Value Based Clinical Commissioning Policies

Hambleton, Richmondshire and Whitby CCG

VERSION FOR GB RATIFICATION – 25/05/17

GREEN - Common to both NE and HRW CCG policies

RED – content where HRW CCG policy is materially different from NE policy

BLUE highlight – content from HRW CCG policy absent from NE policy

Normal type – small differences in wording or additional explanation that is not significant

Version 10 (17 May 2017)
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**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 aims to improve consistency where possible between the different policies across the North East, North Yorkshire and Humber. This helps to stop variation in access to NHS services in different areas (which is sometimes known as ‘postcode lottery’ in the media) and allow fair and equitable treatment for all local patients.

This guide has been developed to assist clinicians answer questions in relation to individual funding requests (IFRs).

**Frequently asked questions**

1. **Why do we need policies?**

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

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

   The Academy of Medical Royal Colleges has launched a Choosing Wisely campaign (http://www.choosingwisely.co.uk/) which is aligned to the North East and Cumbria approach to increasing value and improving population health. This is adopted across the Durham, Darlington, Teesside, Hambleton, Richmondshire & Whitby STP footprint.

   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:

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

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

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

The procedures have low rather than no clinical value. Some may be effective, but may have low value because other (medical) treatments could be tried first.

Other effective procedures may provide large benefits for some patients but less to those with few symptoms, where risks and benefits are closely balanced. There are interventions which are effective in some but give no clinical value in others.

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

3 Who are they for?
They are to assist GPs in making referral decisions, where the principal reason for referral is for surgical intervention. They are also to assist providers of surgical services and are a statement about what the NHS will routinely pay for.

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

5 How have they been developed?
Every effort has been made to get an up to date view of practice. However, some will contain contentious criteria - for example among eligibility for plastic surgery and IVF. We aim to take account of the most up to date clinical evidence, legal precedent and gain consensus before publication.

6 Is securing funding a guarantee of treatment?
Approval for NHS funding is NOT the same as a guarantee of treatment. Funding (the role of the commissioner for a whole population) is often requested before specialist assessment. However, the ultimate decision about safety and appropriateness of treatment is a clinical one, which must be discussed with the patient.
What happens when funding is approved?
It is the applicant i.e. the patient’s clinical representative’s responsibility to refer the patient for treatment. It is expected that this will take place within a maximum period of 12 months. If a referral is not completed within this time, a new application for funding would need to be submitted.

What if funding is declined?
If there are individual circumstances to be considered, and the decision is to decline funding, you will be sent details of how to appeal.

Who tells the patient if funding is declined?
The IFR panel will notify the outcome of any decision with the patient and will also tell the referring clinician, who remains responsible for ongoing treatment and care.

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.

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.
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 if I have a patient whose needs are exceptional?
Exceptionality is defined as:

‘The patient or their circumstances are significantly different from the general population of patients with the condition in question and the patient is likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition.’

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

What about psychological considerations?
Some CCGs have taken account of psychological factors in arriving at a decision about eligibility for NHS funding, but this is hard to do in a clear and fair way. These
considerations have been removed from the current draft of these policies. NICE guidance indicates that clinicians should consider the possibility of Body Dysmorphic Syndrome when making referral for plastic surgery (NICE Clinical Guideline 31).

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

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

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

**Policy – BMI and smoking – Non-urgent elective surgery**

**Pre-surgical preparation**

This approach applies where a GP is referring specifically for an elective procedure as opposed to consultant opinion. It also covers procedures given under both general and local anaesthetic. This approach will exclude hip and knee replacement where we propose to maintain the existing policy of requiring patients to stop smoking and attempt to lose weight.

We will ask practices to consider 5 key areas with patients as part of the pre-surgical referral consultation:

1. **Smoking**

GPs / Practices are asked to:

- Determine a patient’s smoking status if not known (Patients who only use electronic cigarettes will be classified as a non-smoker)
- Clearly inform the patient of the risks associated with smoking, including that the outcomes from surgery may be worse.
- Where a patient agrees they will stop smoking, offer a referral to Smoke Free Life North Yorkshire for smoking cessation support
- Agree with the patient whether the referral should be delayed for up to 6 months to give them time to stop smoking or whether the referral can proceed immediately (this
will be at GP / practice discretion depending on patient circumstance and the nature of the referral)

- Where a patient doesn’t agree to attempt to stop smoking and wants to proceed directly to a referral for an operation, clearly gain documented consent (i.e. discussion documented on clinical system, written consent is not required) that they have understood the risks and are taking personal responsibility

2. BMI

GPs / practices are asked to:

- Weigh the patient and confirm their BMI
- Identify patients with a BMI > 30
- Advise patients that they are at increased health risk and recommend that they should make a sustained attempt to lose weight through a period of Health Optimisation
- Offer appropriate support to address lifestyle factors that would improve their fitness for surgery, including referral to an appropriate weight management programme. This could be:
  - Tier 2 lifestyle / weight management programmes provided by North Yorkshire County Council
  - Tier 3 weight management programmes provided by South Tees Hospitals NHS Foundation Trust (for patients with BMI > 40 or > 35 with comorbidities)
  - Commercial programmes such as Slimming World or Weight Watchers, exercise on referral or,
  - In-house GP weight loss programmes
- Agree with the patient whether the referral should be delayed for up to 6 months to give them time to reduce weight or whether the referral can proceed immediately (this will be at GP / practice discretion depending on patient circumstance and the nature of the referral)
- Where a patient doesn’t agree to attempt to lose weight and wants to proceed directly to a referral for an operation, clearly gain documented consent (i.e. discussion documented on clinical system, written consent is not required) that they have understood the risks and are taking personal responsibility
Where a patient has a BMI >40, these patients are at risk of developing other metabolic conditions. They should be referred to the tier three weight management. This is a year-long programme at the end of which bariatric surgery may be offered.

3. Blood pressure

GPs / practices are asked to:

- Confirm the patient’s blood pressure
- If normotensive record the BP on the referral letter.
- If hypertensive, optimise BP before referral unless the referral is urgent.

4. HbA1C

This test is helpful in both improving diagnosis of diabetes and simplifying pre-referral assessment ahead of surgery.

GPs / practices are asked to:

- Take the patient’s HbA1C where this is clinically indicated, e.g. if the patient is older, has a raised BMI etc. or other risk factors for diabetes
- If diabetic, initiate appropriate management and either delay referral until clinically stabilized, or if clinically indicated refer immediately and inform the hospital of ongoing management

5. Full blood count

Patients being referred for major surgery should have a full blood count and have iron replacement where Hb<120g/l. Low Hb may need further investigation.

Exclusions

It is proposed that this approach wouldn’t automatically apply in the circumstances below. However, GPs should consider on a case-by-case basis whether some patients would benefit from the recommended health optimisation actions:

- Patients with significant cognitive impairment or certain mental health conditions, e.g. clinical depression
- Children under 5 years
- Frail Elderly patients
- Patients whose BMI is above threshold due to high muscle mass
In addition the following referral pathways would also be excluded from the general approach:

- 2WW Referral for suspicion of cancer
- Referrals for interventions of a diagnostic nature e.g. endoscopy, biopsy of basal cell carcinomas
- Elective procedures where any wait in referral risks a significant clinical deterioration e.g. Cholecystectomies, Gallstones

**Advantages of this approach**

- No requirement to refer to IFR
- No requirement for GP practices to formally evidence that a patient has stopped smoking / lose weight
- No risk of delay that might put patients at greater clinical risk or clinicians at risk of litigation
- Reduced risk that their medication (e.g. analgesic) requirements increase, with greater risk of side effects/harm
- Health benefits of reducing weight and stopping smoking should be retained
- Approach can be safely extended to patients with a BMI > 30
- Additional benefits in relation to identifying patients with diabetes or raised blood pressure can be achieved
The following policies and procedures are within the scope of this policy.
Each policy is categorised as either ‘not routinely commissioned’ or ‘restricted’ these are defined as follows:

- **Not routinely commissioned** – This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

- **Restricted (i.e. Subject to Criteria)** – This means CCG will fund the treatment if the patient meets the stated clinical threshold for care.

