Mid & South Essex STP

Service Restriction Policy

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| Approved by: | Mid and South Essex Joint Committee |
| Date approved: | June 2019 |
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| Name/Title of responsible committee/individual: | Mid and South Essex Joint Committee |
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**Version Control**

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| **Version** | **Key Changes** | **Authorisation** |
| Original | New SRP document covering STP | JCC |
| V1.1 | Changes to reflect national Evidence Based Intervention requirements  Change to flash glucose scanning criteria  Policy name reversion to Service Restriction Policy | JCC |
| V1.1a | Date Approved corrected to “April 2019” |  |
| V1.2 | Update of SRP to include the following amendments:   1. Botulinum toxin type A (BTA) addition 2. Fertility preservation – clarification of eligibility criteria and number of attempted gamete collections. 3. Vagus nerve stimulation (gammaCore®) addition | JCC |

**INTRODUCTION**

The over-riding commissioning policy requirement is that all commissioning must be based on value for money, defined as “the best mix of quality and effectiveness for the least outlay”.

Mid & South Essex CCGs’ commissioning position is that treatments/ interventions/device/ procedures\* (hereafter known as procedures\*) not currently included in commissioned established care pathways (as identified for example in the Schedules to the service agreements with acute care provides) or identified for funding through the commissioning process are not routinely funded. For a number of commissioned procedures M&SECCGs operate a **Prior Approvals Scheme** setting out criteria for access, based on evidence of effectiveness or relative priority for funding. Those related to procedures\* are included within this document; those relating to prescribing can be found on the commissioner [**Medicines Optimisation website.**](http://midessexccg.nhs.uk/your-health-services/medicines-optimisation)Providers **must not assume** that because a procedure\* is not included in this document or listed on the Medicines Optimisations website that by default it will be funded.

As a general principle it is expected that patients are managed in a setting which not only meets their clinical needs but is charged at the lowest appropriate tariff charge. For example where a procedure\* can be carried out in an outpatient setting at a lower tariff charge than as a day case, this is what is expected. For a few HRGs there is a single price across outpatient procedures and day cases, or a single price across all settings. This approach has been taken where a price that is independent of setting is clinically appropriate.

Where following audit it is found that procedures could have been carried out in a lower cost setting, the commissioner will only pay at the lowest appropriate tariff charge.

Commissioning policy development is an on-going process and future commissioning policy on future procedures\* as developed or in response to NICE Guidance/Guidelines, health technology assessments etc. will be produced and published periodically on M&SECCGs’ websites – [**Commissioning Policies**](http://midessexccg.nhs.uk/about-us/the-library/service-restriction-policies-1?limit=20&limitstart=20)**.**

Each new referral, regardless of advice provided following a previous referral or episode of care, must be assessed against the policy in place on the date the referral is made. The fact that a patient has previously been treated for the referral condition, or a related condition, and previously met the policy in place at the time does not support a referral or treatment outside the current service restriction policy.

This document sets out access to procedures\* where compliance with the Prior Approvals process is required.

For these procedures\*, the criteria listed apply to **both the referring and treating** clinicians GPs should not refer patients who do not meet criteria which they can assess. This not only takes up an unnecessary outpatient appointment but results in a poor patient experience.

Equally treating clinicians should review referrals and return to the GP those where it is clear from the information provided that the patient does not meet criteria, thus reducing the number of inappropriate outpatient appointments. Providers are contractually obliged to abide with the Prior Approvals scheme, and failure to do so is a breach of that contractual obligation and any unapproved activity will not be funded.

The following sets out the different levels of Prior Approval recognised by M&SECCGs.

**Group Prior Approvals** (previously known as Threshold Approval) – Those procedures\* which are commissioned by M&SECCGs on a restricted basis only for patients who meet the defined criteria set out within the relevant commissioning policy but for which individual prior approval is not required e.g. cataract surgery. M&SECCGs notification of compliance or audit will be required according to contractual arrangements. Providers should be aware that payment may be withheld where they cannot demonstrate that patients treated meet the criteria specified.

Group prior approval should be applied in line with the policy in force at the time the patient is listed (where relevant) for the procedure\*. This approval will last for 12 months. After 12 months have elapsed the patient should be reviewed against the policy in force at the time and the criteria for the procedure\* will apply. Subsequent reviews should be undertaken in line with the policy in force at the time and approval time limits will also be in line with the policy in force at the time.

This process and associated time limits will apply unless an alternative policy is subsequently introduced for a named procedure\*.

**Individual Prior Approvals** – Those procedures\* which are commissioned by M&SECCGs but only for patients who meet the defined criteria set out within the relevant commissioning policy and which require individual funding approval on a patient by patient and, in some circumstances, treatment by treatment basis e.g. botox before the treatment can be provided.

For these procedures\*, the criteria listed apply to **both the referring and treating** clinicians and if a patient is deemed to meet these criteria individual prior approval must be sought. When applicable, GPs should seek individual prior funding approval before a referral is made/outpatient appointment is booked.

Individual prior approval should be sought in line with the policy in force at the time the patient is identified as requiring the procedure\* (where relevant) for the procedure\*. Once approved the individual prior approval will be valid for 12 months. After 12 months have elapsed the patient should be reviewed against the policy in force at the time and the criteria for the procedure\* will apply and, if the procedure\* continues to be required, a new individual prior approval application should be made. Subsequent reviews should be undertaken in line with the policy in force at the time and approval time limits will also be in line with the policy in force at the time.

This process and associated time limits will apply unless an alternative policy is subsequently introduced for a named procedure\*

**Not Funded** – These procedures\* have been assessed as Low Clinical Priority by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.** Applications for funding for these procedures\* can be made using the Individual Funding Request process but should only be made where the patient demonstrates clinical exceptionality.

**Legacy patients** – It is acknowledged where funding criteria has changed there will be patients who have received funding for a procedure\*under a previous policy which is no longer funded or the criteria for funding has changed. Where for clinical reasons a previously funded procedure\* needs repeating / revision / replacement the current policy applies.

**Individual Funding Requests (IFR)** – M&SECCGs always allows clinicians on behalf of their patients the opportunity to make specific funding requests via the IFR process. Requests may include patients with conditions for which M&SECCGs do not have an agreed commissioning policy, including patients with rare conditions, and patients whose proposed treatment is outside agreed commissioning policies (exceptional clinical circumstances) or service agreements. Such requests should not constitute a request for a service development.

**Equality and Diversity** – The Equality Act 2010 protects people against unfair treatment (discrimination) on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. The Equality Act defines ‘disability’ as a physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day to day activities.Providers are reminded that under this Act they must make adequate and reasonable adjustment to services, which includes provision for interpreters, carers and for others from whom patients may require assistance, providing information and/or signage in an appropriate range of formats, media and languages. Providers shall ensure that service and customer care is delivered in an inclusive manner which respects the diversity of users. It is therefore unlikely that an application for additional funding for such adjustments will be successful.

**Children and Families Act 2014** – All providers are also reminded that they must take into account the requirements of the Children and Families Act 2014. Commissioned service provision for children must be delivered to young people 19-25 years of age if they have an Education, Health and Care Plan in place.

**The responsibility for adherence to these policies lies with the treating clinician and failure to adhere to these criteria may result in non-payment of the activity.**

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| **Policy statement:** | **Smoking /Weight Management and Surgery** |

**Smoking and Surgery**

**All patients being referred for non-urgent elective surgery who are smokers should be referred to smoking cessation services by the GP at the time of referral, and strongly encouraged to be non-smokers at the time of surgery.**

There is strong evidence of higher risks and worse surgical outcomes when a patient continues to smoke. The risks associated with smoking mean that it is not always safe for surgery to take place when a patient continues to smoke and, as a result, some surgeons will not carry out procedures until a patient is able to abstain from smoking.

For smokers who are unable to quit, the Royal College of Anaesthetists advises that smokers should give up smoking for at least several weeks before surgery and certainly not to smoke on the day of an operation. Smokers are 38% more likely to die after surgery than non-smokers.

Ref: **Joint briefing: Smoking and surgery** <http://ash.org.uk/files/documents/ASH_1023.pdf>

**Obesity and Surgery**

There is strong clinical evidence that obese patients undergoing surgery are at significantly higher risk of getting infections and suffering heart, kidney and lung problems than people who are a healthy weight. They are also likely to have to spend more time in hospital recovering and their risk of dying as a result of surgery is higher compared to patients with a normal weight.

**Overweight patients are strongly encouraged to lose weight BEFORE their operation and should consider delaying referral for non-urgent elective surgery;** this is particularly applicable to patients who have a BMI over 40 or those with a BMI between 30 and 40 who have metabolic syndrome-a combination of diabetes, high blood pressure and obesity.

Patients should aim to reduce their weight by at least 10% over 9 months or to a BMI of less than 30.

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| **Policy statement:** | **Medicines Management and Optimisation** |

Medicines Optimisation is the clinical, cost-effective use of medicines to ensure that patients get the maximum benefit from the medicines they need, while at the same time minimising potential harm. The aims of medicines management and optimisation is to increase clinical and cost effective prescribing, reduce variance from expected performance, reduce medicines waste, and improve patient outcomes

**Medicines and Devices Covered by CCG Commissioning Policies**

M&SECCGs policy is that medicines not currently included in formulary or prescribing polices or guidelines are not routinely funded. For a number of medicines/devices including High Cost Drugs M&SECCGs have published specific policy statements setting out restrictions on access based on evidence of effectiveness or relative priority for funding. These are available on the relevant CCG website.

For drugs excluded from national tariff, all providers must comply with local and agreed East of England drugs commissioning policies.

