Value Based Clinical Commissioning Policies
Hambleton, Richmondshire and Whitby CCG

DRAFT FOR APPROVAL BY COUNCIL OF MEMBERS AND GOVERNING BODY
Contents
Introduction ........................................................................................................................................ 5
Frequently asked questions .............................................................................................................. 5
Policy - BMI and smoking – Non-urgent elective surgery ............................................................... 10
Policy List ......................................................................................................................................... 10
Cosmetic Surgery .............................................................................................................................. 12
Abdominoplasty or Apronectomy .................................................................................................... 12
Allergy Treatment ............................................................................................................................. 12
Anal Fissure ........................................................................................................................................ 13
Back Pain injections, facet, epidural, rhizolysis (see addendum) .................................................. 14
Breast - Asymmetry ............................................................................................................................ 14
Breast - Augmentation ......................................................................................................................... 15
Breast – Inverted Nipple Correction ................................................................................................ 15
Breast - Mastopexy .............................................................................................................................. 15
Breast – Prosthesis Removal and/or Replacement ............................................................................ 15
Breast - Reduction ............................................................................................................................... 16
Bunions ................................................................................................................................................ 16
Carpal Tunnel ....................................................................................................................................... 17
Cataract Surgery .................................................................................................................................. 17
Cholecystectomy (for asymptomatic gall stones) ............................................................................. 18
Circumcision - Adult ............................................................................................................................ 19
Circumcision - Children ...................................................................................................................... 19
Cleft Earlobe Surgery ......................................................................................................................... 19
Complementary Therapies and Homeopathy ................................................................................... 20
Continuous Glucose Monitoring (CGM) ............................................................................................ 20
Dilatation and Curettage (D&C) for treatment of heavy menstrual bleeding ................................. 21
Dupuytren’s Contracture .................................................................................................................... 21
Endoscopic Thoracic Sympathectomy ............................................................................................... 21
Exogen Ultrasound Bone Healing .................................................................................................... 22
Extracorporeal Shock Wave Therapy ............................................................................................... 22
Face and/or Brow Lift ......................................................................................................................... 22
Functional Electrical Stimulation (FES) Implantable device ........................................... 23
Ganglion Surgery ........................................................................................................... 23
Gastric Neuromodulation ............................................................................................ 24
Gynaecomastia ................................................................................................................ 24
Haemorrhoidectomy ...................................................................................................... 25
Hair Loss Treatment ...................................................................................................... 25
Hair Removal for Hirsutism .......................................................................................... 26
Hernia Repair .................................................................................................................. 26
Hip Arthroscopy (See addendum) .................................................................................. 27
Hip Replacement ............................................................................................................. 28
Hyperhidrosis Treatment with Botulinum Toxin ......................................................... 29
Hysterectomy for menorrhagia ...................................................................................... 29
Ilizarov Technique ........................................................................................................... 30
In vitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI) See Addendum 30
Knee Arthroscopy ........................................................................................................... 34
Knee replacement ............................................................................................................ 35
Liposuction ...................................................................................................................... 36
Minor Foot Problems ..................................................................................................... 36
Myringotomy/grommets/Otitis Media with Effusion ...................................................... 37
Oculoplasty (eyelid surgery) .......................................................................................... 37
Paediatric foot problems – curly toes and metatarsus varus (metatarsus adductus) ....... 39
Penile implants ............................................................................................................... 39
Pinnaplasty ..................................................................................................................... 39
Removal of Benign Skin Lesions including Scars ......................................................... 40
Removal of Tattoos ......................................................................................................... 41
Resperate Device for hypertension ............................................................................... 41
Resurfacing: Dermabrasion, Chemical Peels and Laser Treatment ......................... 41
Reversal of Female Sterilisation ..................................................................................... 42
Reversal of male sterilisation ......................................................................................... 42
Rhinoplasty/Septoplasty for nasal deformities ............................................................. 42
Sacral Nerve Stimulation ............................................................................................... 42
Surgery for refractive error ............................................................................................ 44
Surgical Fillers ........................................................................................................................................ 44
Tonsillectomy ........................................................................................................................................ 44
Trigger Finger ...................................................................................................................................... 45
Vaginoplasty and Labiaplasty .................................................................................................................. 45
Varicose Vein Surgery .......................................................................................................................... 46
Vasectomy under GA ............................................................................................................................ 46
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.