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<td>Anal fissure (treatment of)</td>
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<td>Blepharoplasty/ptosis</td>
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<tr>
<td>Breast reduction (plus white light scanning)</td>
<td>Not routinely commissioned</td>
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<tr>
<td>Bunion surgery</td>
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<td>Cataract Surgery</td>
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<td>Cervical spinal disc prosthesis</td>
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<td>Cholecystectomy for gallstones/lithotripsy</td>
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<tr>
<td>Circumcision (adults and children)</td>
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<td>Cleft earlobe surgery</td>
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<tr>
<td>Complementary therapies and homeopathy</td>
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<tr>
<td>Continuous Glucose Monitoring</td>
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<td>Dilatation and curettage (D&amp;C) for treatment of heavy menstrual bleeding</td>
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<td>Dupuytren's contracture surgery</td>
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<td>Endoscopic thoracic sympathectomy</td>
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<td>Excimer laser for cases with poor refraction after corneal transplant or cataract surgery</td>
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<td>Exogen ultrasound bone healing</td>
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<tr>
<td>Service</td>
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<tr>
<td>Extracorporeal shockwave therapy</td>
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<tr>
<td>Face, neck, brow lift</td>
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<td>Fertility preservation for cancer patients</td>
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<td>Functional electrical stimulation (implantable)</td>
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<td>Ganglion surgery</td>
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<td>Gastric neuromodulation/gastro</td>
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<td>Gynaecomastia surgery</td>
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<td>Hair loss treatment</td>
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<td>Hair removal (for hirsutism)</td>
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<td>Hernia repair</td>
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<td>Hip arthroscopy</td>
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<td>Hip replacement</td>
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<td>Hyperhidrosis treatment with Botulinum (Botox)</td>
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<td>Hysterectomy for menorrhagia</td>
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<td>Ilizarov technique</td>
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<td>Invitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI)</td>
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<td>Knee arthroscopy</td>
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<td>Knee replacement</td>
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<td>Liposuction</td>
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<td>Minor foot problems</td>
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<td>Oculoplastic -eye problems entropion/ectropion/tear duct surgery</td>
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<td>Penile implants</td>
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<td>Pinnaplasty (otoplasty)</td>
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<td>Port wine stain</td>
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<td>Removal of benign skin lesions</td>
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<td>Removal of tattoos</td>
<td>Not routinely commissioned</td>
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<tr>
<td>Repair of lobe of external ear</td>
<td>Restricted / S2C</td>
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<tr>
<td>Resperate device</td>
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<td>Resurfacing: dermabrasion, chemical peels and laser treatment</td>
<td>Not routinely commissioned</td>
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<tr>
<td>Reversal of sterilisation in men and women</td>
<td>Not routinely commissioned</td>
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<tr>
<td>Rhinoplasty/septoplasty for nasal deformities</td>
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<tr>
<td>Sacral nerve stimulation</td>
<td>Not routinely commissioned</td>
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<tr>
<td>Surgery for refractive error</td>
<td>Not routinely commissioned</td>
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<tr>
<td>Surgical fillers</td>
<td>Not routinely commissioned</td>
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<tr>
<td>Thigh lift, buttock lift, arm lift, excision of redundant skin or fat</td>
<td>Not routinely commissioned</td>
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<tr>
<td>Tonsillectomy</td>
<td>Restricted / S2C</td>
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<td>Procedure</td>
<td>Commissioning Status</td>
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<tr>
<td>Trigger finger surgery</td>
<td>Restricted / S2C</td>
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<tr>
<td>Vaginaplasty and labiaplasty</td>
<td>Not routinely commissioned</td>
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<tr>
<td>Varicose vein surgery</td>
<td>Restricted / S2C</td>
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<tr>
<td>Vasectomy under GA</td>
<td>Restricted / S2C</td>
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Cosmetic Surgery

Background: Surgery for primarily cosmetic reasons is not eligible for NHS funding. A significant degree of exceptionality must be demonstrated before funding can be considered outside of these policies. Specifically, psychological factors are not routinely taken into consideration in determining NHS funding.

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

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

- Abdominoplasty or apronectomy
- Blepharoplasty
- Breast augmentation (Breast enlargement)
- Breast prosthesis removal or replacement
- Breast reduction
- Breast asymmetry
- Bunion surgery
- Chalazion/meibomian cyst removal
- Circumcision
- Cleft earlobe surgery
- Face lift or brow lift
- Ganglion removal
- Gynaecomastia surgery
- Hair loss treatment
- Hair removal for hirsutism
- Inverted nipple correction
- Liposuction for excessive tissue
- Mastopexy
- Pinnaplasty
- Removal of benign skin lesions
- Removal of tattoos
- Revision of mammoplasty
- Rhinoplasty
- Scar revision and skin resurfacing
- Thigh lift, buttock lift and arm lift
- Vaginoplasty, Labial Vulvoplasty and Vulvar lipoplasty
- Varicose vein surgery

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 are NOT routinely commissioned.

Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8.

Allergy Treatment

Background: An allergy is a damaging immune response by the body to a substance, especially a particular food, pollen, fur, or dust, to which it has become hypersensitive.

Policy: Refer to Dermatology only if there is a dermatological manifestation

Patients with wheeze, food allergy or anaphylaxis should not be referred to dermatology – adult
patient should be referred to consultant immunologist, children to consultant paediatrician
All other requests should be submitted to Individual Funding Request (IFR) panel prior to referral.

<table>
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<tr>
<th>Anal Fissure</th>
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**Background:** An anal fissure is a tear in the lining of the lower rectum (anal canal) that causes pain during bowel movements.

An anal fissure that hasn’t healed after 8 to 12 weeks is considered a long-term (chronic) fissure. A chronic fissure after failed conservative management may require referral to secondary care.

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

- Suspicion of underlying cancer (e.g. associated with rectal bleeding) or Crohn’s disease. For detailed advice on cancer referral see NICE Clinical Guideline 27
- All adults who are asymptomatic but whose anal fissure remains unhealed after 12–16 weeks despite topical therapy
- Multiple, off the midline, large or irregular (atypical fissures) as these may be the manifestation of underlying disease
- Children whose anal fissure has not healed after 2 weeks

**Consider referring**
- an elderly person earlier to exclude an anal or low rectal malignancy.
  - People who are symptomatic and whose anal fissure has not healed by 6–8 weeks

**Initial treatment in primary care should be:**

- Manage constipation or diarrhoea accordingly
- Check if patient taking nicorandil
- GTN 0.4% ointment (Rectogesic®) first line every day, twice a day, for 8 weeks. Counsel patient regarding risk of headache and stress the importance of adherence. Don't use other strengths of GTN, as unlicensed and costly.
- If not tolerated use diltiazem 2% ointment twice a day for 8 weeks. This is unlicensed and more expensive than GTN 0.4% ointment. Stress to patients the importance of adherence.