<http://midessexccg.nhs.uk/your-health-services/medicines-optimisation/high-cost-drugs-pro-forma/2337-commissioning-policies-for-pbr-excluded-drugs-and-devices-april-2017/file>

Providers commissioned to provide services on behalf of M&SECCGs are required to follow the formulary and prescribing policies/guidance as referenced above and detailed in their contract (Medicines Management Service Specification).

**Introduction of New Drugs and Technologies**

M&SECCGs will not fund new drugs/technologies on an ad-hoc basis through the mechanism of individual case funding. To do so risks inequity, since the treatment will not be offered openly and equally to all with equal need. There is also the risk that diversion of resources in this way will de-stabilise other areas of health care which have been identified as priorities by the CCGs. The CCGs expects consideration of new drugs/technologies to take place within the established planning frameworks of the NHS. This will enable clear prioritisation against other calls for funding and the development of implementation plans which will allow access for all patients with equal need.

**NICE New Technology Appraisals (TAs).**

Drugs and technologies that are approved as the result of a NICE Technology Appraisal (TA) need to be implemented within 3 months of the appraisal being published. The CCG will, within resource constraints, seek to ensure implementation of NICE TAs without delay but recognises that the CCG may take the full period of 3 months before a new commissioning policy can be brought into place where significant service change and/or development are required as part of the implementation. NICE also produces other guidelines which are a valuable source of good practice which the CCG will take into account in developing policy but the CCG retains discretion and is not mandated by Directions to implement such Guidance within a fixed time period or at all.

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| **Policy statement:** | **NHS England Commissioning-Specialised Services** |
| **Status:** | **Not Commissioned by M&SECCGs** |

NHS England is responsible for commissioning specialised services to meet a wide range of health and care needs. These include a range of services from renal dialysis and secure inpatient mental health services, through to treatments for rare cancers and life threatening genetic disorders. The commissioning of specialised services is a prescribed direct commissioning responsibility of NHS England.

**A list of all specialised services commissioned by NHS England can be found**

<https://www.england.nhs.uk/wp-content/uploads/2017/10/prescribed-specialised-services-manual-2.pdf>

M&SECCGs are not the responsible commissioners for the specialised services listed within the Prescribed Services Manual, and any requests for funding must be directed to NHS England. Exceptional funding requests for specialised services must be directed to NHS England and will not be considered by M&SECCGs

M&SECCGs will not fund any activity (or associated drugs/devices) for these specialised services if undertaken in CCG commissioned providers. Patients must be referred to specialised centres commissioned by NHS England.

The following are commonly requested treatments / procedure that at the time of publication are the responsibility of NHS England. The list is not exhaustive, and providers must check the NHS England website for the current commissioning position.

* Autologous chondrocyte implantation (ACI) of the knee
* [Bone Anchored Hearing Aids](#BoneAnchoredHearingAid)
* Cochlear Implants
* Dental Procedures (Orthodontics, Wisdom Teeth)
* Gender Dysphoria
* Gastro Electrical Stimulation
* Penile Prosthesis/Implants
* Sacral nerve modulation

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| **Policy statement:** | **[Low](#Index) Clinical Priority Procedures\*** |
| **Status:** | **Not Funded** |

A number of procedures\* have been assessed as **Low Clinical Priority** by M&SECCGs and will not be fundedunless there are **exceptional clinical circumstances.**

Applications for funding for these procedures can be made through the IFR process but should only be made where the patient demonstrates clinical exceptionality.

In making a case for special consideration in relation to a restricted treatment on grounds of clinical exceptionality, it needs to be demonstrated that:

* The patient is 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

Only evidence of clinical need will be considered. Factors such as gender, ethnicity, age, lifestyle or other social factors such as employment or parenthood cannot lawfully be taken into account.

It is not necessary to obtain a psychiatric opinion to support an application. M&SECCGs expect mental health professionals to treat related problems through established services commissioned from the mental health trust(s) and this does not include surgery. M&SECCGs’ Exceptional Cases Panels consistently takes the view that psycho-social considerations should not be a justification for surgery. In such cases, psychological treatment such as counselling or cognitive behavioural therapy may be considered as an appropriate alternative to surgery. The effect of the problem on essential activities of day-to-day livingis a key factor in decision-making.

Where referrers consider that there may be exceptional clinical circumstances they must provide details of these exceptional clinical circumstances bearing in mind the points above.

Where indicated in the policy or where relevant, all individual funding requests should be accompanied by suitable clinical photography that demonstrates the extent of the problem. This, of course, would be subject to patient consent.

**Cosmetic surgery/treatments/interventions** are not funded. Plastic surgery is only funded as detailed in policies or commissioned pathways e.g. as part of surgical management of trauma; serious congenital malformation. Post-surgical reconstruction is commissioned as per service level agreements for surgical services and in line with separate policies where in place.

**Correction of privately funded treatments** M&SECCGs do not routinely fund the correction of privately funded treatments cosmetic or otherwise. Where such treatments give rise to clinical problems, these will be managed through routine commissioned pathways and in line with any relevant commissioning policies.

**Commissioning Policies** This document has been written to be as complete as possible however it is not an exhaustive list, providers **must not assume** that because a device or treatment/intervention/procedure is not included that by default it will be funded. M&SECCGs’ commissioning policy is that devices/treatments/interventions/procedures not currently included in established commissioned pathways (as identified for example in the Schedules to the service agreements with acute care provides) or identified for funding through the commissioning process are not routinely funded.

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| **Policy statement:** | **Interventional Procedure Guidance** |

**NICE issues Interventional Procedure Guidance (IPGs) with the aim of protecting the safety of patients and supporting the NHS in the process of introducing new procedures. The IPGs are not covered by the Secretary of State’s directions to NHS organisations to fund the implementation of NICE recommendations within a given timescale because this direction relates only to NICE Technology Appraisal Guidance (TAGs).**

Interventional Procedure Guidance makes recommendations on the safety of the procedure and how well it works. The guidance does not recommend whether the NHS should fund a procedure; or not and these decisions are therefore for M&SECCGs.

M&SECCGs recognises that it is not within the remit of the NICE IPG Programme to evaluate the cost-effectiveness of interventional procedures or to advise the NHS whether interventional procedures should be funded. **M&SECCGs will not fund and providers must not introduce new interventional procedures where NICE has considered them to be safe but which give rise to additional cost/activity without approval of a business case by the M&SECCGs.**

**Specific commissioning position with respect to different categories of IPG is laid out below:**

**Special Arrangements**

**M&SECCGs will not fund** health care interventions that are subject to a NICE IPG where the IPG states:

* Current evidence on safety is inadequate.
* Current evidence on efficacy is inadequate.
* Evidence of safety and efficacy is on small numbers of patients and of limited quality.
* No major safety concerns, but efficacy has not been shown.
* Evidence is limited to a small number of patients. Good short term efficacy but little evidence of long term efficacy.
* There is adequate evidence of safety and efficacy but the technical demands are such that is should not be used without special arrangements.
* Evidence for short term efficacy is limited and long term outcomes are uncertain.

**Research Only**

**M&SECCGs will not fund** health care interventions that the NICE IPG programme has recommended should only be undertaken in the context of research. Clinicians wishing to undertake such procedures should ensure they fulfil the normal requirements for undertaking research.

Where there is a possibility that NHS funded care may be impacted following the cessation of the trial, or a patient’s completion of a trial, clinicians must agree this with M&SECCGs before the trial commences.

**Do not use**

**M&SECCGs will not fund** health care interventions where a NICE IPG recommends that the intervention should not be used in the NHS.

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| **Policy statement:** | **Medical Technologies Guidance (MTG)** |

The NICE Medical Technologies Evaluation Programme (MTEP) identifies and selects medical devices and diagnostic technologies and routes them to appropriate evaluation programmes at NICE. It also develops guidance and advice on the effective and cost efficient use of these technologies for the NHS and its social care partners, and where appropriate, commissions research on the clinical utility of technologies with an underdeveloped evidence base.

Medtech innovation briefings (MIBs) provide a description of the technology, including its likely place in therapy, the costs of using the technology and a critical review of the strengths and weaknesses of the relevant published evidence. Their purpose is to provide a rapid service that gives objective information on device and diagnostic technologies to aid local decision-making by clinicians, managers and procurement professionals. By making this information available, NICE helps to avoid the need for NHS organisations to produce similar information for local use.

MIBs are not NICE guidance. They differ in format, contain no judgement on the value of the technology and do not constitute a guidance recommendation.

**M&SECCGs will not fund and providers must not introduce new medical devices, diagnostics or digital technology recommended by NICE which give rise to additional cost / activity without approval of a business case by the M&SECCGs.**

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| **Policy statement:** | **Multi-staged procedures** |

All procedures will be funded for a single stage procedure except where specifically indicated otherwise in a commissioning policy. Individual prior approval is required for a two or more staged procedures and must be reviewed internally by the provider in advance of applications to M&SECCGs for funding. The application must clearly indicate the intended number of stages that the procedure will occur in and the cost associated with the complete pathway of care

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| **Policy statement:** | **Individual CCG commissioning policies** |

Across mid and south Essex for the following procedures\* individual CCGs will retain an individual commissioned policy and will not be part of the common Mid & South Essex CCGs common set of value based commissioning policies.

Access criteria for procedures\* may vary between CCGs and GPs/providers must confirm funding arrangements before referral/treatment.

At the time of publication these include:

* Assisted Conception –including IVF/ICS/IUI-specialist fertility services
* Bariatric Surgery
* Breast asymmetry
* Breast reduction
* Female Sterilisation
* Vasectomies

Individual policies for each CCG in embedded documents.