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 - a statement about what the NHS will 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.

7 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.

8 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.

9 Who tells the patient if funding is declined?
We will tell the referring clinician, who remains responsible for ongoing treatment and care. It is the responsibility of the clinician submitting the request to communicate the outcome of any decision with the patient.
10 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.

11 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.

12 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.

13 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?
Clinical photographs will only be considered if the referring clinician is assured that they enhance the case for clinical exceptionality.

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

These guidelines apply for all non-urgent referrals where a GP is referring specifically for an elective procedure as opposed to consultant opinion. The clinical thresholds apply to for procedures given under both general and local anaesthetic.

The guidelines exclude hip and knee replacement where existing policies are already established and described later in this document.

Smoking

All non-urgent referrals to Surgical Specialties where the patient is a smoker to be offered a referral to Smoke Free Life North Yorkshire for smoking cessation. The patient’s referral will be held for a period of 6 months to give the patient the opportunity for a period of health optimisation. If Smoke Free Life North Yorkshire confirm a positive quit to the patients GP within this period then the referral could be expedited.

Where patients quit smoking for 4 weeks without the support of the North Yorkshire smoking cessation service then this would need to be evidenced by the referring GP practice using a CO monitor.

If the clinician feels that there are exceptional circumstances which would mean the period of health optimisation would be detrimental to the health of the patient or is inappropriate then the patient may be referred to the Independent Funding Request Panel.

It is suggested that patients with the following are excluded from these thresholds:

- Significant cognitive impairment

In addition the following referral pathways are excluded from the Policy:

- 2WW Referral for suspicion of cancer
- Referrals for interventions of a diagnostic nature e.g. endoscopy, biopsy of basal cell carcinomas.

Patients who only use electronic cigarettes will be classified as a non-smoker for the purposes of the threshold.

BMI

**BMI ≥ 35 - 40:**
All non-urgent referrals to the Surgical Specialties with a BMI of ≥ 35 and 40 to 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 6 months.

Either of the following must be undertaken and documented within the patient’s medical records:-
1. They have attended a weight management programme for six 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

If the clinician feels that there are exceptional circumstances which would mean the period of health optimisation would be detrimental to the health of the patient or is inappropriate then the patient may be referred to the Independent Funding Request Panel.

**BMI > 40**
The CCG will not routinely commission elective routine 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.

**Exceptions / exclusions**
The following group/patients with the following conditions will not be subject to this policy:

- Patients with a significant cognitive impairment
- Children under 5 years
- Frail Elderly
- Patients whose BMI is above threshold due to high muscle mass

In addition the following referral pathways are excluded from the Policy:

- 2WW Referral for suspicion of cancer
- Referrals for interventions of a diagnostic nature e.g. endoscopy, biopsy of basal cell carcinomas.
## Policy List – specific procedures

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** – This means CCG will fund the treatment if the patient meets the stated clinical threshold for care.

