases. **New section added September 2018**
Enquiries and applications should be directed to NHS England..

77. Orthodontics. **New section added September 2018**
Enquiries and applications should be directed to NHS England.

78. Orthognathic Surgery. **New section added September 2018**
Enquiries and applications should be directed to NHS England.

79. Osteopathy. **Updated September 2018**
This is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

80. Pain Management Programme (Residential). **New section added September 2018**
Enquiries and applications should be directed to NHS England.

81. Penile Implants. **Updated September 2018**
This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

82. Periapical Surgery
Enquiries and applications should be directed to NHS England.

83. Pinnaplasty. **Updated September 2018**
This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

84. Plastic Surgery to Umbilicus. **Updated September 2018**
This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

85. Primary Hip replacement added January 2018, updated September 2018

The scope of this Policy is for Primary Hip replacement surgery secondary to Chronic Osteoarthritis only. All referrals for surgery should be done after a detailed MDT assessment and conservative treatment in an intermediate MSK service.

The CCG will **only** fund Primary Knee replacement in patients if **both** criteria **1 and 2** are met.

1. Uncontrolled, intense, persistent pain resulting in substantial impact on quality of life and moderate functional limitations which have failed a reasonable period of conservative treatment of at least 6 months. **Decisions need to incorporate a shared decision making process (a documented process, not simply a presumed discussion).**

   Patients must have been given an opportunity in primary / intermediate care to complete the Decision Aid tool online at NICE

2. Symptoms refractory to at least 6 months conservative management for the condition. Prior conservative management **must include all** of the following:
   - **Medication**. The patient should be taking Optimal tolerated doses of analgesia. Patients should have gained an understanding of their correct uses (Paracetamol, NSAIDs or Opioid analgesics).
   - **Physiotherapy.** NICE "core" treatments of either guided exercise and muscle strengthening programmes **or** supervised physical therapy must have been given and/or offered as appropriate in elderly. **Note**: Physiotherapy is ineffective in bone on bone osteoarthritis.
   - **Patient Education and Orthosis**. Patient education such as elimination of damaging influence on hips (by reducing weight **and** loading), activity modification (avoid impact and excessive exercise) and lifestyle adjustment.
   - **Lifestyle improvement** is paramount prior to major surgery.
     - Patients who smoke should be advised to attempt to stop smoking 8 to 12 weeks before the operation to reduce the risk of surgery and the risk of post-surgery complications. Patients who smoke should be routinely offered referral to smoking cessation services to reduce these surgical risks.
     - Patients with a BMI greater than 35 kg/m2 should be routinely offered referral to a weight management service to reduce these risks. Patients who are morbidly obese (BMI > 40) should not normally be listed for hip joint replacement surgery unless all reasonable attempts have been made to reduce weight and there are compelling circumstances such as:
       - Patients whose pain is so severe and/or mobility so compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this threat,

       or
       - patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulty of the procedure.

Variable	Definition
Pain level	
Mild	• Pain interferes minimally on an intermittent basis with usual daily activities • Not related to rest or sleep • Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin at regular doses, paracetamol
Moderate	• Pain occurs daily with movement and interferes with usual daily activities Vigorous activities cannot be performed • Not related to rest or sleep • Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin at regular doses, paracetamol
Severe	• Pain is constant and interferes with most activities of daily living • Pain at rest or interferes with sleep • Pain not controlled, even by narcotic analgesics
Previous non-surgical treatments	
Correctly Done	NSAIDs, paracetamol, aspirin or narcotic analgesics at regular doses during 6 months with no pain relief; weight control treatment if overweight, physical therapies done
Incorrectly Done	NSAIDs, paracetamol, aspirin or narcotic analgesics at inadequate doses or less than 6 months with no pain relief; or no weight control treatment if overweight, or no physical therapies done
Functional Limitations	
Minor	• Functional capacity adequate to conduct normal activities and self-care • Walking capacity of more than one hour • No aids needed
Moderate	• Functional capacity adequate to perform only a few or none of the normal activities and self-care • Walking capacity of about one half hour • Aids such as a cane are needed
Severe	• Largely or wholly incapacitated • Walking capacity of less than half hour or unable to walk or bedridden • Aids such as a cane, a walker or a wheelchair are required

86. Primary Knee replacement added January 2018

The scope of this Policy is for Primary Knee replacement surgery secondary to Chronic Osteoarthritis only.