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| **Policy statement:** | **[Abdominoplasty](file:///M:\\Exceptional%20Cases%20Panel\\SRP%20Comparisions%20docs%20April%202016\\v2%20from%20Paula\\ESRSRP2016001ApronectomyAbdominoplasty.docx" \l "Index)/Apronectomy** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission Abdominoplasty/Apronectomy on a restricted basis -

**A** For patients where it is required as part of abdominal hernia correction or other abdominal wall surgery  
  
This could include patients with scarring resulting in skin tethering to deep tissues **and** severe functional problems\* **or** severe pain, but does not include contour irregularities and moderate asymmetry which are predictable following surgery. Any post-surgical cosmetic irregularities (including dog ears or unequal fat distribution) will not be funded by M&SECCGS for revision surgery. Patients who have predictable abdominal changes due to pregnancy will not be funded.

**OR**

**B** Those patients from the following groups who have significant abdominal aprons as a result of weight loss **and** have severe functional problems\*

* Patients with excessive abdominal folds who had an initial BMI >40 and have achieved a reduction in BMI to < 25 and have maintained the BMI < 25 for at least 2 years.

OR

* Patient with excessive abdominal folds who have an initial BMI > 50 and have achieved their maximum weight loss goal (which must be a minimum drop of 25 BMI points) and have maintained at that lowest weight for at least 2 years, without fluctuation up or down.

\**Severe functional problems include*:

* Chronic and persistent skin condition (for example, intertriginous dermatitis, cellulitis or skin ulcerations) beneath the skin fold that is refractory to at least six months of consistent medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics
* Experiencing severe difficulties with daily living i.e. ambulatory restrictions. These patients will need full assessment by the appropriate professional e.g. OT prior to referral
* Abdominal wall prolapse with proven urinary symptoms
* Problems associated with poorly fitting stoma bags which cannot be resolved by specialist stoma nurses/consultant other than with surgery.

Multi-staged procedures

All funding for abdominoplasty/apronectomy will usually be for a single stage procedure. Applications for a 2 stage abdominoplasty must be reviewed internally by the trust in advance of applications to M&SECCGs for funding. The application must clearly indicate that the procedure will occur in two stages and the cost associated with this pathway of care.

Patients not meeting the above criteria will not be funded unless there are **clinically exceptional circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**Patient Information:**

<https://www.nhs.uk/conditions/cosmetic-treatments/>

**References:**

1. Mammaplasty and Abdominoplasty. Dafydd, Juma, Meyers, Shokrollahi (2009) The Contribution of Breast and Abdominal Pannus Weight to Body Mass Index Implications for Rationing of Reduction Annals of Plastic Surgery.

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| **Policy statement:** | **[Acne](file:///M:\\Exceptional%20Cases%20Panel\\SRP%20Comparisions%20docs%20April%202016\\v2%20from%20Paula\\ESRSRP2016001ApronectomyAbdominoplasty.docx" \l "Index) Vulgaris-Laser/Resurfacing/Surgical treatments** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund laser, resurfacing or other surgical treatments for treatment of acne vulgaris.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Adenoidectomy-Adjuvant** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission adenoidectomy on a restricted basis. This policy should be read in conjunction with commissioning policy **Grommets** and **Tonsillectomy**

Adenoids are small lumps of tissue at the back of the nose, above the roof of the mouth. Adenoids are part of the immune system, which only children have. They start to grow from birth and are at their largest when a child is around three to five years of age. Adenoids tend to shrink by adulthood and will often have disappeared.

**Adjuvant adenoidectomy** is funded in patients meeting the criteria listed below:

Children 18 years of age or under

**AND**

* with Otitis Media with Effusion (OME) who meet the CCG commissioning criteria for ventilation tubes (grommets) **and** in the presence of persistent and/or frequent upper respiratory tract infections (see Grommets)

**OR**

* Children where obstructive sleep apnoea (OSA) is demonstrated by sleep study or diagnosed clinically in the presence of excessively large tonsils and adenoids with documented evidence of failure to thrive assessed as per NICE guidance- NG 75 (see Tonsillectomy)

**Adenoidectomy as a separate procedure will not be funded.**

Patients not meeting the above criteria will not be funded unless there are **clinically exceptional circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**Ref:**Faltering growth: recognition and management of faltering growth in children (NG 75) September 2017

<https://www.nice.org.uk/guidance/ng75/chapter/Recommendations#weight-loss-in-the-early-days-of-life>

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| **Policy statement:** | **Allergy Disorder- Unconventional Treatments** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund unconventional treatments for allergy disorder.

Only standard treatments with evidence of clinical effectiveness will be funded under the NHS. These include allergen avoidance, drugs and immunotherapy. Unconventional approaches to the management of allergy disorders will not be funded. These include clinical ecology, acupuncture, homeopathy, hypnosis, ionisation and herbal medicine.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGS and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Arthroscopic Shoulder Decompression** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission athroscopic shoulder decompression on a restricted basis.

Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only be offered in appropriate cases. To be clear-‘pure subacromial shoulder impingement’ means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calicific tenidinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases.

Primary care referral can be considered for surgical opinion for patients who meet **all** of the following criteria:

* Patient has had symptoms for at least 3 months from the start of treatment
* Symptoms are intrusive and debilitating (for example waking several times a night, pain when putting on a coat)
* Patient has been compliant with conservative intervention (education, rest, NSAIDs, simple analgesia, appropriate physiotherapy) for at least 6 weeks
* Patient has initially responded positively to a steroid injection but symptoms have returned despite compliance with conservative management
* Referral is at least 8 weeks following steroid injection
* Patient confirms they wish to have surgery.

RED FLAG SYMPTOMS

Emergency referral - same day:

* Acutely painful red warm joint– e.g. suspected infected joint.
* Trauma leading to loss of rotation and abnormal shape - unreduced shoulder dislocation.

2WW referral to secondary care:

* Shoulder mass or swelling - suspected malignancy
* Sudden loss of ability to actively raise the arm (with or without trauma) - acute cuff tear.
* New symptoms of inflammation in several joints - systemic inflammatory joint disease (rheumatology referral).

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**Reference**

<https://www.oxfordshireccg.nhs.uk/professional-resources/documents/commissioning-statements/269b-subacromial-decompression-of-the-shoulder.pdf>

Evidence based interventions- guidance for CCGs.

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| **Policy statement:** | **[Arthroscopy Hip](#ArthroscopyHip) including Femoro-Acetabular Impingement (FAI)** |
| **Status:** | **Group Prior Approval/Individual Prior Approval** |

M&SECCGs commission hip arthroscopy on a restricted basis.

Patients will be funded if they meet the criteria as listed for the following conditions.

**Group Prior Approval**

Arthroscopy of the hip can be carried out for the following:

* **Sepsis of the Hip Joint (Septic arthritis /Infectious arthritis) –** Hip arthroscopy is supported in the washout of an infected hip joint in patients refractory to medical management; patients with underlying disease or patients who are immunosuppressed
* **Loose Bodies –** Hip arthroscopy is supported for the removal of radiologically proven loose bodies within the hip joint **with an associated acute traumatic episode**. Arthroscopy is not supported as a diagnostic tool where there is suspicion of loose bodies.
* **Excision/repair of Radiological Proven Labral Tears in the Absence of Osteoarthritis or Femoro-Acetabular Impingement Syndrome (FAI) –** Hip arthroscopy is supported for the excision of radiological proven labral tears **associated with an acute traumatic episode** in the absence of osteoarthritis or FAI syndrome.

**Individual Prior Approval**

**Femoro-Acetabular Impingement (FAI)**

M&SECCGs will fund open or arthroscopic hip surgery for the treatment of femoro-acetabular impingement (FAI) **ONLY** when patients fulfil **ALL** of the following criteria:

* Diagnosis of definite femoro-acetabular impingement defined by appropriate investigations, X-rays, MRI and CT scans.
* An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis. This should include discussion of each case with a specialist musculoskeletal radiologist.
* Severe symptoms typical of FAI with duration of at least six months where diagnosis of FAI has been made as above.
* Failure to respond to all available conservative treatment options including activity modification, pharmacological intervention and specialist physiotherapy.
* Compromised function, which requires urgent treatment within a 6-8 months’ time frame, or where failure to treat early is likely to significantly compromise surgical options at a future date.
* Treatment with more established surgical procedures is not clinically viable.

**Exclusions for FAI**

M&SECCGs will not fund hip arthroscopy in patients with femoro-acetabular impingement (FAI) where any of the following criteria apply:

* Patients with advanced osteo-arthritic change on preoperative X-ray (Tonnis grade 2 or more) or severe cartilage injury (Outerbridge grade lll or lV).
* Patients with a joint space on plain radiograph of the pelvis that is less than 2mm wide anywhere along the sourcil.
* Patients who are a candidate for hip replacement.
* Any patient with severe hip dysplasia or with a Crowe grading classification of 4.
* Patients with generalised joint laxity especially in diseases connected with hypermobility of the joints, such as Marfan syndrome and Ehlers-Danlos syndrome.
* Patients with osteogenesis imperfecta.

Treatment of FAI should be restricted to centres experienced in treating this condition and staffed by surgeons adequately trained in techniques addressing FAI and all governance and audit undertaken in accordance with NICE IPG 403 and 408.

Funding for hip arthroscopy for all other circumstances will only be made available for clinically exceptional cases.

Patients not meeting the above criteria will not be funded unless there are **clinically exceptional circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

Ref:

NICE interventional procedure guidance 408 and 403

<https://www.nice.org.uk/guidance/ipg403>

<https://www.nice.org.uk/guidance/ipg408>

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| **Policy statement:** | **Arthroscopy Knee** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission knee arthroscopy on a restricted basis. Cases will only be funded if they meet the criteria below:

Arthroscopy of the knee can be undertaken where a competent clinical examination (or MRI scan if there is diagnostic uncertainty or red flag\* symptoms/signs/conditions/ reason) has demonstrated clear evidence of an internal joint derangement (meniscal tear, ligament rupture or loose body) and where conservative treatment has failed or where it is clear that conservative treatment will not be effective.