<table>
<thead>
<tr>
<th>Policy</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominoplasty/apronectomy/liposuction</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Allergy treatment</td>
<td>Restricted</td>
</tr>
<tr>
<td>Anal fissure (treatment of)</td>
<td>Restricted</td>
</tr>
<tr>
<td>Back pain injections, facet, epidural, rhizolysis</td>
<td>Restricted</td>
</tr>
<tr>
<td>Blepharoplasty/ptosis</td>
<td>Restricted</td>
</tr>
<tr>
<td>Breast asymmetry</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Breast augmentation</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Breast mastopexy (sagging)</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Breast nipple correction</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Breast prosthesis removal and/or replacement</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Breast reduction (plus white light scanning)</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Bunion surgery</td>
<td>Restricted</td>
</tr>
<tr>
<td>Carpal tunnel surgery</td>
<td>Restricted</td>
</tr>
<tr>
<td>Cataract Surgery</td>
<td>Restricted</td>
</tr>
<tr>
<td>Cholecystectomy for gallstones/lithotripsy</td>
<td>Restricted</td>
</tr>
<tr>
<td>Circumcision</td>
<td>Restricted</td>
</tr>
<tr>
<td>Cleft earlobe surgery</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Complementary therapies and homeopathy</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Continuous Glucose Monitoring</td>
<td>Restricted</td>
</tr>
<tr>
<td>Dilatation and curettage (D&amp;C) for treatment of heavy menstrual bleeding</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Dupuytren’s contracture surgery</td>
<td>Restricted</td>
</tr>
<tr>
<td>Endoscopic thoracic sympathectomy</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Exogen ultrasound bone healing</td>
<td>Restricted</td>
</tr>
<tr>
<td>Extracorporeal shockwave therapy</td>
<td>Restricted</td>
</tr>
<tr>
<td>Face, neck, brow lift</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Functional electrical stimulation (implantable)</td>
<td>Restricted</td>
</tr>
<tr>
<td>Ganglion surgery</td>
<td>Restricted</td>
</tr>
<tr>
<td>Gastric neuromodulation/gastro</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Procedure</td>
<td>Commission Status</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Gynaecomastia surgery</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Haemorrhoidectomy</td>
<td>Restricted</td>
</tr>
<tr>
<td>Hair loss treatment</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Hair removal (for hirsutism)</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Hernia repair</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Hip arthroscopy</td>
<td>Restricted</td>
</tr>
<tr>
<td>Hip replacement</td>
<td>Restricted</td>
</tr>
<tr>
<td>Hyperhidrosis treatment with Botulinum (Botox)</td>
<td>Restricted</td>
</tr>
<tr>
<td>Hysterectomy for menorrhagia</td>
<td>Restricted</td>
</tr>
<tr>
<td>Ilizarov technique</td>
<td>Restricted</td>
</tr>
<tr>
<td>Invitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI)</td>
<td>Restricted</td>
</tr>
<tr>
<td>Knee arthroscopy</td>
<td>Restricted</td>
</tr>
<tr>
<td>Knee replacement</td>
<td>Restricted</td>
</tr>
<tr>
<td>Liposuction</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Minor foot problems</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Myringotomy/grommets/otitis media with effusion</td>
<td>Restricted</td>
</tr>
<tr>
<td>Oculoplastic-eye problems</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Paediatric foot problems</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Penile implants</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Percutaneous tibial nerve stimulation (PTNS)</td>
<td>Restricted</td>
</tr>
<tr>
<td>Pinnaplasty (otoplasty)</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Removal of benign skin lesions</td>
<td>Restricted</td>
</tr>
<tr>
<td>Removal of tattoos</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Resperate device</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Resurfacing: dermabrasion, chemical peels and laser treatment</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Reversal of sterilisation in men and women</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Rhinoplasty/septoplasty for nasal deformities</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Sacral nerve stimulation</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Surgery for refractive error</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Surgical fillers</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Tonsillectomy</td>
<td>Restricted</td>
</tr>
<tr>
<td>Trigger finger surgery</td>
<td>Restricted</td>
</tr>
<tr>
<td>Vaginaplasty and labiaplasty</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Varicose vein surgery</td>
<td>Restricted</td>
</tr>
<tr>
<td>Vasectomy under GA</td>
<td>Restricted</td>
</tr>
</tbody>
</table>
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
- Blepharoplasty
- Breast augmentation (Breast enlargement)
- Breast prosthesis removal or replacement
- Breast reduction
- Breast asymmetry
- Bunion surgery
- Chalazion/meibomian cyst removal
- 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
- Vaginaplasty and labiaplasty
- 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.

---

**Anal Fissure**

**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.
Back Pain injections, facet, epidural, rhizolysis

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 for back pain are not routinely commissioned. Therapeutic injections included in this policy are:

- Epidural injections
- Facet joint injections (FJI) (by exception)
- Rhizolysis/ medial branch block/ nerve root ablation
- Trigger point injections

Therapeutic injections will only take place following referral to the commissioned low back pain service and only as part of agreed management through this service in the exceptional circumstances outlined below.