If this fails, refer to secondary care to consider sphincter botox injections or lateral sphincterotomy.

**For children,** GTN 0.05% to 0.1% ointment may be used to relax the anal sphincter, relieve pain, and encourage healing. This should be prescribed by a specialist as it is not licensed for use in people aged less than 18 years. Also use a stool softener.

<table>
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<th>Autologous cartilage transplantation</th>
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**Policy:** Autologous cartilage transplantation will not be routinely funded.
**Back Pain procedures**

**Background:** Back pain is a common problem that affects most people at some point in their life. The pain can be triggered by bad posture while sitting or standing, bending awkwardly, or lifting incorrectly. Back pain is not generally caused by a serious condition and; in most cases; it gets better within 12 weeks. It can usually be successfully treated by taking painkillers and keeping mobile. In most cases, the pain disappears within six weeks but may come back (recur) from time to time. Chronic (persistent) pain develops in some cases and further treatment may then be needed.

**Policy:** Therapeutic injections and surgical procedures will only take place following referral to the commissioned low back pain service and only as part of agreed management through this service. Therapeutic injections and surgical procedures for back pain outside of the low back pain pathway are not routinely commissioned.

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

Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8.

**Bone Morphogenetic Proteins**

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

- Non-union of tibia of at least 9 month duration, secondary to trauma
- Skeletally mature patient
- Previous treatment with autograft has failed or the use of autograft is unfeasible.
**Breast Asymmetry**

**Background:** Breast asymmetry is a degree of difference in the size of an individual's breasts and is entirely normal. The difference can be corrected surgically and may involve breast reduction surgery or breast augmentation surgery.

**Policy:** Surgical correction of breast asymmetry is **NOT routinely commissioned**

This policy does not apply to breast reconstruction as part of the treatment for breast cancer. **Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8.**

**Breast - Augmentation**

**Background:** Breast Augmentation/enlargement involves inserting artificial implants behind the normal breast tissue to improve its size and shape

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

**Policy:** Breast augmentation is **NOT routinely commissioned.**

This policy does not apply to breast reconstruction as part of the treatment for breast cancer. **Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8.**

**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 is **NOT routinely commissioned.**  
**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8.**

**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 is **NOT routinely commissioned.**

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8.**
Breast – Prosthesis Removal and/or Replacement

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

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

**Policy:**

**Removal** 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 commissioned 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.

**Replacement**

Breast implant replacement is commissioned for patients who had their original surgery on the NHS where there is clear clinical need for replacement, for example, capsular contracture or rupture and the case for replacement is supported by an NHS breast or plastic surgeon. Requests for funding under this circumstance will need to be approved by the IFR Panel.

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

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8.**

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.

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8.**

**Policy:** Breast reduction will only be funded in accordance with the criteria specified below (to be approved via IFR).

For women:

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

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

**AND**
- has a preoperative body mass index (BMI) of less than 27.0 kg/m².
- Has a minimum cup size of \( \geq E \) (6 inches difference)

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

### Bunions

**Background:** A bunion is a deformity of the joint connecting the big toe to the foot and is known as a hallux abducto valgus among medical professionals. It is characterized by medial deviation of the first metatarsal bone and lateral deviation of the hallux (big toe), often erroneously described as an enlargement of bone or tissue around the joint at the bottom of the big toe (known as the metatarsophalangeal joint).

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

- There is ulceration over the bunion

  **OR**

  - Conservative methods of management have failed including
    - Avoiding high heel shoes and wearing wide fitting leather shoes which stretch
    - Applying ice and elevating painful and swollen bunions
    - Non-surgical treatments such as bunion pads, splints, insoles or shields available from community pharmacies
    - Specialist podiatry/biomechanical referral (where available)

  **AND**

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

    **AND**

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

### Carpal Tunnel

**Background:** Carpal tunnel surgery, also called carpal tunnel release (CTR) and carpal tunnel decompression surgery, is a surgery in which the transverse carpal ligament is divided. It is a treatment for carpal tunnel syndrome and recommended when there is static (constant, not just intermittent) numbness, muscle weakness, or atrophy, and when night-splinting no longer controls intermittent symptoms of pain in the carpal tunnel. In general, milder cases can be controlled for months to years, but severe cases are unrelenting symptomatically and are likely
to result in surgical treatment

**Policy:** Prior approval is not required for patients meeting the following criteria:
- Advanced or severe neurological symptoms of CTS such as constant pins and needles, numbness, muscle wasting and prominent pain
- OR where the patient meets ALL of the following:
  - Symptoms significantly affecting activities of daily living Moderate symptoms
  - A diagnosis of CTS is certain (where there is diagnostic uncertainty a specialist opinion is required)
  - The patient has not responded to a minimum of 6 months of conservative management, including:
    - 8 weeks of night-time use of wrist splints
    - Corticosteroid injection in appropriate patients
    - Lifestyle modification, as appropriate

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### Cataract Surgery

**Background:** A cataract is a clouding of the lens in the eye leading to a decrease in vision. It can affect one or both eyes. Often it develops slowly. Symptoms may include faded colours, blurry vision, halos around light, trouble with bright lights, and trouble seeing at night. This may result in trouble driving, reading, or recognizing faces. Poor vision may also result in an increased risk of falling and depression. Cataracts are the cause of half of blindness and 33% of visual impairment worldwide.

Cataracts are most commonly due to aging but may also occur due to trauma or radiation exposure, be present from birth, or occur following eye surgery for other problems. Risk factors include diabetes, smoking tobacco, prolonged exposure to sunlight, and alcohol. Either clumps of protein or yellow-brown pigment may be deposited in the lens reducing the transmission of light to the retina at the back of the eye. Diagnosis is by an eye examination.

**Policy:**

**First eye Surgery for cataract (i.e. prime [sole] pathology)**
All referrals by Optometrists should be made via the Choice Office following assessment and completion of Referral Form (see cataract pathway/clinical guidance). The threshold for referral is a binocular visual acuity of 6/12 or worse plus a completed patient questions section. If a patient does not reach the referral threshold of visual acuity of 6/12 or worse but has exceptional circumstances (be it medical reasons or social reasons) meaning they would benefit from cataract surgery, this will need IFR approval. All GP referrals should similarly comply with this policy.

**Second eye surgery**
Second eye surgery will be decided in the ophthalmology clinic either at the first appointment (the patient will then be booked for sequenced surgery) or at follow up after first eye surgery. Medical indications for second eye surgery (e.g. glaucoma, diabetes, anisometropia) should be recorded in the patient letter in case evidence is required for validation purposes. In other cases second eye surgery will be allowed if the patient is symptomatic and there is visually significant cataract.
Cervical Spinal Disc Prosthesis

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

Cholecystectomy (for asymptomatic gall stones)

Background: Gallstones are small stones usually made of cholesterol that form in the gallbladder. In most cases they do not cause any symptoms i.e. they are asymptomatic. Cholecystectomy is the surgical removal of the gall bladder; this is not usually indicated in patients with asymptomatic gallstones.