Knee arthroscopy can therefore be carried out for:

* Removal of loose body where there is a clear history of locking and other treatment has failed
* Meniscus resection/meniscectomy or meniscus repair
* Articular cartilage debridement/chondroplasty or microfracture of chondral defect
* Anterior or posterior ligament reconstruction-primary or revision
* Synovectomy / symptomatic plica
* To assist selection of appropriate patients for uni-compartmental knee replacement
* Treatment of osteoarthritis with arthroscopic lavage (washout) and debridement only if the person has knee osteoarthritis with a clear history of mechanical locking (not gelling, ‘giving way’ or X-ray evidence of loose bodies)
* Continuing diagnostic uncertainty following MRI, but only in the following circumstances:
  + When the MRI is of low quality and cannot be interpreted
  + The report shows a significant degree of movement artefact
  + Where the patient has had an Anterior Cruciate Ligament
  + reconstruction and the metal screws are affecting the image quality
  + Patient has a pacemaker

Knee arthroscopy **will not be funded** for any of the following indications:

* Diagnostic purposes only (noting the above exception)
* Investigation of knee pain (MRI is a less invasive alternative for the investigation of knee pain)
* Treatment of osteoarthritis including arthroscopic lavage (washout) and debridement without a clear history of mechanical locking (not gelling, ‘giving way’ or X-ray evidence of loose bodies).

\*Red flag symptoms or signs include recent trauma, constant progressive non- mechanical pain (particularly at night), previous history of cancer, long term oral steroid use, history of drug abuse or HIV, fever, being systematically unwell, recent unexplained weight loss, persistent severe restriction of joint movement, widespread neurological changes, and structural deformity. Red flag conditions include infection, carcinoma, nerve root impingement, bony fracture and avascular necrosis.

Funding for knee arthroscopy outside the defined criteria will only be funded in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

References:

* Osteoarthritis – National Clinical Guideline for Care and Management in Adults, (2008) NICE <https://www.nice.org.uk/guidance/CG59>
* Vincken PW et al: Effectiveness of MR imaging in selection of patients with arthroscopy of the knee. Radiology.2002 Jun: 223(3(:739-46)
* Brooks, S, Morgan, M: Accuracy of clinical diagnosis in knee arthroscopy. Annals of the Royal College of Surgeons of England 2002, 84:265-268

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| **Policy statement:** | **Arthroscopy Shoulder** |
| **Status:** | **Individual Funding Approval** |

M&SECCGs commission shoulder arthroscopy on a restricted basis.

Shoulder arthroscopy will only be funded for patients with adhesive capsulitis (‘frozen shoulder’) if the following treatments have all been tried and failed:

1. Activity modification
2. Physiotherapy and exercise programme
3. Oral analgesics including NSAIDs (unless contraindicated)
4. Intra-articular steroid injections

GPs should not refer unless all the above have been tried and failed, and referrals must include objective information to demonstrate this.

For the avoidance of doubt the CCG does not commission shoulder arthroscopy in the following:

* As a diagnostic tool
* For frozen shoulder or adhesive capsulitis except if the above criteria are met.

In the majority of circumstances a clinical examination (history and physical examination) by a competent clinician will give a diagnosis and demonstrate if internal joint degeneration is present. If there is a diagnostic uncertainty despite competent examination or if there are ‘red flag’ symptoms/signs/conditions then an MRI scan (not shoulder arthroscopy) might be indicated.

The CCGs commission shoulder arthroscopy as part of a procedural treatment i.e. as a less invasive surgical treatment which does not require prior approval. However if used to treat adhesive capsulitis will only be funded if the above criteria are met and prior approval obtained.

Red Flag symptoms or signs including:

* Recent trauma,
* Constant progressive non-mechanical pain (particularly at night),
* Previous history of cancer,
* Long term steroid use,
* History of drug abuse,
* History of HIV,
* Fever,
* Being systematically unwell,
* Recent unexplained weight loss,
* Persistent severe restriction of joint movement,
* Widespread neurological changes,
* Structural deformity.

Red Flag conditions cont’d:

* Infection, carcinoma,
* Nerve root impingement,
* Bony fracture
* Avascular necrosis.

Providers should be aware that payment may be withheld if they cannot demonstrate that patients meet these criteria.

Patients not meeting the above criteria will not be funded unless there are **clinically exceptional circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Autologous Cartilage Transplantation** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund Autologous Cartilage Transplantation.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGS and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Benign Skin Conditions** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs do not fund laser/pulse dye laser/intense pulsed light (IPL) treatment of clinically benign skin lesions/conditions.

M&SECCGs do not commission surgical removal or cryotherapy of clinically benign skin lesions/conditions for purely cosmetic reasons. Surgery or treatments to improve appearance alone is not provided for normal changes such as those due to ageing. The fact that a patient wants to have a lesion removed does not constitute a sound reason for doing so at NHS expense.

M&SECCGs commission surgical removal of benign skin lesions on a restricted basis only when criteria as detailed below are met. **Individual prior approval** is required (except A below). GPs should not refer patients who do not meet the criteria detailed below. Providers will not be funded where patients are treated outside the commissioned service.

GPs providing Minor Surgery as an Additional Service (curettage and cautery and, in relation to warts, verrucae and other skin lesions e.g. seborrhoeic keratosis, cryocautery) or Minor Surgery as a Directed Enhanced Service (DES) under GMS/APMS contracts must adhere to the restrictions as detailed within this service restriction policy. Although these services are commissioned by NHS England, GPs should note that removal of benign skin lesions for purely cosmetic reasons will **not be funded** by NHS England under this DES and as such should apply this policy.

**A - All suspected malignant lesions are excluded from this policy** – these should be managed via the 2 week wait with the exception of Basal Cell Carcinoma (BCC), where low risk BCC may be removed in the community in line with NICE recommendations and high risk BCC should be referred through the usual pathway.

Lipomas on the body larger than 5cms, or in a sub-facial position with rapid growth and / or pain should be referred to a sarcoma clinic.

Once it is established that a skin lesion is not malignant its removal will not normally be funded by the NHS though a clinician may request exceptional funding. Clinicians referring on this basis should make the patient explicitly aware that removal of the lesion may not be funded by the NHS.

**Examples** of lesions covered by this policy include, but are not exhaustive:

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| * Benign pigmented naevi (moles) * Comedones * Corn/Callous * Dermatofibromas (skin growths) * Lipomas * Milia * Molluscum contagiosum * Neurofibromata * Port wine stains * Rosacea | * Sebaceous cysts (epidermoid and pilar cysts) * Seborrhoeic keratoses (benign skin growths, basal cellpapillomas) * Skin tags including anal tags * Spider naevus (telangiectasia) * Thread veins * Warts and plantar warts * Xanthelasma (cholesterol deposits underneath the skin), |

**Individual prior approval must be obtained** before referral in **ALL** circumstances other than where a patient meets criteria A below.

**B - Individual Prior Approval**

Requests for surgical removal of benign skin lesions will be considered where at least one of the following criteria is met:

* The lesion is obstructing an orifice or impairing field of vision.

**OR**

* Lesions with confirmed, evidenced history of recurrent infection (two or more, in a year, of the same lesion) requiring systemic antibiotics.

**OR**

* Lesions causing significant pain (as direct result of the lesion) requiring regular prescribed strong analgesics.

**OR**

* Sebaceous cysts where there has been more than one episode of infection requiring treatment with antibiotics;

**OR**

* Lesions which cause demonstrable severe functional impairment which prevents the individual from fulfilling activities of daily living.

**OR**

* Lesions on the face where the extent, location and size of the lesion can be regarded as considerable disfigurement, and which sets them apart from the cohort of people with similar lesions.

**OR**

* Lesions are rapidly growing or abnormally located (e.g. sub-fascial, sub-muscular)

**OR**

* Lesions where there is clinical evidence that a commonly benign or non-aggressive lesion may be changing to a malignancy, or there is sufficient doubt over the diagnosis to warrant removal.

Evidence that previous treatment has been pursued before referral has been made will be required. For those requiring prior approval this evidence must be provided with the request for funding.

Referral to appropriate speciality service (e.g. dermatology or plastic surgery):

* The decision as to whether a patient meets the criteria is primarily with the referring clinician. If such lesions are referred, then the referrer should state that this policy has been considered and why the patient meets the criteria.

Funding for patients not meeting the defined criteria will only be funded in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Biologic Mesh** |
| **Status:** | **Individual Prior Approval** |

Biologic and Synthetic Mesh are forms of surgical mesh- loosely woven sheet of either biologic or synthetic materials, used as either a permanent or temporary support for organs and other tissues during surgery.

Bıological meshes are excluded from National Tariff.

**Synthetic mesh** is not excluded from National Tariff and the cost of synthetic mesh is within tariff and not funded separately.

**Synthetic Equivalents** This wording was included within 2014/15 PbR exclusions and is intended to allow for the possibility that there are synthetic materials in use which may represent a similar disproportionate cost as biological mesh – synthetic equivalents to biologic mesh are therefore also excluded from 2014/15.

M&SECCGs **will separately fund** use of biological mesh for the following indications whilst it is listed as an exclusion from National Tariff

* **eLAPE reconstructive surgery for low rectal cancer**: when used as part of eLAPE (extra-Levator Abdomino Perineal Excision of the rectum) reconstructive surgical technique for low rectal cancer to achieve wound closure where all the following circumstances are met:
* **Breast reconstruction**-when used in patients
  + with cancer of the breast, ductal carcinoma in situ and those patients identified with the high risk BRCA gene
  + for single stage skin sparing mastectomy/reconstruction to avoid the need for a 2 stage operation involving mastectomy and reconstruction.