There are three exceptions:

1. For the treatment of acute and non-chronic spinal pain of up to 12 weeks duration, as part of the acute/sub-acute back pain pathway,
   - one epidural or transforaminal injection will be commissioned within an acute back pain service

Facet joint injections will NOT be commissioned for acute or acute on chronic spinal pain

2. Facet joint injections for diagnostic purposes:

For patient with complex multi-level disease requiring assessment for surgical intervention (specialist MSK service; orthopaedic or neurosurgical services) the CCG will commission a maximum of two facet joint injections for diagnostic purposes to help define surgical management of spinal pain with nerve root involvement. These should be performed no more than 6 weeks apart.

3. Spinal injections required to treat cancer related spinal pain

The CCG commissions spinal injections for patients with chronic spinal pain (>12 weeks) only in clinically exceptional circumstances.

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.

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: All patients must be referred to the podiatry service for prior approval. Surgery to treat bunions will only be commissioned following clinical authorisation from the responsible podiatrist in accordance with the criteria specified below:

- Conservative Measures have failed, including specialist footwear, orthoses and analgesia with podiatry referral
AND

- The patient suffers from either:
  - Severe deformity (with or without lesser toe deformity) that causes significant functional impairment

OR

- Severe deformity that prevents patients from finding comfortable footwear OR
- Severe pain that causes significant functional impairment
- There is evidence of recurrent ulceration

NB This does not affect existing pathway for the diabetic foot pathway

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
    - The symptoms are interfering with activities of daily living

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, please complete page 2 of the form.

**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.

---

**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
- Asymptomatic gall bladder polyp(s) reported on ultrasound
- Symptomatic gall bladder ‘sludge’ reported on ultrasound
- Elective cholecystectomy surgery will only be commissioned where the patient fulfils any of the criteria below:
  - Gall bladder polyp(s) larger than 8mm or growing rapidly
  - 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 routinely commissioned for social, cultural or religious reasons. Circumcision will only be commissioned for specific medical reasons in accordance with the criteria specified below.

Medical reasons for funding circumcision include:
- Adult Phimosis
- Recurrent balanitis;
- Balanitis xerotica obliterans
- Paraphimosis
- Suspected malignancy
- Dermatological disorders unresponsive to treatment
- Congenital urological abnormalities when skin is required for grafting
- Interference with normal sexual activity in adult males

**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)
- Recurrent urinary tract infections with a phimotic foreskin.

**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 indication 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 complementary 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.
- Complete loss of awareness of hypoglycaemia.
- Frequent (more than 2 episodes a week) asymptomatic hypoglycaemia that is causing problems with daily activities.
- Extreme fear of hypoglycaemia.
- 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 (D&C) for treatment of heavy menstrual bleeding

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

**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:** Referral for surgery should only be considered when the patient meets at least one of the following functional difficulties:

- Metacarpophalangeal joint contracture or proximal interphalangeal joint contracture of 30 degrees or more at least in one joint (inability to put hand flat on table) OR
- Patient under 45 years of age with disease affecting 2 or more digits and loss of extension exceeding 10 degrees
- AND
- all additional risk factors for aggressive progression are present, specifically - bilateral disease, family history of condition, ectopic lesions, age under 50 and male gender

- AND
- there is significant threat to hand function
- AND
- surgery is likely to restore function

Treatment in all other circumstances is not normally commissioned and should not be referred unless there is prior approval by the Individual Funding Request Panel. Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes there is an exceptional clinical need that justifyes deviation from the rule of this policy. Individual cases will be considered by the individual funding request panel.

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.

**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.

**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.
**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 commissioned in accordance with the criteria specified below.

Surgical excision will not be commissioned for cosmetic reasons and access to secondary care will only be considered if specific criteria are met:

- The ganglion has resulted in significant functional impairment, OR
- The patient is experiencing considerable pain as a result of the ganglion’s size or position despite use of analgesics

OR
- Where there is doubt about the diagnosis (with or without pain).
- Two aspirations if possible has been attempted
**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 fulfils 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 GNM will only be commissioned where the insertion of a temporary GNM has, after at least 48 hours, resulted in a significant objective improvement in gastroparesis symptoms.