All referrals for surgery should be done after a detailed MDT assessment and conservative treatment in an intermediate MSK service.

The CCG will **only** fund Primary Knee replacement in patients if **both** criteria **1 and 2** are met:

1. Uncontrolled, intense, persistent pain resulting in substantial impact on quality of life and moderate functional limitations which have failed a reasonable period of conservative treatment of at least 6 months.

   Decisions need to incorporate a shared decision making process (a documented process, not simply a presumed discussion).

   Patients must have been given an opportunity in primary / intermediate care to complete the Decision Aid tool online at NICE

2. Symptoms refractory to at least 6 months conservative management for the condition. Prior conservative management **must include all** of the following:

   - **Medication**. The patient should be taking Optimal tolerated doses of analgesia. Patients should have gained an understanding of their correct uses (Paracetamol, NSAIDs or Opioid analgesics).
   - **Physiotherapy.** NICE "core" treatments of **either**, guided exercise and muscle strengthening programmes **or** supervised physical therapy must have been given and/or offered as appropriate in elderly. **Note**: Physiotherapy is ineffective in bone on bone osteoarthritis.
   - **Patient Education and Orthosis**. Patient education such as elimination of damaging influence on knees (by reducing weight loading), activity modification (avoid impact and excessive exercise) and lifestyle adjustment.

Variable	Definition
Pain level	
Mild	• Pain interferes minimally on an intermittent basis with usual daily activities • Not related to rest or sleep • Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin at regular doses, paracetamol
Moderate	• Pain occurs daily with movement and interferes with usual daily activities Vigorous activities cannot be performed • Not related to rest or sleep • Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin at regular doses, paracetamol
Severe	• Pain is constant and interferes with most activities of daily living • Pain at rest or interferes with sleep • Pain not controlled, even by narcotic analgesics
Previous non-surgical treatments	
Correctly done	NSAIDs, paracetamol, aspirin or narcotic analgesics at regular doses during 6 months with no pain relief; weight control treatment if overweight, physical therapies done
Incorrectly done	NSAIDs, paracetamol, aspirin or narcotic analgesics at inadequate doses or less than 6 months with no pain relief; or no weight control treatment if overweight, or no physical therapies done
Functional Limitations	
Minor	• Functional capacity adequate to conduct normal activities and self-care • Walking capacity of more than one hour • No aids needed
Moderate	• Functional capacity adequate to perform only a few or none of the normal activities and self-care • Walking capacity of about one half hour • Aids such as a cane are needed
Severe	• Largely or wholly incapacitated • Walking capacity of less than half hour or unable to walk or bedridden • Aids such as a cane, a walker or a wheelchair are required

87. Ptosis of Eyelid

The CCG will not fund surgery for aesthetic purposes only.

The CCG will fund surgical intervention where the patient presents with **one or more** of the following:

- Vision is compromised by >30%.
- Where the proportion of visual field affected is uncertain a visual field test should be used to assess. The above criteria apply.
- Where there is congenital deformity.
- Where the proposed intervention is part of major facial surgery.
- Where the condition is a direct consequence of an acquired condition that will not resolve spontaneously.

Surgical Treatment of Eyelid Cysts and Lesions, Papillomas and Ingrowing Eyelashes – see chalazion and minor skin lesion

88. Prosthesis for Body Part. New section September 2018

Enquiries and applications should be directed to NHS England..