**M&SECCGs will not separately fund** as an exclusion from National Tariff

* Biological mesh when used for any indication not listed above.
* Synthetic mesh for any indication
* Synthetic equivalents (as defined above) to biological mesh.

M&SECCGs will not fund use of biologic mesh for complex abdominal wall hernia repair & closure of laparostomy. Given the uncertainties in the literature regarding evidence and circumstances for use, the use of biological mesh in complex abdominal wall hernia repair and closure of laparostomy is not separately funded as tariff exclusion at the current time.

The CCGs fund biological mesh for the above criteria and in accordance with the table below:

|  |  |
| --- | --- |
| Size | Upper cost per single dressing (£) |
| Smaller than 10X10 cm | 500 |
| 10x10 cm | 1200 |
| 10x15 cm | 1600 |
| 15-20x20 cm | 6000 |
| >20x20 cm | 6400 |

Funding for patients not meeting the defined criteria will only be funded in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**Reference:**

Funding arrangements for the use of biologic and synthetic mesh equivalents-January 2017-Worcestershire CCGs

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| **Policy statement:** | **Blepharoplasty** |
| **Status:** | **Group Prior Approval/Individual Prior Approval** |

M&SECCGs commission blepharoplasty on a restricted basis for functional reasons only for patients who meet the criteria below. M&SECCGs do not fund blepharoplasty for cosmetic reasons.

**Group Prior Approval:** The correction of ectropion or entropian affecting the lower lid.

**Individual Prior Approval**

**In all cases photography will be required for the individual prior approval** Photographs must be taken from the front with the camera at eye level and the individual looking straight ahead (primary gaze).

**Upper Lid  
A**

* Excess eyelid tissue (Dermatochalasis) causing functional visual impairment AND
* Documented complaints of interference with vision or visual field-related activities such as difficulty reading or driving due to upper eyelid skin drooping, looking through the eyelashes or seeing the upper eyelid skin.

AND

* Photographic evidence must show redundant skin overhanging the upper eyelid margin and resting on the upper eyelashes when gazing straight ahead.

NOTE: excess tissue below the eye rarely causes functional visual impairment and therefore lower lid blepharoplasty is not funded for this indication.

**B**

* Rehabilitation of eyelids affected by the pathological processes of thyroid eye disease, nerve palsy or blepharochalasis   
  AND
* Causing either functional visual impairment (complaints of interference with vision or visual field-related activities such as difficulty reading or driving due to upper eyelid skin drooping, looking through the eyelashes or seeing the upper eyelid skin) or corneal exposure/irritation.

**C**

* To correct prosthesis difficulties in an ophthalmic socket

Visual field testing is not necessary to determine the presence of excess upper eyelid skin; a patient could cause a visual field defect by lowering their lids during the test. Photographs that document redundant skin overhanging the upper eyelid margin and resting on the upper eyelashes when gazing straight ahead provide a practical indication of the need for surgery. If visual field tests are performed, the tests should show that eyelids impinge on visual fields reducing field to 120° laterally and 40° vertically.

**Individual Prior Approval**

**Lower Lid**

This will be funded for

* The removal of lesions of the eyelid skin or lid margin which impair function.

Also see related policy Dysthyroid eye disease.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**References:**

Cahill,K.V., Bradley,E.A., Meyer,D.R., et al. (2011) Functional Indications for Upper Eyelid Ptosis and Blepharoplasty Surgery : A Report by the American Academy of Ophthalmology. **Ophthalmology**. 118(12): 2510-2517

Ho,S.F., Morawski,A., Sampath,R., Burns,J. (2011) Modified visual field test for ptosis surgery (Leicester Peripheral Field Test). **Eye**. 25:365–369

Rahman,I. and Sadiq,S. (2007) Ophthalmic management of facial nerve palsy: A review. **Survey of Ophthalmology**. 52(2): 121-144.

Nerad,J. (2009) **Techniques in ophthalmic plastic surgery**. Elsevier: London Koursh,D., Modjtahedi,S., Selva,D. and Leibovitch I. (2009) The blepharochalasis syndrome. **Survey of ophthalmology**. 54(2):235-44

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| **Policy statement:** | **Bobath Therapy** |
| **Status:** | **Not Funded** |

M&SECCGs do not commission Bobath therapy.

Referral for assessment and/or treatment at specific Bobath centres outside commissioned therapy services will not be funded.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGS and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **[Bone Morphogenic](#BoneAnchoredHearingAid) Protein (BMP)** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission use of BMP on a restricted basis and only in line with the East of England policy for use of BMP:

**Acute tibial fractures with Grade 111B fractures (i.e. more severe cases)**

Dibotermin alfa is recommended as an adjunct to standard care using open fracture reduction and intramedullary nail fixation in patients in whom there is a substantial risk of non-union. It is restricted to patients treated with undreamed intramedullary nails.

OR

**Non-union of long bones exceeding nine months which have been assessed for bone autograft and found to be unsuitable for such procedure:**

Eptotermin alfa combined with bovine collagen should only be considered third line

Treatment is restricted by named consultants for use in tibial, ulnar, radial, humoral, femoral and clavicular non-union.

The CCGs do not commission BMP for:

* In skeletal immature individuals defined as those who can reasonably be expected to not have fusion of the long bone epiphyses, in other words they are still growing (variant; normally in girls below 16 years and in boys below 19 years. To be individually confirmed)
* For repeat doses or sequential use of BMPs due to the possible development of antibody production.

Funding for patients not meeting the above criteria will only be granted in **exceptional clinical circumstances**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Botulinum toxin type A (BTA Botox)** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission the use of BTA on a restricted basis, only in line with the East of England Prescribing Advisory Committee (2015) and NICE guidance

The CCGs do not commission (fund) use of botulinum toxin type A (BTA) for cosmetic use.

The CCGs do not commission (fund) use of any other type of botulinum toxin.

The use of BTA will be funded when used in line with defined criteria for:

* Chronic anal fissure in adults
* Severe blepharospasm in adults
* Hemi-facial spasm in adults
* Cervical dystonia of a predominantly rotational form (spasmodic torticollis) in adults
* Hyperhidrosis -see separate SRP on Hyperhidrosis
* Focal spasticity in adults in upper and lower limb
* Achalasia- in patients with high risk of perforation with pneumatic dilatation treatment
* Frey’s syndrome- facial hyperhidrosis secondary to parotidecotomy
* Dysphagia caused by achalasia in patients at high risk of perforation during pneumatic dilatation treatment or aspiration.
* Overactive bladder only when non non-pharmaceutical and pharmaceutical pathway has proven unsuccessful
* Disease induced hypersalivation (NOT drug induced)
* Migraine Positive in line with NICE technology appraisal guidance (TA260), issued June 2012

Patients will only be funded when they meet the criteria as detailed in the prior approval proforma and only when individually approved prior to each treatment. Retrospective funding will not be approved.

**Note: Spasticity treatment in paediatric cerebral palsy (lower and upper limb) is commissioned by NHSE.**

**M&SECCGs will only fund a maximum of 4 treatments per annum for commissioned treatments except for the following treatments where the maximum frequency of funded treatments is as stated:**

Chronic anal fissure Single use

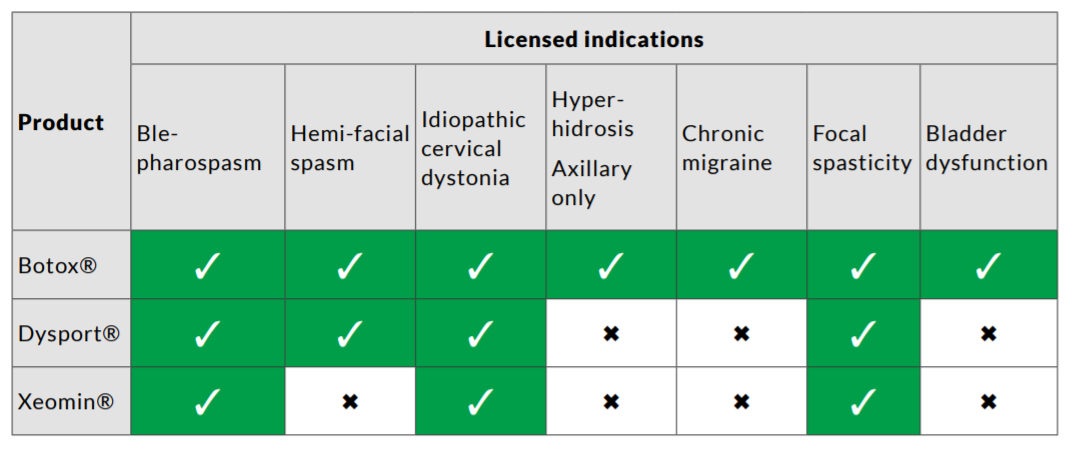
Achalasia 6 monthly

Frey’s syndrome 6 monthly

Hyperhidrosis 6 monthly

Overactive bladder 6 monthly

**BTA product licensed indications (does not include cosmetic uses)**



**Overactive bladder and urinary continence**

M&SECCGs only fund use of BTA in the use of overactive bladder and urinary continence when all other steps in the pathway have been trialled with no and evidenced in the application.