**Gynaecomastia**

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

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

**Policy:** Surgery to correct gynaecomastia is NOT routinely commissioned.

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

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/Electrolosis 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:** hernia repair is not routinely commissioned

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;
- Is troubled by clinically significant function limitation resulting in diminished quality of life
- 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 6 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 six 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.
  2. They can demonstrate at least a 5% reduction in weight over the last year without support from outside agencies
- An Oxford hip score indicating severe symptoms e.g. 24 or less
- The patient has been a non-smoker for at least 4 weeks
- Radiological evidence confirming diagnosis

Patients who do not fulfil these criteria will not routinely be able to access hip arthroplasty unless:
- Surgery is considered urgent
- Surgery is related to trauma
- The patient is considered clinically exceptional

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, (Stop Sweat) Avoid tight clothing and manmade fabrics, wear white or black clothing to minimize the signs of sweating, consider dress shields to absorb excess sweat) AND
- 20% aluminium chloride hexahydrate has failed or is contraindicated AND
- Any underlying anxiety has been identified and managed AND
- In the opinion of an experienced dermatologist, other treatment options have been exhausted

Hysterectomy for 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>
<thead>
<tr>
<th>Ref</th>
<th>Eligibility criteria for treatment</th>
<th>Definition</th>
<th>Additional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Female Age – under 40 years</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 full cycles of IVF, with or without intracytoplasmic sperm injection (ICSI). 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>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>
</tr>
<tr>
<td>2.</td>
<td>Female Age – 40 to 42 years</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</td>
<td>1 full cycle of IVF (Including associated frozen/thaw transfers) provided that all other criteria are met. <strong>Ovarian reserve testing</strong> The aim is to select those with at least 10% chance of successful treatment. The</td>
</tr>
<tr>
<td>Ref</td>
<td>Eligibility criteria for treatment</td>
<td>Definition</td>
<td>Additional Notes</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------------</td>
<td>------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td>of IVF, with or without ICSI, provided all the following 4 criteria are fulfilled:</td>
<td>- They have never previously had IVF treatment AND - There is evidence of good ovarian reserve as identified by a specialist clinician AND - There has been a discussion of the additional implications of IVF and pregnancy at this age AND - Specialist clinical opinion that there is no likelihood of pregnancy with expectant management e.g. confirmed tubal blockage (absolute infertility)</td>
<td>criteria remain under review. At present use the following criteria to predict the likely ovarian response to gonadotrophin stimulation in women who are eligible for IVF treatment. - total antral follicle count of more than or equal to 4 AND - anti-Müllerian hormone of more than or equal to 5.4 pmol/l.</td>
</tr>
<tr>
<td></td>
<td>Treatment must start before the woman’s 43rd birthday</td>
<td>3. Minimum length of unexplained infertility</td>
<td>2 years of regular unprotected intercourse and unexplained infertility at time of treatment. Unexplained infertility is a diagnosis made by exclusion in couples who have not conceived and in whom standard investigations including semen analysis, tubal patency tests and assessment of ovulation have not detected any abnormality.</td>
</tr>
<tr>
<td></td>
<td>4. 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</td>
</tr>
<tr>
<td>Ref</td>
<td>Eligibility criteria for treatment</td>
<td>Definition</td>
<td>Additional Notes</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------------</td>
<td>------------</td>
<td>------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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>
<td></td>
</tr>
<tr>
<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>
</tr>
<tr>
<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>
</tr>
<tr>
<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>
</tr>
<tr>
<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</td>
<td>Treatment is offered to couples irrespective of sexual orientation. The NHS does not fund donor insemination to establish fertility in same sex couples.</td>
</tr>
<tr>
<td>Ref</td>
<td>Eligibility criteria for treatment</td>
<td>Definition</td>
<td>Additional Notes</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------------</td>
<td>------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td>from an accredited sperm bank for at least six cycles over two years or absolute infertility documented after clinical investigation.</td>
<td></td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Length of time resident in catchment area</td>
<td>Both partners should be patients registered for one year with a GP practice that is itself a member of one of the Clinical Commissioning Groups subscribing to these policies. This applies to all treatments including those using gonadotrophins for fertility treatment including ovulation induction and for donor insemination.</td>
<td>This excludes short term students who are otherwise eligible for NHS treatment.</td>
</tr>
<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>
<td></td>
</tr>
</tbody>
</table>

**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 commissioned 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) with symptomatic and functional impairment

AND
• Where conservative treatment has failed or where it is clear that conservative treatment will not be effective.