Policy: Cholecystectomy for Asymptomatic Gallstones is NOT routinely commissioned. Elective referral into secondary care for a cholecystectomy assessment will only be commissioned if the patient fulfils any of the criteria below:

- Symptomatic gallstones
- BMI under 35
- A dilated common bile duct on ultrasound
- Asymptomatic gallstones with abnormal liver function test (LFT) results
- Symptomatic gall bladder ‘sludge’ reported on ultrasound
- Gall bladder polyp(s) larger than 8mm or growing rapidly reported on ultrasound
- Common bile duct stones
- Acute pancreatitis
- N.B. Patients with suspected gallbladder carcinoma or severe complications should be referred/treated immediately, without delay.

Circumcision - Adult

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

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

Medical reasons for funding circumcision include:

- Carcinoma of the penis.
- Pathological phimosis: the commonest cause is lichen sclerosus – balanitis xerotica obliterans (BXO) is an old fashioned descriptive term
- Recurrent episodes of balanoposthitis
Relative indications for circumcision or other foreskin surgery:

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

**Circumcision - Children**

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

No religious circumcisions will be commissioned
This procedure is not commissioned unless there is evidence of any of the following clinical indications:

- Distal scarring of the preputial orifice. A short course of topical corticosteroids might help with mild scarring.
- Balanitis Xerotica Obliterans
- Painful erections secondary to a tight foreskin
- Recurrent bouts of infection (balanitis/ balanoposthitis)

**Cleft Earlobe Surgery**

**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:** Surgical repair of acquired ear lobe clefts is NOT routinely commissioned as this is considered a cosmetic procedure. This includes:

- partially split lobes (i.e. where the split does not reach the edge of the lobe);
- elongated holes in lobes;
- a split that recurs after a previously repaired earlobe has been pierced.

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8**

**Complementary Therapies and Homeopathy**

**Background:** Complementary Therapies such as Massage, Reflexology and Aromatherapy are all holistic in that they treat the individual on all levels of being – mind – body – spirit. When a treatment is given alongside receiving conventional medicine it is called complementary as it works in conjunction with the former.

Homeopathy is a 'treatment' based on the use of highly diluted substances, which practitioners claim can cause the body to heal itself. A 2010 House of Commons Science and Technology
Committee report on homeopathy said that homeopathic remedies perform no better than placebos, and that the principles on which homeopathy is based are "scientifically implausible". Some complimentary therapies are used within pathways of care for certain conditions. Other complementary and homeopathic therapies are not routinely commissioned.

**Policy:** Funding is **NOT routinely** commissioned for complementary therapies and homeopathy.

### Continuous Glucose Monitoring (CGM)

**Background:** CGM systems are used in Type 1 Diabetes, as a diagnostic tool to temporarily help patients better manage their blood glucose levels (short term CGM) or as a continuous aid in the glycaemic control (long term CGM). The CGM system measures glucose levels displays glucose levels and any rate of change every few minutes.

CGM systems use a small needle-like sensor, implanted just below the skin, to measure glucose levels in interstitial fluid. Readings are transmitted to a display unit, worn like a pager, which displays glucose levels and rate of change every few minutes. Alarm functions can be used to alert the user to high or low readings, or to rapidly rising or falling levels.

**Policy:** Commissioning with be considered in adults with Type 1 Diabetes who are willing to commit to using it at least 70% of the time and to calibrate it as needed, and who have any of the following despite optimised use of insulin therapy and conventional blood glucose monitoring:

- More than 1 episode a year of severe hypoglycaemia with no obviously preventable precipitating cause. **AND / OR**
- Complete loss of awareness of hypoglycaemia **AND / OR**
- Frequent (more than 2 episodes a week) asymptomatic hypoglycaemia that is causing problems with daily activities **AND / OR**
- Extreme fear of hypoglycaemia **AND / OR**
- Hyperglycaemia (HbA1c level of 75 mmol/mol [9%] or higher) that persists despite testing at least 10 times a day. Continue real time continuous glucose monitoring only if HbA1c can be sustained at or below 53 mmol/mol (7%) and/or there has been a fall in HbA1c of 27 mmol/mol (2.5%) or more.

For adults with type 1 diabetes who are having real time continuous glucose monitoring, use the principles of flexible insulin therapy with either a multiple daily injection insulin regimen or continuous subcutaneous insulin infusion (CSII or insulin pump) therapy.

Real-time continuous glucose monitoring should be provided by a centre with expertise in its use, as part of strategies to optimise a person’s HbA1c levels and reduce the frequency of hypoglycaemic episodes.

### Dilatation and curettage

**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).
**Policy:** Funding is NOT routinely commissioned as a therapeutic treatment for heavy menstrual bleeding or any other uterine bleeding disorder.

### Dupuytren’s Contracture

**Background:** Dupuytren’s contracture (Dupuytren's disease) is a condition that affects the hands and fingers. It causes one or more fingers to bend into the palm of the hand. It can affect one or both hands, and sometimes affect the thumb.

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

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

**Collagenase injections**

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

Radiotherapy for Dupuytren’s contracture is not routinely funded.

### Endoscopic Thoracic Sympathectomy

**Background:** Endoscopic thoracic sympathectomy (ETS) is a surgical procedure in which a portion of the sympathetic nerve trunk in the thoracic region is destroyed. ETS is used to treat focal hyperhidrosis, facial blushing, Raynaud's disease and reflex sympathetic dystrophy. By far the most common complaint treated with ETS is palmar hyperhidrosis, colloquially known as "sweaty palms". The intervention is controversial and illegal in some jurisdictions. Like any surgical procedure, it has risks; the endoscopic sympathetic block (ESB) procedure and those procedures that affect fewer nerves have lower risks.

**Policy:** Endoscopic Thoracic Sympathectomy is not routinely commissioned. Funding will only be considered by the individual Funding Request Panel (IFR) where exceptional clinical circumstances are demonstrated. All cases require prior approval.

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

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

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

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**Exogen Ultrasound Bone Healing**

**Background:** 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.

**Policy:** Exogen® system to treat long bone fractures with non-union, in accordance with defined clinical criteria as follows:
- Patient age > 18 years
- Non-union of fracture > 9 months
- Not to be used in cases of unstable surgical fixation, not well aligned or where inter-fragment gap is > 10mm
- Not to be used in cases with infection
- Not to be used in pregnancy, patients with pacemakers or vertebral/skull fractures
- Only when lifestyle factors addressed*

*Note: patients with lifestyle factors which are known to delay fracture healing rates e.g. smoking and excess alcohol intake, will be appropriately counselled and required to eliminate these risks before determining non-union status and ultimately eligibility for Exogen®. Where appropriate, referrals to specific support services should be arranged e.g. smoking cessation service.

The use of the Exogen® system to treat long bone fractures with delayed union or any other indications is not commissioned.

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**Extracorporeal Shock Wave Therapy**

**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 commissioned for musculo skeletal.
**Face and/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 commissioned to treat the natural processes of ageing.

**Policy:** Face lift or brow lift is NOT routinely commissioned.

Surgery for primarily cosmetic reasons is not eligible for NHS funding - see p8.

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**Fertility Preservation for Cancer Patients**

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

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

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

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

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

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

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

The service will store cryopreserved material for an initial period of 10 years. The service will offer men the option to continue the storage of cryopreserved sperm beyond the 10 years if they remain at risk of significant infertility.
Functional Electrical Stimulation (FES) Implantable device

**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.

**Policy:** Functional Electrical Stimulation for drop foot is routinely commissioned with the non-implantable device, in line with NICE IPG2781, providing normal arrangements are in place for clinical governance, consent and audit.

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.