**References**

* Botulinum toxin type A for the prevention of headaches in adults with chronic migraine Technology Appraisal 260 (TA260); issued June 2012- <https://www.nice.org.uk/guidance/ta260>
* Spasticity in children and young adults with non-progressive brain disorders, Clinical Guideline 145 (CG145), issued July 2012. <https://www.nice.org.uk/guidance/cg145>
* Urinary incontinence in neurological disease: assessment and management Clinical Guideline 148 (CG148), issued August 2012 <https://www.nice.org.uk/guidance/CG148>
* Lower urinary tract symptoms in men, (CG97), Issued May 210; updated June 2015 <https://www.nice.org.uk/guidance/cg97>
* Urinary incontinence and pelvic organ prolapse in women: management NICE guideline [NG123] Published date: April 2019 <https://www.nice.org.uk/guidance/ng123>
* M&SECCG treatment pathways- see Medicines Management section on relevant CCG website
* The East of England Priorities Advisory Committee Guidance Botulinum Toxin Type A v.3 issued June 2015 (see embedded document)



* South West Essex oral medication pathway for overactive bladder and urinary continence (accessed 29.05.19)

<https://www.thurrockccg.nhs.uk/about-us/document-library/medicines-management/formulary-and-prescribing-guidelines/chapter-07-genito-urinary-system/3767-oab-medicines-pathway/file>

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| **Policy statement:** | **Breast Augmentation** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund surgery or treatments for Breast Augmentation.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Breast Implants** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs only commission the removal/replacement of breast implants on a restricted basis.

**Removal**

* The implant(s), whether funded privately or on the NHS, need to be removed for clinical reasons, such as implant rupture, infection or capsular contraction.
* Where implants are privately funded patients will be offered the choice of removing both prostheses in the event that only one has ruptured with the intention of preserving symmetry.

**Replacement**

* Implants removed for clinical reasons under this policy may be replaced when insertion of the removed implants was funded by the NHS.
* The *replacement* of privately funded breast implants removed for clinical reasons under this policy will not be funded.

**Individual prior approval for funding is required.**

Funding for patients not meeting the above criteria will only be granted in **exceptional clinical circumstances**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Breast Lift – Mastopexy** |
| **Status:** | **Not Funded** |

M&SECCGs do not commission surgery or treatments for [Breast](file:///M:\Exceptional%20Cases%20Panel\SRP%20Comparisions%20docs%20April%202016\v2%20from%20Paula\ESRSRP2016018BreastLiftMastoplexy.docx#Index) Lift – Mastopexy

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGS and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | [**Breast**](#Index) **Reconstruction** |
| **Status:** | **Group Prior Approval / Individual Prior Approval** |

M&SECCGs commissions breast reconstruction surgery on a restricted basis in the following circumstances:

**Group Prior Approval**

* after a mastectomy or lumpectomy causing significant deformity when undertaken as part of treatment or prophylaxis of cancer

**OR**

* as part of post-trauma reconstruction surgery

**Individual Prior Approval**

* congenital amastia (complete absence of breast tissue)

Breast surgery to rebuild the normal contour of the affected and the contralateral unaffected breast to produce a more normal appearance, is considered **reconstructive,** following a mastectomy, lumpectomy, or other breast surgery carried out in circumstances detailed above.

In all cases M&SECCGs only routinely fund two elective operation for an individual patient as part of the episode of care for the purpose of breast reconstruction- the first during or soon after the initial surgery e.g. mastectomy (although this may be delayed for medical reasons) followed by one further operation which is usually carried out as a day case. The second operation may include for example contra-lateral reduction, nipple reconstruction, lipofilling and removal of dog-ears.

All patients must be advised that further requests for surgery to address concerns about appearance, size, position, angle or balance- breast asymmetry- will be considered to be cosmetic and as such will not be routinely funded.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Bunion (Hallux valgus) Surgery** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission surgery for bunions on a restricted basis.

Funding requests for Bunion surgery will only be considered when either of the following criteria are met. :

**Criteria 1**

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

**AND**

* all appropriate conservative\* measures have been tried over a 6 month period and failed to relieve symptoms, including up to 12 weeks of evidence based non-surgical treatments, i.e. analgesics/painkillers/bunion pads, footwear modification

**AND**

* there is radiographic evidence of joint damage (at point of referral).

**AND**

* the patient understands that they will be out of sedentary work for 2-6 weeks and physical work for 2-3 months and they will be unable to drive for 6-8 weeks, (2 weeks if left side and driving automatic car)

**Criteria 2**

* there is an increased risk of ulceration or other complications, for example, neuropathy, for patients with diabetes. Such patients should be referred for an early assessment.

\***Conservative measures** include:

Avoiding high heel shoes and wearing wide fitting leather shoes

Non-surgical, self-funded treatments such as bunion pads, splints, insoles or shields or exercise where appropriate

\*\***Significant functional impairment** is defined as:

The patient complains of severe joint pain not relieved by extended non-surgical management and analgesics **AND** has severe impact on their ability to undertake activities of daily living.

A patient should **not** be referred for surgery for prophylactic or cosmetic reasons for asymptomatic bunions. Concerns about cosmetic appearance should be managed by the patient and not referred into secondary care or a Community Podiatric service.

Detailed documentation against the above criteria that are fulfilled is mandatory in the referral letter to secondary care. Clinically inappropriate referrals will be returned to GPs.

Follow up will be capped at one follow up unless there are exceptional circumstances.

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Caesarean Section (Elective)** |
| **Status:** | **Group Prior Approval** |

Elective Caesarean Section will only be funded when **one** of the following criteria is met:

* Breech presentation.
* Multiple pregnancy.
* Preterm birth
* Small for gestational age.
* Placenta praevia.
* Morbidly adherent placenta.
* For cephalopelvic disproportion in labour,
* Mother-to-child transmission of maternal infections
* Mother has a disability or condition which prevents or restricts her ability to proceed with a vaginal delivery.
* Maternal request, including mothers who have had previous C-section(s), following an assessment by a health professional with expertise in perinatal mental health and meeting NICE guidance– see NICE. <https://www.nice.org.uk/Guidance/CG132>.

.

Guidance for mothers considering birth options after previous C-sections can be found here:

<https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-birth-options-after-previous-caesarean-section.pdf>

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Capsule Endoscopy Double Balloon Endoscopy** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission wireless capsule endoscopy and double balloon endoscopy on a restricted basis in the following circumstance

**Diagnostic - Wireless capsule endoscopy (WCE) and double balloon enteroscopy (DBE) in obscure gastrointestinal bleeding**

M&SECCGS will fund wireless capsule endoscopy or double balloon enteroscopy for obscure gastrointestinal bleeding under the following circumstances.

Capsule endoscopy for investigation

* Patients with gastrointestinal bleeding who have undergone a gastroscopy and/or endoscopy and results are negative.

Double balloon enteroscopy for treatment

* If wireless capsule endoscopy identifies source of bleeding in small bowel and such treatment is appropriate.

If results of wireless capsule endoscopy are normal but there is persistent bleeding then

* Consider second look wireless capsule endoscopy

OR

* Double balloon enteroscopy for investigation and treatment where appropriate

Rationale

* The evidence available shows that WCE and DBE are safe and effective diagnostic procedures for the detection of OGIB. Both have a higher diagnostic yield than conventional methods.
* WCE and DBE have common indications but different features. WCE can cover the whole GI tract, requires no sedation and is better tolerated by patients. Its major limitations are the inability to obtain a biopsy, precisely localise a lesion, or perform therapeutic endoscopy. DBE has the advantage of being controllable and enabling therapeutic treatment to take place simultaneously. The procedure is invasive and not as well tolerated as WCE, requiring additional staff, typically two physicians or an additional specialist nurse.
* Cost-effectiveness modelling suggests that that CE-guided DBE may be associated with better long-term outcomes because of the potential for fewer complications and decreased utilisation of endoscopic resources.

**Diagnostic - Wireless capsule endoscopy and double balloon enteroscopy in Crohn’s disease**

M&SECCGs will fund wireless capsule endoscopy or double balloon enteroscopy for Crohn’s disease in the following circumstances

Following inconclusive ileocolonoscopy and/or small bowel radiology clinical suspicion of Crohn’s disease remains then:

* Wireless capsule endoscopy for diagnosis-If pain is not a significant feature or where pain is a significant feature and there is no evidence of strictures on small bowel radiography.
* Double balloon enteroscopy to obtain histology-If pain is significant feature and there is evidence of strictures on small bowel radiography or wireless capsule endoscopy results are inconclusive.

Rationale

* The evidence available shows that WCE is a safe and effective diagnostic procedure for the detection of Crohn’s disease. WCE has a higher diagnostic yield than push enteroscopy and other conventional methods. The results suggest that it is superior to conventional radiological procedures in the detection of lesions in patients with Crohn's disease. However, the high number of patients with strictures limits its use as a first line diagnostic test in patients previously diagnosed.
* Capsule retention remains a risk in patients with Crohn’s disease with significant strictures. The risk is greater in patients with established Crohn’s disease compared to patients suspected to have Crohn’s disease.

Evidence

NICE produced interventional procedure guidance on WCE in 2004

Guidelines produced by British Society of Gastroenterologists in 2008, state DBE should be used complementary to WCE, particularly in the context of therapeutic intervention beyond the reach of push enteroscopy.

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**References:**

1. NICE. 2004. IPG 101. Wireless capsule endoscopy for investigation of the small bowel – guidance.

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| **Policy statement:** | **[Carpal Tunnel](#CarpalTunnel)** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission surgery for carpal tunnel syndrome on a restricted basis.

Patients with wasting of the hand muscles should be urgently referred to the acute hospital (outside the scope of this policy).

**Nerve conduction studies** (EMG) are not indicated in the diagnosis of classical carpal tunnel syndrome and will not generally be funded. These may be done where there is doubt about the diagnosis, which is uncommon.

M&SECCGs will only fund surgery in patients diagnosed with Carpal Tunnel Syndrome meeting **ONE** of following criteria:

* The patient has severe neurological symptoms at presentation, for example altered sensation, muscle wasting or weakness of thenar abduction (wasting or weakness of abductor pollicis brevis).

OR

* The patient has severe symptoms (fewer than 5% of patients) uncontrolled by conservative measures, significantly interfering with activities of daily living.