OR
Where an MRI scan is not appropriate

Arthroscopy is NOT routinely commissioned:

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

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

Knee replacement

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 6 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 six 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 e.g. 23 or less

AND
• The patient has been a non-smoker for at least 4 weeks
Radiological evidence confirming diagnosis

Patients who do not fulfil these criteria will not routinely be able to access knee arthroplasty unless:
- Surgery is considered urgent
- Surgery is related to trauma
- The patient is considered clinically exceptional

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.

**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**

**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

**Myringotomy/grommets/Otitis Media with Effusion**

**Background:** Is a surgical procedure in which a tiny incision is created in the eardrum (tympanic membrane) to relieve pressure caused by excessive buildup of fluid, or to drain pus from the middle ear.

**Policy:** Myringotomy will only be commissioned for children under 12 years old with bilateral otitis media with effusion (OME) under the following circumstances:

- There has been a period of 3 months watchful waiting from the date of the first appointment with an audiologist

**AND**

- OME persists after 3 months and the child suffers from **at least one** of the following:
  - At least 5 recurrences of acute otitis media in a year
  - Evidenced delay in speech development
  - Hearing level in the better ear of 25-30 dBHL or worse averaged at 0.5, 1, 2, & 4 KHZ (or equivalent dBH where dBHL not available)
  - Hearing loss of less than 25-30 dBHL where the impact on a child’s development, social or educational status is judged to be significant
  - A second disability such as Down’s syndrome or cleft palate

**OR**

- OME is overlaying sensorineural deafness or is delaying diagnosis or treatment with aids or cochlear implants (this would be an indication for immediate grommets).

**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 pingueculum
• 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 Blepharitis 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.

**Policy:** Pinnaplasty is NOT routinely commissioned.

**Surgery for primarily cosmetic reasons is not eligible for NHS funding- see p8**
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 (raised 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 Benign Skin Lesions including Scars

Background: Benign skin lesions include a wide range of skin disorders such as sebaceous cyst, dermoid cyst, skin tags, anal skin tags, milia, molluscum contagiosum, lipoma, seborrhoeic keratoses (basal cell papillomata), spider naevus (telangiectasia), warts, xantheasma, dermatofibromas, benign pigmented moles, comedones and corn/callous. Disfiguring scars and keloid whether arising from prior injury or surgery are also included in the scope of this policy. Removal of these is mostly requested on purely cosmetic grounds. The risks of surgical scarring must be balanced against the appearance of the lesion.

Policy: Removal of benign skin lesions for cosmetic reasons will not be commissioned. Removal will only be commissioned in accordance with the criteria specified below:

- infection
- OR
- recurrent bleeding

This guidance covers benign skin lesions only.

N.B. Patients should be referred under the two week referral pathway if there is any diagnostic uncertainty or possibility of malignancy.

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 significant 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.

**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
- 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
- Correction of complex congenital conditions e.g. cleft lip and palate.

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

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 a 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 over activity 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 over activity 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.

**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
- OR
- 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 surgery is commissioned in accordance with the following criteria:

- Symptoms have not resolved or recur after 2 cortico-steroid injections
- Co-existing inflammatory or degenerative disorders of the hand
- Co-existing nerve entrapment syndromes or Dupuytren’s disease
- Chronic or worsening symptoms
- Intermittent locking

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.

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 for secondary care vascular are accepted:
After unsuccessful six month trial of conservative management for patients with CEAP classification C4-6 and significant, intractable signs such as:
- Significant haemorrhage from a ruptured superficial vein or recurrent bleeds (required attendance at A&E)
  OR
- Intractable ulceration secondary to venous stasis
  OR
- Recurrent documented thrombophlebitis
  OR
- Persistent skin changes (eczema, pigmentation or lipodermatosclerosis)

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

**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

OR

- 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