Ganglion Surgery

**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.
The Panel will only consider requests in exceptional cases where it is clear that the patient fulfills the following criteria:

- The symptoms of gastroparesis are chronic, severe and debilitating, with objective documentation of vomiting, weight loss and hospital admissions
- Priority will be given to patients with unstable type 1 diabetes because of refractory gastroparesis
- Symptoms are refractory to all previous treatments including dietary modifications, drug treatment (prokinetics and antiemetics) and nutritional support (feeding tube or total parenteral nutrition [TPN])
- Where the only remaining treatment option would be irreversible surgery (gastrectomy, jejunostomy, pyloroplasty)

Implantation of permanent GES will only be commissioned where the insertion of a temporary GES has, after at least 48 hours (to be finalised), resulted in a significant objective improvement in gastroparesis symptoms.

### Grommets in Children

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

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

**Referral for a Specialist opinion when:**

- Persistence of bilateral otitis media with effusion (OME) and hearing loss over 3 months
  
  **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. (Referral should be urgent within 2 weeks).

**Grommets in Children**
The child has Down's syndrome or has a cleft palate.

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

- There is evidence that the risks and benefits of treatments options have been clearly discussed with the parent/ carer using the NHS Rightcare Shared Decision Making tool [http://sdm.rightcare.nhs.uk/pda/glue-ear/](http://sdm.rightcare.nhs.uk/pda/glue-ear/)

**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.

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

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### 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 is NOT routinely commissioned.

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8**

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### Haemorrhoidectomy

**Background:** Definition of degrees of haemorrhoids:

- **First grade:** the haemorrhoids remain inside at all times
- **Second grade:** the haemorrhoids extend out of the rectum during a bowel movement but return on their own
- **Third grade:** the haemorrhoids extend out during a bowel movement but can be pushed back inside
- **Fourth grade:** the haemorrhoid is always outside

**Policy:** Haemorrhoidectomy will be commissioned 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 6 months.
• Grade III or IV haemorrhoids (i.e. prolapsed)
• Symptoms suggestive of systemic disease e.g. inflammatory bowel disease

NB Fast track referral - In patients over 40 years old with rectal bleeding due to suspected haemorrhoids, specialist opinion is indicated to rule out colorectal cancer. If symptoms of suspected cancer are present then patient should be referred under the 2 week rule

Definition of haemorrhoid grades:
• Grade I: the haemorrhoids remain inside at all times
• Grade II: the haemorrhoids extend out of the rectum during a bowel movement but return on their own
• Grade III: the haemorrhoids extend out during a bowel movement but can be pushed back inside
• Grade IV: the haemorrhoid is always outside

All other circumstances require prior approval.

**Hair Loss Treatment**

**Background:** Hair loss, also known as alopecia or baldness, refers to a loss of hair from the head or body. Baldness can refer to general hair loss or male pattern hair loss. Hair loss and hypotrichosis 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). Hair loss severity occurs across a spectrum with extreme examples including alopecia totalis (total loss of hair on the head) and alopecia universalis (total loss of all hair on the head and body).

**Policy:** Reconstructive treatment for the correction of disfiguring permanent hair loss from face/scalp that is the result of previous surgery or trauma, including burns. (e.g. reconstruction of the eyebrow).

The following are not routinely commissioned:
• Surgical treatments for hair loss e.g. hair transplantation;
• The ‘Intralace’ hair system or
• Dermatography (tattooing)

To manage hair loss for solely cosmetic reasons:
(i) It should be noted that the provision of wigs or hair loss treatment for Gender Dysphoria patients is NOT part of the NHS commissioned pathway for transgender patients and is not routinely commissioned
(ii) Additionally, it should be noted that this policy does NOT affect the existing local NHS pathways that exist for the provision of wigs to chemotherapy or alopecia patients.

Patients who are not eligible for treatment under this policy may be considered on an individual
basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed as per the CCG policy.

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8.**

### Hair Removal for Hirsutism

**Background:** IPL/Laser/Electrolysis 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.

**Policy:** Surgical or Medical Hair removal for Hirsutism is NOT routinely commissioned

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8**

### Hernia Repair

**Background:** Hernia repair refers to a surgical operation for the correction of a hernia (a bulging of internal organs or tissues through the wall that contains it.) Hernias can occur in many places, including the abdomen, groin, diaphragm, brain, and at the site of a previous operation.

**Policy:** Referral for a surgical opinion should only be made if there are any of the following circumstances:

- **Ventral Hernia**
  - Para-umbilical & Epigastric
  - Symptomatic – Patient complaining of pain and/or atrophic skin changes

- **Incisional Hernia**
  - Symptomatic
  - Asymptomatic but increasing in size

- **Groin Hernia**
  - Female groin hernia
  - Male femoral hernia

**Male Inguinal hernias that meet one of the following criteria:**

- Visible hernia on clinical examination (asymmetry on visual clinical examination whilst patient standing/coughing) and symptomatic (pain, nuisance, affecting activities of daily living or work)
- Large inguinal/inguinal scrotal hernia – refer for opinion even if asymptomatic
- No hernia seen on clinical examination but other persistent symptoms
- Visible hernia on clinical examination but no symptoms (If patient opts for surgery ensure that there has been discussion in primary care with the patient and that they are fully aware of the risk/benefit of undertaking surgery for an asymptomatic hernia, which may in itself result in chronic groin pain or numbness).
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
- An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist
- The patient has had severe FAI symptoms (restriction of movement, pain and ‘clicking’) or significantly compromised functioning for at least 6 months
- 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 clinician still recommends this treatment, an Exceptional Treatment Request should be submitted for consideration.

Hip Arthroscopy is NOT be routinely commissioned 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 Replacement

**Background:** A hip replacement is a common type of surgery where a damaged hip joint is replaced with an artificial one (known as a prosthesis)

**Policy:** Experiencing moderate-to-severe persistent pain not adequately relieved by an extended course of non-surgical management to include, pain management programme, pharmacological interventions, physio, etc.

- Pain is at a level at which it interferes with activities of daily living i.e. washing, dressing, lifestyle and sleep;
  AND
- Is troubled by clinically significant function limitation resulting in diminished quality of life
  AND
- The patient is fit for surgery.
• Patients with a BMI of 35 - 40 should be advised and given appropriate support to address lifestyle factors that would improve their fitness for surgery. They must demonstrate a sustained attempt to lose weight through a period of Health Optimisation for at least 4 months. Either of the following must be undertaken and documented within the patient’s medical records:-
  1. They have attended a weight management programme over 4 months, with or without any weight loss. Appropriate programmes include Tier 2 & 3 lifestyle/weight management, commercial programmes such as Slimming World or Weight Watchers, exercise on referral or in-house GP weight loss programmes.
  or
  2. They can demonstrate at least a 5% reduction in weight over the last year without support from outside agencies.

AND
• An Oxford hip score indicating severe symptoms i.e. 24 or less
AND
• The patient has been a non-smoker for at least 4 weeks prior to surgery
AND
• Radiological evidence confirming diagnosis
AND
• A confirmation that patients have been made aware of the options available as an alternative to surgery and the risks associated with surgery (such as a patient decision aid)

Patients who do not fulfil these criteria will not routinely be able to access hip arthroplasty unless:
• Surgery is considered urgent as defined by a consultant orthopaedic surgeon
• Surgery is related to trauma
• The patient is considered clinically exceptional (agreed through IFR)

The CCG will not routinely commission hip replacement surgery for any patient with a BMI >40. These patients are at risk of developing other metabolic conditions and should be referred to the tier three weight management. This is a year-long programme at the end of which bariatric surgery may be offered.