89. Rectus Abdominus Muscle – surgical repair in adults. New section September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

90. Refashioning of Scar. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

91. Reflexology. Updated September 2018

This is not routinely funded by the CCG. *In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism* for Individual Funding Requests.

92. Repair External Ear. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

93. Retractile Penis Surgery. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

94. Reversal of Vasectomy. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

95. Rhinophyma. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

96. Rhinoplasty / Septorhinoplasty updated December 2017 and September 2018

These procedures are **not routinely funded**.

The CCG will only fund these procedures for the following conditions:

- Correction of nasal deformity causing nasal blockage.

or

- Correction of nasal deformity associated with recognised facial congenital disorders, unless this is the commissioning responsibility of NHS England.

"Severe nasal blockage" = severe symptoms significantly impacting on daily life and /or 50% reduction in bilateral flow.
These procedures should not be carried out for cosmetic reasons.

NB: Policy Exclusions.

- Rhinoplasty / Septo-Rhinoplasty to address the effects of facial trauma as part of the initial care pathway for that **trauma are excluded** from this policy
- Rhinoplasty / Septo-Rhinoplasty as part of the pathway of care for **relevant cancers are excluded** from this policy

97. Skin Graft for Scar. New section September 2018

Not routinely funded unless for burns, or as part of reconstruction surgery following major trauma.

98. Sleep Apnoea added January 2018, updated September 2018

As defined by British Snoring and Sleep Apnoea Association – using the Epworth Sleepiness Scale found at:
www.britishsnoring.co.uk/sleep_apnoea/epworth_sleepiness_scale.php#topLink

Sleep apnoea is graded into:-

- 0 - 10 - considered normal
- 11-14 - considered as mild day time sleepiness
- 15-18 - considered as moderate day time sleepiness
- 19-24 - considered as severe day time sleepiness

Mild sleep apnoea (score of 11-14):

- Behavioural interventions offered
- Patient information leaflets to help manage their condition (Appendix 2 Sample patient information leaflet).
- **NOT** normally be referred to secondary care. In those circumstances where patients are referred to secondary care then:
    - CPAP provision funding – **only in** exceptional individual case basis if the patient has symptoms that seriously affects their quality of life and ability to go about their daily activities **and** if lifestyle advice and any other relevant treatment options have been considered and deemed inappropriate or unsuccessful.

- IOD/MAD may be provided if deemed clinically appropriate.

Moderate sleep apnoea (score of 15-18):

- Patients should also be offered behavioural interventions
- Patient information leaflets.
- Are eligible for NHS funding of an appropriate management option as determined by the treating respiratory physician.
  - CPAP and IOD/MAD are appropriate treatment options for patients with moderate OSA.

Severe sleep apnoea (score of 19-24):

- Patients should also be offered behavioural interventions
- Patient information leaflets.
- Are eligible for NHS funding of an appropriate management option as determined by the treating respiratory physician.
  - In the first instance, this should involve use of a CPAP machine.
  - IOD/MAS is an appropriate treatment option for patients with severe OSA who are unable to tolerate CPAP.

Surgery: The CCG does not routinely commission surgical treatment for Sleep Apnoea

Tonsillectomy for sleep apnoea will be funded by CCG if the following are met

- Severe sleep apnoea and
- Large tonsils and
- Patient and physician consider it to be appropriate and
- Decision needs to be made in consultation with an ENT physician.

99. Stereotactic Radiation Therapy. New section September 2018

Enquiries and applications should be directed to NHS England..