OR

* The patient has moderate symptoms as defined below AND has not responded to a **minimum of 6 months of conservative**\* **management before referral** for surgery is made.

\*Community based conservative treatment before referral must include the following:

* Splinting with a cock-up splint (night time only or constant) for at least 12 weeks-(not as effective as steroid injections)

**AND**

* Steroid injections-unless contra-indicated – which **should be administered at least once**, with in interval of at least 12 weeks, prior to referral for consideration of surgery - good evidence for short term (8-12 week) effectiveness.

**AND**

* The symptoms are interfering with activities of daily living.

**All GPs should seek access to carpal tunnel steroid injections prior to referral for surgery if they are not able to provide these themselves.**

Where applicable, referral letter must detail conservative methods tried and the length of time that each of these was carried out, along with confirmation that the referrer and the patient have discussed treatment options for carpal tunnel syndrome using the Shared Decision tool.



**Classification for Severity of Carpal Tunnel Syndrome:**

**Mild:** Intermittent paraesthesia with or without pain that may be nocturnal, or occurs with a certain hand position.

**Moderate:** Paraesthesia that interferes with activities of daily living or causes constant night waking and/or reversible numbness and/or pain (perhaps by clenching and unclenching of fist or hand shaking).

**Severe:** Constant numbness or disabling pain with wasting of thenar muscles and/or weakness of thumb muscles (Abductor Pollicis Brevis and Opponens Pollicis).

**Rationale:**

Conservative treatment offers short-term benefit (1-3 months) similar to surgery and many patients’ symptoms may resolve for at least a year after conservative treatment. After corticosteroid injection, up to 50% of patients may report minor or no symptoms at one year.

The benefits of conservative therapy are seen early after treatment and then decrease while the benefits of surgery take longer to be fully realised.

Corticosteroid injections and nocturnal splinting are effective conservative therapies. Therefore patients would not normally be referred for carpal tunnel syndrome unless they have had one local steroid injection into the carpal tunnel together with the provision of night splints.

Electro-diagnostic tests are not indicated in the diagnosis of classical carpal tunnel syndrome. These may be done where there is doubt about the diagnosis, which is uncommon.

In the longer term (3-18 months), surgery is better than conservative therapy with up to 90% of patients reporting complete or much improvement at 18 months.

A trial of conservative therapy offers the opportunity to avoid surgery for some patients.

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **[Cataracts](#CarpalTunnel)/Lens Extraction** |
| **Status:** | **Group Prior Approval/Individual Prior Approval** |

M&SECCGs commission surgery for cataracts/lens extraction on a restricted basis.

Referrals should not be based simply on the presence of a cataract.

**Group Prior Approval**

M&SECCGs commission surgery for cataracts/lens extraction where the patient

* is willing to have eye surgery. The referring optometrist or GP must discuss this with the patient before referring. The Shared Decision Making leaflet - **Deciding what to do about cataracts-** must form the basis for this discussion.



* **AND** with best corrected visual acuity 6/12 or worse in the worst eye assessed by the clinician as being due to a rectifiable lenticular opacity,
* **AND** where the reduced visual acuity significantly interferes with activities of daily living,

**Individual Prior Approval**

Patients with best corrected visual acuity of better than 6/12 in the worst eye will not normally be offered surgery unless there is evidence of very significant impact on activities of daily living. A description of this impact must accompany the referral information (as detailed below), and including confirmation that the patient is willing to have eye surgery. The referring optometrist or GP should discuss this with the patient before referring. The Shared Decision Making leaflet - **Deciding what to do about cataracts-** will form the basis for this discussion. Individual prior approval will be required.

**All referrals** must be accompanied by a **completed proforma** and provide the following information. Incomplete proformas will be returned to the referrer for completion, and will delay the referral.

* Details of the optical prescription
* Corrected distance visual acuity
* Corrected near visual acuity
* Co-existing other eye conditions, management and current status
* Other co-existing medical conditions affecting vision or the eyes; management and status e.g.
  + Diabetes
  + Glaucoma
  + Any other medical condition impacting on vision.
* Confirmation that the patient is willing to have eye surgery.
* Using the patient’s own words, the reasons why the patient’s vision and lifestyle are adversely affected by the cataract, and the likely benefit from surgery must be included in the referral.

**Second eye -**Patients will be offered second eye surgery provided they fulfil the referral criteria (see above).

Second eye surgery should be deemed urgent when there is resultant symptomatic anisometropia i.e. a large refractive difference between the two eyes resulting in poor binocular vision (this should be clearly recorded in the patient’s notes).

**M&SECCGs do not commission** cataract surgery/lens extraction solely for the purpose of correcting longstanding pre-existing myopia (short sighted or near sighted) or hypermetropia (long sighted).

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Chalazion (cyst on or in eye lid)** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission surgery for chalazia on a restrictive basis.

Chalazia are benign, granulomatous lesions caused by blockage of the Meibomian gland duct, which will normally resolve within 6 months with conservative management in primary care. They can be unsightly and, if large enough, obscure vision. In rare cases, they can lead to conjunctivitis or cellulitis. Conservative treatment is the regular i.e. three or four times a day application of hot compression to the cyst (e.g. hot wet flannel) to encourage it to spontaneously drain.

When chalazia are treated with conservative treatment for one month, rates of resolution are around 50%. Further conservative treatment may increase rates of resolution but, where conservative treatment fails, patients may be treated with surgery or steroid injections, which give high rates of resolution (80-90%).

Excision of chalazion will be funded for those patients with **TWO** or more of the following criteria:

* Present for more than **six months**
* Present on the **upper** eyelid
* Source of regular infection (at least twice within the last six month) requiring medical treatment.
* Interferes significantly with vision
* Conservative management with heat and compression has been tried for at least six months & failed and there is no appropriate alternative to surgical intervention.
* The site of the lesion or lashes renders the condition as requiring specialist intervention.

OR

* where the chalazion interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy.

OR

* if malignancy is suspected e.g. Madarosis / recurrence / other suspicious features in which case the lesion should be removed and sent of histology- as for all suspicious lesions.

Patients meeting the above criteria may be treated in community (Tier 2) services where commissioned.

Patients meeting the following criteria should be referred to secondary care:

* All children should be referred.
* Any recurrent chalazion should be referred.
* Any atypical features i.e. lash loss, bleeding should be referred.
* Any patient with previous history of Basal cell carcinoma (BCC) or Squamous cell carcinoma (SCC) or where malignancy is suspected should be referred.

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Chronic Fatigue Syndrome** |
| **Status:** | **Group Prior Approval** |

M&SECCGs commission specialist treatment for chronic fatigue syndrome / myalgic encephalomyelitis (CFS/MS on a restricted basis.

All specialist treatment for chronic fatigue syndrome / myalgic encephalomyelitis (CFS/MS) is accessed through a referral from the patient’s clinician to the Essex CFS/ME Service.

Patients should be managed by GPs as recommended by NICE clinical guideline number 53 – Chronic Fatigue syndrome/ myalgic encephalomyelitis (or encephalopathy) – Diagnosis and management of CFS/ME in adults and children.

Patients can be referred for unexplained fatigue lasting at least 4 months once the following alternative diagnosis have been considered and excluded:

* Obesity (BMI >40kg/m2).
* Organ failure.
* Chronic infections.
* Chronic inflammatory diseases.
* Major neurological diseases.
* Systemic treatment for neoplasms.
* Untreated endocrine diseases.
* Primary sleep disorders.
* Alcohol/Substance abuse.
* Reversible causes of fatigue (medications, infections or recent major surgery).
* Psychiatric conditions.

The clinical guideline also states the following:

* Do not use the following drugs for the treatment of CFS/ME: monoamine oxidase inhibitors, glucocorticoids (such as hydrocortisone), mineralocorticoids (such as fludrocortisone), dexamphetamine, methylphenidate, levothyroxine or antiviral agents.
* There is insufficient evidence for the use of supplements – such as vitamin B12, vitamin C, co-enzyme Q10, magnesium, NADH (nicotinamide adenine dinucleotide) or multivitamins and minerals – for people with CFS/ME, and therefore **they should not be prescribed for** **treating the symptoms of the condition**. Some people with CFS/ME have reported finding these helpful as a part of a self-management strategy for their symptoms, and in which case should purchase such products.
* People with CFS/ME who are using supplements should be advised not to exceed the safe levels recommended by the Food Standards Agency.

M&SECCGs do not provide funding for NHS prescribing of these medicines/supplements and therefore GPs must not prescribe these medicines/supplements on FP10s for this condition.

M&SECCGs do not fund referral to secondary care specialists in CFS/ME care for assessment or treatment on either an in-patient or outpatient basis outside this commissioned service.

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Circumcision** |
| **Status:** | **Group Prior Approval** |

Male circumcision is defined as the surgical removal of all or part of the foreskin of the penis.

M&SECCGs commission circumcision on a restricted basis and this procedure will only be funded for therapeutic reasons if the patient meets one of the following criteria:

* Suspicion or evidence of malignancy (use 2ww cancer referral pathway), dermatological disease (such as lichen planus or eczema) which is unresponsive to other treatment, where biopsy is required, and occasionally for selected patients with urinary tract infections (normally referred by a paediatrician)
* Traumatic foreskin injury where it cannot be salvaged.
* Phimosis (inability to retract the foreskin due to a narrow prepucial ring) in children when associated with recurrent infection. This does NOT include normal non-retractile foreskin of childhood.
* Adult phimosis, usually caused by recurrent balanitis or Balanitis Xerotica Obliterans (BXO)(chronic inflammation leading to a rigid fibrous foreskin).
* Paraphimosis (inability to pull forward a retracted foreskin).
* Balanoposthis (recurrent bacterial infection of the prepuce).