Patients should all be referred via MSK regardless of where they wish to have further treatment if required. The referral letter should clearly state the patient’s choice of provider and all other appropriate information to enable paper triage to their chosen provider.

**Hyperhidrosis Treatment with Botulinum 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 axillas, the palms, the soles of the feet, armpits and the face of otherwise healthy people. [http://cks.nice.org.uk/hyperhidrosis#!scenario](http://cks.nice.org.uk/hyperhidrosis#!scenario).
**Policy:** Botulinum Toxin will only be commissioned twice per year 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). The hyperhidrosis support group www.hyperhidrosisuk.org gives patient advice including other commercially available products. AND
- 20% aluminium chloride hexahydrate has failed or is contraindicated AND
- Any underlying anxiety has been identified and managed AND
- In the opinion of an experienced dermatologist, other treatment options have been exhausted

**Hysterectomy for menorrhagia**

**Background:** There are several types of operation that can be used to treat menorrhagia after medication is proved ineffective to stop the heavy bleeding.

**Policy:** For the avoidance of doubt this means that ‘patient choice’ to opt for Hysterectomy without any form of prior conservative treatment is not routinely commissioned.

Hysterectomy for menorrhagia is not routinely commissioned for heavy menstrual bleeding with fibroids of 3-5 cm or without fibroids, except where:

- Other treatments (such as non-steroidal anti-inflammatory agents [NSAIDs], tranexamic acid, a combined oral contraceptive pill or endometrial ablation) have not successfully relieved symptoms after 6 months or are not appropriate or are contra-indicated in line with NICE CG44
- There has been a prior 3 month trial with levonorgestrel intrauterine system (Mirena® unless contraindicated) which has not relieved the symptoms.

AND

- If surgical intervention is being considered discuss with the patient the option of endometrial ablation, if appropriate, as an alternative to hysterectomy.

**Ilizarov Technique**

**Background:** The Ilizarov apparatus is a type of external fixation used in orthopedic 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 the regional 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.

Cases that will be routinely commissioned after approval by the MDT include the following:
- Complex mal-union or non-union of fractures (after at least 6 months duration or 9 months where the ‘Exogen’ ultrasound bone healing system (ref 2) has been tried and failed)
- Bone deformity (affecting the leg/knee/ankle), including limb length discrepancy, that has resulted in chronic pain and/or difficulty walking and/or an increased risk of developing osteoarthritis (ref 3).

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

This policy describes the eligibility criteria for NHS commissioned 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.

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. 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 commissioned after at least 2 years of unexplained 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).

**Policy:** Funding for egg donation and/or surrogacy is NOT routinely commissioned. IVF treatment will be commissioned in accordance with the criteria specified below:
<table>
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<tr>
<th>Ref</th>
<th>Eligibility criteria for treatment</th>
<th>Definition</th>
<th>Additional Notes</th>
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<tbody>
<tr>
<td>1.</td>
<td><strong>Female Age – under 40 years</strong></td>
<td>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 1 full cycle of IVF, with or without intracytoplasmic sperm injection (ICSI) provided they have never previously had IVF treatment (1 full cycle constitutes previous treatment). 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.</td>
<td>1 full cycle of IVF&lt;br&gt;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.</td>
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<td>2.</td>
<td><strong>Female Age – 40 to 42 years</strong></td>
<td>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 cycle of IVF, with or without ICSI, provided all the following 4 criteria are fulfilled:&lt;br&gt;• They have never previously had IVF treatment&lt;br&gt;AND</td>
<td>1 full cycle of IVF&lt;br&gt;(Including associated frozen/thaw transfers) provided that all other criteria are met. <strong>Ovarian reserve testing</strong>&lt;br&gt;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</td>
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<td>• 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</td>
<td>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.</td>
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<tr>
<td>3.</td>
<td>Minimum length of unexplained infertility</td>
<td>2 years of regular unprotected intercourse and unexplained infertility at time of treatment.</td>
<td>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.</td>
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<tr>
<td>4.</td>
<td>Female Body Mass Index (BMI)</td>
<td>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.</td>
<td>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 likely to improve their chance of conception</td>
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<tr>
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<td>5.</td>
<td>Male Body Mass Index (BMI)</td>
<td>If the male partner has mild male factor infertility which, after clinical assessment could be improved should weight be reduced, then the male partner should be re-assessed for fertility once weight has reduced to a BMI of 30 or below</td>
<td>Men who have a BMI of 30 or over should be informed that they are likely to have reduced fertility</td>
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<td>6.</td>
<td>Existing children</td>
<td>Treatment will only be offered to couples where neither partner has any living children from current or previous relationship. This applies to all treatments including those using gonadotrophins for fertility treatment including ovulation induction and for donor insemination.</td>
<td>This criterion includes adopted children, but excludes fostered children.</td>
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<td>7.</td>
<td>Smoking Status</td>
<td>Both partners should be non-smokers when referred for IVF. This is part of primary care general assessment procedures. Assessment of smoking status will be through the use of carbon monoxide monitors in primary care or stop smoking services. This applies to all treatments including those using gonadotrophins for fertility treatment including ovulation induction and for donor insemination.</td>
<td>Women who smoke should be informed that this is likely to reduce their fertility. Women who smoke should be offered a referral to a smoking cessation programme to support their efforts to stop smoking. Women should be informed that passive smoking is likely to affect their chance of conceiving. Men who smoke should be informed that there is an association between smoking and reduced semen quality.</td>
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<td>8.</td>
<td>Same sex couples and single women</td>
<td>Treatment will only be offered where the partner wishing to become pregnant is sub-fertile. Documentary evidence for subfertility is either no live birth following donor insemination from</td>
<td>Treatment is offered to couples irrespective of sexual orientation. The NHS does not fund donor insemination to establish fertility</td>
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<tr>
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<td>an accredited sperm bank for at least six cycles over two years or absolute infertility documented after clinical investigation.</td>
<td>in same sex couples.</td>
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<tr>
<td>9.</td>
<td>Previous Sterilisation</td>
<td>No previous sterilisation history in either partner. This applies to all treatments including those using gonadotrophins for fertility treatment including ovulation induction and induction of spermatogenesis, and for donor insemination.</td>
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<td>10.</td>
<td>Length of time resident in catchment area</td>
<td>Both partners should be patients registered for one year with a GP practice that is itself a member of one of the Clinical Commissioning Groups subscribing to these policies. This applies to all treatments including those using gonadotrophins for fertility treatment including ovulation induction and for donor insemination.</td>
<td>This excludes short term students who are otherwise eligible for NHS treatment.</td>
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<tr>
<td>11.</td>
<td>Residence in UK</td>
<td>Must be eligible for free hospital treatment in line with the Overseas Visitors Charging Regulations. This applies to all treatments including those using gonadotrophins for fertility treatment including ovulation induction and for donor insemination.</td>
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Knee Arthroscopy

**Background:** Knee arthroscopy is a type of keyhole surgery to look inside your knee joint to find out more about problems, such as inflammation or an injury. You can also have treatment during a knee arthroscopy, for example, your surgeon may repair or remove any damaged tissue and cartilage.

**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

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Knee replacement

**Background:** Knee replacement surgery (arthroplasty) involves replacing a damaged, worn or diseased knee with an artificial joint.