100. Submental Lipectomy. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

101. Tattooing . Updated September 2018

This procedure is not routinely funded by the CCG **unless** part of an established cancer treatment package. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

102. Tattoo Removal. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

103. Thigh Lift. Updated September 2018

This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

104. Tonsillectomies. updated December 2017 and September 2018

Tonsillectomy with or without adenoidectomy will be routinely funded according to the following criteria:

- **Malignancy:** Suspicion or evidence of malignancy. Patients should be referred and treated as appropriate.

or

- **Tonsillitis:** one of the following:
  - Seven or more well documented and diagnosed, clinically significant, adequately treated episodes of acute tonsillitis in the preceding year.
  - Five or more such episodes in each of the preceding two years.
  - Three or more such episodes in each of the preceding three years. Episodes must be disabling and prevent normal functioning. (two or more weeks' absence from work / school / college / duties as a carer).
- **Peritonsillar abscesses** (PTA): Two or more episodes resulting in hospital stay.

or

- **Obstructive sleep:** disordered breathing in people aged under 16 demonstrated by accepted method of diagnosis including sleep study, which impacts on development, behaviour and quality of life.

or

- **Obstructive sleep:** disordered breathing in people aged 16 and over Tonsillectomy for sleep apnoea will be funded by CCG if the following are met:
  - Severe sleep apnoea **and**
  - Large tonsils **and**
  - Patient and physician consider it to be appropriate **and**
  - Decision needs to be made in consultation with an ENT physician.

or

- **Other:** People with specific clinical conditions that require tonsillectomy as part of their on-going management strategy (e.g. psoriasis, nephritis, periodic fever aphthous pharyngitis and cervical adenopathy [PFAPA] syndrome).

Shared decision making tools should be used in discussions between patients and their healthcare professionals about management options before referral to surgery and in Acute care before deciding to have surgery.

Traumatic Clefts due to Avulsion of Body Piercing – see Repair External Ear

105. Trigger Finger updated December 2017 and September 2018

Conservative methods of treatment should always be pursued in the first instance either by the patient's GP or, where appropriate, the MSK service before referring into secondary care.

The CCG will agree to fund surgical intervention for trigger finger where the following criteria have been met:

- The patient has failed to respond to conservative management over a period of 6 months including at least two corticosteroid injections except where the corticosteroid injection is contraindicated.

and one of the following:

- The patient has a fixed flexion deformity that cannot be corrected by conservative measures.

or

- The patient is suffering from significant functional impairment. Significant functional impairment is defined by the CCG as;
    - Symptoms prevent the patient fulfilling routine work or educational responsibilities,
      or
    - Symptoms prevent the patient carrying out routine domestic or carer activities.

*Patients with Trigger Finger **and** Inflammatory Arthritis.*
The CCG will agree to fund surgical intervention for trigger finger where:

- The patient has been diagnosed with inflammatory arthritis.
  and
- There is a joint agreement by the patient's Rheumatoid Arthritis Consultant and Hand Surgeon that their trigger finger is unlikely to be corrected by conservative treatment. This needs to be documented in the patient's medical record through relevant clinic letters.

106. Upper Arm Reduction. Updated September 2018
This procedure is not routinely funded by the CCG. In exceptional circumstances, funding may be approved on an individual basis, via the agreed CCG mechanism for Individual Funding Requests.

107. Uterine Fibroids - Minimal Access Surgery added January 2018
This procedure is **not routinely funded** by the CCG.

This treatment will only be funded when following criteria are met **in full**:

1. Symptomatic fibroids where:
    - The fibroid is greater than 3 cm in diameter,
      or
    - Women with symptomatic fibroids for whom appropriate conservative management has been unsuccessful (conservative management revolves around control of symptoms such as heavy menstrual bleeding and pain).

2. Women who are unsuitable for, or do not wish to undergo, open surgery.

For those patients diagnosed with a fibroid through subfertility investigations, referrals into secondary care for a fibroid will only be accepted if patient has been seen and reviewed by subfertility specialist first.

108. Varicose Veins updated January 2018
Interventional treatments for varicose veins will only be funded for patients who have **any one** of the following:

- Bleeding varicose veins.
- Significant Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency.
- Superficial vein thrombosis (characterized by the appearance of hard, painful veins) and suspected venous incompetence.

- A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks).
- A healed venous leg ulcer.