**Policy:** Experiencing moderate-to-severe persistent pain not adequately relieved by an extended course of non-surgical management. Pain is at a level at which it interferes with activities of daily living i.e. washing, dressing, lifestyle and sleep;

*AND*

- Is troubled by clinically significant function limitation resulting in diminished quality of life

*AND*

- The patient is fit for surgery.

- Patients with a BMI of 35 - 40 should be advised and given appropriate support to address lifestyle factors that would improve their fitness for surgery. They must demonstrate a sustained attempt to lose weight through a period of Health Optimisation for at least 4 months. Either of the following must be undertaken and documented within the patient’s medical records:-
1. They have attended a weight management programme over 4 months, with or without any weight loss. Appropriate programmes include Tier 2 & 3 lifestyle/weight management, commercial programmes such as Slimming World or Weight Watchers, exercise on referral or in-house GP weight loss programmes.

or

2. They can demonstrate at least a 5% reduction in weight over the last year without support from outside agencies

AND

- An Oxford Knee score indicating severe symptoms i.e. 23 or less

AND

- The patient has been a non-smoker for at least 4 weeks prior to surgery

AND

- Radiological evidence confirming diagnosis

AND

- A confirmation that patients have been made aware of the options available as an alternative to surgery and the risks associated with surgery (such as a patient decision aid).

Patients who do not fulfil these criteria will not routinely be able to access knee arthroplasty unless:

- Surgery is considered urgent as defined by a consultant orthopaedic surgeon
- Surgery is related to trauma
- The patient is considered clinically exceptional (agreed through IFR)

The CCG will not routinely commission knee replacement surgery for any patient with a BMI >40. These patients are at risk of developing other metabolic conditions and should be referred to the tier three weight management. This is a year-long programme at the end of which bariatric surgery may be offered.

Patients should all be referred via MSK regardless of where they wish to have further treatment if required. The referral letter should clearly state the patient's choice of provider and all other appropriate information to enable paper triage to their chosen provider.

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**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 is NOT routinely commissioned.

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8**

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**Minor Foot Problems**

**Background:** The referral for prophylactic or cosmetic reasons for minor foot problems will not be considered.
**Policy:** When considering referral to secondary care for minor foot lesions, prior approval is required all patients need to have had a podiatry referral and the following criteria or all cases has to be met:

- 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 or deviation to adjacent toes OR
- severe pain that causes significant functional impairment AND
- one of the criteria below severe pain on walking not relieved by chronic standard analgesia OR
- deformity such that fitting adequate footwear is difficult OR
- overlapping or underlapping of adjacent toe(s) OR
- hammer toes OR
- recurrent or chronic ulceration OR
- bursitis or tendinitis of the first metatarsal head.
- If the patient has diabetic peripheral neuropathy and the foot lesion is expected to lead to amputation of a toe, then this is not a minor foot lesion and referral is automatic

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**Oculoplasty (eyelid surgery)**

**Background:** Oculoplasty is a branch of ophthalmology that focuses on plastic surgery procedures relating to the eyes, as well as the structures that surround it. This pertains to cosmetic or reconstructive surgery on areas around the eyes, such as the eyelids and orbit (eye socket). Droopy upper eyelids, tumors around the orbit, and thyroid disease, are some of the conditions that may require oculoplastic surgery eyelid surgery).

**Policy:** Oculoplastic procedures are not routinely commissioned as many are for cosmetic reasons. However there are a number of conditions which affect vision and functionality affecting activities of daily living and quality of life which may be considered via IFR for surgical correction.

The Following eyelid surgery procedures will NOT be commissioned unless there is any diagnostic uncertainty:

- Removal of eyelid papillomas or skin tags
- Surgery for cyst of moll
- Surgery for cyst of zeis
- Surgery for pinguiculum
- Excision of other lid lumps
- Excision of other lid lumps
- Surgery for cosmetic reasons

The following conditions are NOT routinely commissioned but there are specified criteria which may be considered by IFR for referral and treatment in secondary care:
Ectropion

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

**Policy:** Ectropion is not routinely commissioned unless:
- conservative management has been exhausted and there is evidence of significant impairment of the punctum
- there is recurrent infection in surrounding skin.

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:** Entropian is NOT routinely commissioned unless there is risk of corneal damage

Ephithoria

**Background:** Ephiphora is an overflow of tears onto the face. A clinical sign or condition that constitutes insufficient tear film drainage from the eyes in that tears will drain down the face rather than through the nasolacrimal system.

**Policy:** Refer to the IFR Panel for watery eyes surgery when, despite undergoing conservative management, the patient is experiencing a daily impact of significant watering of the eyes indoors and outdoors affecting visual function and/or interfering markedly with quality of life.

Chalazion/Meibomian cyst

**Background:** A chalazion is a slowly developing lump that forms due to blockage and swelling of an oil gland in the eyelid.

**Policy:** Removal of chalazion is not routinely commissioned. Cases may be considered by the IFR if:
- the chalazion has been present for 6 months and conservative management has been exhausted

OR
- the chalazion is symptomatic - painful and has recurrent infection treated with antibiotics
- there is significant impact on vision affecting functionality

N.B. for diagnostic uncertainty or suspicious symptoms to be referred under the 2 week wait.

Blepharitis

**Background:** Blepharitis is a common condition where the edges of the eyelids (eyelid margins) become red and swollen (inflamed).
Policy: Referral to secondary care for Belpharitis is NOT routinely commissioned. Refer to IFR if symptoms are persistent and have exhausted antibiotic therapy. If lids persistently swollen consider alternative diagnosis e.g. malignancy and refer under the 2 week referral wait.

Paediatric foot problems – curly toes and metatarsus varus (metatarsus adductus)

Background: The referral for prophylactic or cosmetic reasons for minor foot problems will not be considered.

Policy: All patients to be referred to local podiatry services prior to referral to secondary care.

Metatarsus varus (metatarsus adductus)
Note: This condition is associated with developmental dysplasia of the hips so this should also be checked for when a child presents with intoeing.
Referral to secondary care should only be made if there are any of the following circumstances:
- Child has had podiatry review (please include any documentation)
- Child is ≥ 5 years and intoeing is still evident

Curly toes
Referral to secondary care should only be made if there are any of the following circumstances:
- Severe deformity (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.)
- When there is significant history of pain.

Penile implants

Background: A penile prosthesis is another treatment option for men with erectile dysfunction (ED). These devices are either malleable or inflatable. The simplest type of prosthesis consists of a pair of malleable (bendable) rods surgically implanted within the erection chambers of the penis.

Policy: Penile implants for erectile dysfunction are NOT routinely commissioned.

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 normally be funded.
Port wine stain

**Background:** Pulsed dye laser treatment is the only treatment for port wine stain and is likely to be more effective in children as the skin becomes more affected (raided and bumpy over time). Treated with laser these effects are less likely to occur. As a number of complications are associated with port wine stains infants should have early specialist assessment to rule these out.

**Policy:** Port wine stain removal is NOT routinely commissioned apart from in the following circumstances.

- Port wine stain birth marks which, in the opinion of our clinicians, do have functional implication, i.e. the affected area can become thickened, lumpy and sensitive, they can cause discomfort therefore on the body too and can weep, soft tissue hypertrophy may also occur.
- As this can vary significantly from person to person we would not set a limit on these but expect that assessment and treatment is undertaken at an appropriate specialist centre by a consultant with expertise in treating the condition to ensure the most appropriate pathway and advice is offered.

Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8

Removal of Tattoos

**Background:** Surgery for cosmetic reasons is not usually available on the NHS if, for example, you no longer like or want your tattoo.

**Policy:** The IFR panel will only consider commissioning tattoo removal as follows:

Where the tattoo:

- Is the result of past trauma i.e. scarring from grit, coal or graphite (that in some cases may have remained despite immediate post injury cleansing treatment); OR
- Was inflicted against the patient’s will; OR
- Was applied during a period of documented mental illness; OR
- Has resulted in a significant allergic reaction or impairment to daily living, OR
- Where the individual was a child and not ‘Gillick competent’, and therefore not responsible for their actions at the time of the tattooing.

Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed as per the CCG policy.

Surgery for primarily cosmetic reasons is not eligible for NHS funding – see p8

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.

Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed as per the CCG policy.

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### Removal of Benign Skin Lesions including Scars

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

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

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

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

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

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

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8**

**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.
Repair of Lobe of External Ear

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

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

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

Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8

Resurfacing: 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.

**Policy:** Resurfacing procedures are NOT routinely commissioned.

Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8

Reversal of Female Sterilisation

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

**Policy:** Reversal of sterilisation is NOT routinely commissioned.

Reversal of Male Sterilisation

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

**Policy:** Reversal of sterilisation is NOT routinely commissioned.

Rhinoplasty/Septoplasty for Nasal Deformities

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

**Policy:** Rhinoplasty/septoplasty for nasal deformities will only be commissioned in accordance with the criteria specified below:

*Where conservative treatment has been exhausted*
• 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 e.g. cleft lip and palate.

Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8

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### Sacral Nerve Stimulation

**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 the event that the nerves and the brain are no longer communicating effectively, resulting in a bowel/bladder disorder, this type of treatment is designed to imitate a signal sent via the central nervous system.

One of the major nerve routes is from the brain, along the spinal cord and through the back. This is commonly referred to as the sacral area. This area controls the everyday function of the pelvic floor, urethral sphincter, bladder and bowel. By stimulating the sacral nerve (located in the lower back), a signal is sent that manipulates a contraction within the pelvic floor. Over time these contractions rebuild the strength of the organs and muscles within it. This effectively alleviates all symptoms of urinary/faecal disorders, and in many cases eliminates them completely.

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

### Women

SNS for urinary incontinence, urgency-frequency syndrome or non-obstructive urinary retention in women is not routinely commissioned unless the patient meets the following criteria:

- Symptoms are refractory to lifestyle modification (caffeine reduction, modification of fluid intake, weight loss if BMI >30)
- 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)
- 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)]
- 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
- Symptoms are refractory to injections of Botulinum Toxin Type A into the bladder wall (only in patients willing and able to perform clean intermittent catheterisation). (NB If
Botox has not been tried, the IFR should include a valid clinical explanation for this.

The IFR Panel will consider requests for SNS from Consultant Urologists for women with non-obstructive urinary retention who fulfil all the following criteria:

- Symptoms are refractory to behavioural and lifestyle modification (diet, weight management, modification of fluid intake):
- Bladder retraining
- Bladder catheterisation
- The woman has a confirmed diagnosis defined by urodynamic assessment and has been reviewed by a Urology MDT

**Men**

Requests for SNS from a Consultant Urologist for men with overactive bladder (OAB) caused by detrusor overactivity who fulfil ALL the following criteria:

- Symptoms are refractory to conservative management lifestyle advice, advice on fluid intake, supervised bladder training and use of containment products (pads, sheaths, etc.)
- 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)]
- The man has been referred to secondary care for specialist assessment and a diagnosis of detrusor overactivity has been confirmed
- Symptoms are refractory to injections of Botulinum Toxin Type A into the bladder wall (only in patients willing and able to self-catheterise). (NB If Botox has not been tried, the IFR should include a valid clinical explanation for this)

Before a temporary SNS device is fitted, ALL prospective patients must be:

- Able to record voiding diary data so that clinical results of the implantation can be evaluated
- Fully informed of the risks and benefits of the procedure and, therefore, able to make an appropriate choice and consent to treatment

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 commissioned 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).

**Surgery for refractive error**

**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.

**Policy:** Surgery for refractive error is NOT routinely commissioned.

### 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 any indication that may be deemed as a cosmetic procedure are not routinely commissioned.

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 commissioned.

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

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

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

Surgery for primarily cosmetic reasons is not eligible for NHS funding - see p8

### 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 commissioned in accordance with the criteria specified below for recurrent acute sore throat in adults and children in the following circumstances:

- The sore throats are due to tonsillitis;
- The episodes of sore throat are disabling and prevent normal functioning;
- Seven or more well documented, clinically significant, adequately treated episodes of sore throat in the previous year;
OR
• Five or more such episodes, 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
• In addition there is no restriction on funding for tonsillectomy to treat the following conditions:
  • Quinsy
  • Tonsil bleeding
  • Severe neck infection
  • To exclude possible malignancy e.g. lymphoma
  • 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).
  • Sleep disordered breathing (apnoea) in children

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

**Trigger Finger**

**Background:** Trigger finger is a condition that affects one or more of the hand’s tendons, making it difficult to bend the affected finger or thumb. If the tendon becomes swollen and inflamed it can ‘catch’ in the tunnel it runs through (the tendon sheath). This can make it difficult to move the affected finger or thumb and can result in a clicking sensation.

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

- The patient has co-morbidities associated with an increased risk of trigger finger (e.g. rheumatoid arthritis or diabetes mellitus) and the patient’s symptoms have not improved with at least 4 months of conservative treatment (e.g. NSAIDs, splintage, physiotherapy).

**OR**
- The patient’s symptoms have not resolved despite at least one steroid injection in the last 4 months.

**OR**
- The specialist opinion is that surgery is needed promptly to prevent the development of flexion contractures.

**Vaginoplasty and Labiaplasty**

**Background:** Surgery for Vaginoplasty, Labial Vulvoplasty and Vulvar lipoplasty are all cosmetic procedures and are not routinely commissioned. This policy does not cover vaginal repair following delivery and is part of obstetric or gynaecological treatment. Clinicians should refer to the following guidance from the Royal College of Obstetricians and Gynaecologists: Joint RCOH BritSPAG release – vaginoplasty.

**Policy:** Vaginoplasty is NOT routinely commissioned.
Female circumcision is prohibited in law by the Female Genital Mutilation Act 2003 (ref 1) and is the subject of multi-agency guidelines from the Department of Health (ref 2).


**Varicose Vein Surgery**

**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.

**Policy:** Varicose vein surgery is not routinely commissioned unless it is in accordance with the following criteria:

**Referral to a vascular service guidance**¹: Refer people with bleeding varicose veins to a vascular service³ immediately.

**Referral guidance:** Refer people to a vascular service¹ if they have any of the following:

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

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8**

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¹A team of healthcare professionals who have the skills to undertake a full clinical and duplex ultrasound assessment and provide a full range of treatment.
**Vasectomy under GA**

**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 GA is not routinely commissioned. Vasectomy is not commissioned at all from acute trusts and patients should be referred to approved providers.

Considerations may be considered with patients who have the following:
- previous scrotal surgery
- serious scrotal injury
- history of allergy to Local anesthetic or iodine
- large varicocele or hydrocele
- history of co-agulation disorder, inguinal scrotal hernia or crypt orchidism.