There are several alternatives to treating retraction difficulties (e.g. steroid creams) before circumcision is carried out.

It is important that all those performing circumcision should follow the General Medical Council (GMC) guidelines.

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

References:  
British Medical Association. The law and ethics of male circumcision: guidance for doctors. London: BMA,2006

Patient Information:  
<https://www.nhs.uk/conditions/circumcision-in-men/>

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| **Policy statement:** | **Complementary and Alternative Therapies** |
| **Status:** | **Not Funded** |

M&SECCGSs do not fund standalone treatments using complementary or alternative therapies. This restriction applies equally to primary and secondary care provision, and GPs **must not** prescribe such products e.g. homeopathic remedies/supplements/desensitising injections on FP10s. This list is not exhaustive but provides examples.

*Acupuncture*

*Osteopathy*

* Children with spastic cerebral palsy
* Paediatric dysfunctional voiding
* Adults with Lumber or Cervical pain not warranting surgical referral.
* Adults with large joint pain as part of a care pathway that may lead to joint replacement.

*Biofeedback*, for:

* Chronic constipation (biofeedback is the primary treatment option for patients with dyssynergic defecation).
* Irritable bowel syndrome.
* Levator ani syndrome.
* Migraine and tension headaches (muscle, thermal or skin biofeedback);
* Neuromuscular rehabilitation of stroke and traumatic brain injury (TBI) (policy does not cover neuromuscular electrical stimulators).
* Raynaud's disease.
* Refractory severe subjective tinnitus – See Tinnitus.
* Temporomandibular joint (TMJ) syndrome – See TMJ.
* Urinary incontinence.

*Electrical stimulation*

As an adjunct or as an alternative to the use of drugs either in the treatment of acute postoperative pain in the first 30 days after surgery, or for certain types of chronic, intractable pain not adequately responsive to other methods of treatment including, as appropriate, physical therapy and pharmacotherapy. A physician evaluated trial lasting between 1 and 2 months should determine if treatment is to continue.

*Selected use in palliative care*

* Mistletoe in cervical cancer.
* Meditation and Tai Chi in selected elderly patients with optimally treated heart failure – evidence of reduction in sympathetic activity (SIGN 95).

*Hypnotherapy*

* Severe chronic insomnia.
* IBS.

*Manipulation and Stretching*

* Selected cases of osteoarthritis of the hip as an adjunct to core treatment.
* Sub-acute and chronic low back pain of more than six weeks duration.
* Acute low back pain of less than six weeks.
* Mobilisation of the neck.

*Complementary and Alternative Therapies*

The CCGs will *NOT* fund the following therapies because of lack of sufficient evidence of effectiveness\* (not an exhaustive list):

* Homeopathy
* Aromatherapy
* Herbal remedies
* Clinical ecology
* Active release technique
* Acupressure
* Alexander technique
* AMMA therapy
* Antineoplastons -- see CPB 240 - Antineoplaston Therapy and Sodium–
* Apitherapy
* Applied kinesiology
* Art therapy
* Autogenous lymphocytic factor
* Auto urine therapy
* Bioenergetic therapy
* Biofield Cancell (Entelev) cancer therapy
* Bioidentical hormones
* Brain integration therapy
* Carbon dioxide therapy
* Cellular therapy
* Chelation therapy for Atherosclerosis --
* Chiropractic services
* Chung Moo Doe therapy
* Coley's toxin
* Colonic irrigation
* Clinical ecology
* Conceptual mind-body techniques
* Craniosacral therapy
* Cupping
* Dance/Movement therapy
* Digital myography
* Ear Candling
* Egoscue method
* Electrodiagnosis according to Voll (EAV)
* Equestrian therapy --
* Essential Metabolics Analysis (EMA)
* Essiac
* Feldenkrais method of exercise therapy (also known as awareness through movement)
* Flower essence
* Fresh cell therapy
* Functional intracellular analysis (also known as essential metabolic analysis, intracellular micronutrient analysis, leukocyte nutrient analysis, as well as micronutrient testing).
* Gemstone therapy
* Gerson therapy
* Glyconutrients
* Graston technique
* Greek cancer cure
* Guided imagery
* Hair analysis –
* Hako-Med machine (electromedical horizontal therapy)
* Hellerwork
* Hoxsey method
* Human placental tissue
* Hydrolysate injections
* Humor therapy
* Hydrazine sulfate
* Hypnosis
* Hyperoxygen therapy
* Immunoaugmentive therapy
* Infratronic Qi-Gong machine
* Insulin potentiation therapy
* Inversion therapy
* Iridology
* Iscador
* Juvent platform for dynamic motion therapy
* Kelley/Gonzales therapy
* Laetrile
* Live blood cell analysis
* Macrobiotic diet
* Magnet therapy
* MEDEK therapy
* Meditation/transcendental meditation
* Megavitamin therapy (also known as orthomolecular medicine)
* Meridian therapy
* Mesotherapy
* Moxibustion (except for fetal breech presentation)
* MTH-68 vaccine
* Music therapy
* Myotherapy
* Neural therapy
* Ozone therapy
* Pfrimmer deep muscle therapy
* Polarity therapy
* (Poon's) Chinese blood cleaning
* Primal therapy
* Psychodrama
* Purging
* Qigong longevity exercises
* Ream's testing
* Reflexology (zone therapy)
* Reflex Therapy
* Reiki
* Remedial massage
* Revici's guided chemotherapy
* Rife therapy/Rife machine
* Rolfing (structural integration)
* Rubenfeld synergy method (RSM)
* 714-X (for cancer)
* Sarapin injections
* Shark cartilage products
* Telomere testing
* Therapeutic Eurythmy-movement therapy
* Therapeutic touch
* Thought field therapy (TFT) (Callahan Techniques Training)
* Trager approach
* Visceral manipulation therapy
* Whitcomb technique
* Wurn technique/clear passage therapy
* Yoga

These services/procedures have been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

\*Adapted from the AETNA Complementary and Alternative Medicine Policy.

Complimentary therapies are seen by an increasing number of people (with increasing requests for treatment) as a more holistic and ‘natural’ approach to dealing with a variety of complaints. Attractions include the comparably longer interaction time with the practitioner and the belief that such therapies will work, affecting a complex mix of factors impacting on health. However there is much uncertainty about benefit/effectiveness, evidence of complications for some therapies and considerable grounds to suspect other adverse effects may occur. Since conventional medicine also aspires to a holistic approach, this means that some alternative therapies should be considered where evidence exists.

The types of complimentary therapies covered under this policy include Homoeopathy, Acupuncture, Osteopathy, Biofeedback, Hypnotherapy, Chiropractic Therapy, Massage, Reflexology, Clinical Ecology, Aromatherapy, Herbal Remedies, Chinese medicines, Psychotherapy and Meditation. This list is not exhaustive and other treatments not listed here but that are considered ‘alternative’ or ‘complimentary’ therapies will be considered in the same way. Some procedures may be available through services in hospices and hospitals as part of a palliative care package; these are usually through charitable services and not part of commissioned services.

Some patients may also be treated as part of an integrated conventional and complimentary service for a specific condition where these are commissioned, although exceptionality would need to be demonstrated.

**Evidence Base**

The House of Commons Science and Technology Committee enquiry into the provision of homeopathic services within the NHS in 2009 recommended that homeopathic treatments should not be routinely available within the NHS.1 The committee report included a robust review of the evidence base for a variety of homeopathic treatments but found no evidence of effectiveness for any condition from published RCTs and systematic reviews. A previous report commissioned by the Association of Directors of Public Health in 20072 and more recent reviews by AETNA3 are all consistent in confirming the lack of sufficient evidence of effectiveness of homeopathic treatments despite many years of research and hundreds of studies.

There is some evidence of clinical benefit for some complimentary therapies such as acupuncture, osteopathy, biofeedback and hypnotherapy for certain conditions. For example, NICE recommends Acupuncture for up to ten sessions for the treatment of sub-acute and chronic low back pain of more than six weeks duration. NICE also suggests that manipulation and stretching should be considered as an adjunct to core treatment for osteoarthritis of the hip, sub-acute and chronic low back pain of more than six weeks duration, acute low back pain of less than six weeks duration and mobilisation of the neck.4,5,6,7

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| **Policy statement:** | **Continuous Glucose Monitoring** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs fund continuous glucose monitoring in adults, children or young people with Type 1 Diabetes on a restricted basis.

Funding for real-time continuous glucose monitoring (CGM) with alarms for children or young people with type 1 diabetes will be **considered** on a case by case basis only when despite optimised management the patient has:

* frequent severe hypoglycaemia or
* impaired awareness of hypoglycaemia associated with adverse consequences (for example seizures) or
* inability to recognize or communicate about symptoms of hypoglycaemia (for example, because of cognitive or neurological disabilities.

Requests for funding CGM in adults with Type 1 diabetes will be **considered** on a case by case basis only when despite optimised management the patient has

* complete loss of awareness of hypoglycaemia or
* frequent (more than 2 episodes a week) asymptomatic hypoglycaemia that is causing problems with activities of daily living.

Individual prior approval is required in all cases.

M&SECCGs commission the provision of continuous subcutaneous insulin infusions (via insulin pumps) in line with NICE Technology Appraisal 151. In accordance with NICE principles and the ethos of NICE clinical guideline Type 1 diabetes in adults: diagnosis and management ([nice.org.uk/guidance/ng17](https://www.nice.org.uk/guidance/ng17)) M&SECCGS supports funding of the insulin pump with the lowest acquisition cost that meets the clinical needs of the patient, and without consideration of a patient’s desire to self-fund CGM. Co-funding, which involves both private and NHS funding for a single episode of care, is not permitted for NHS care. The choice of pump in very young children should take into account the ability to deliver a very low basal rate,

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Continuous Positive Airway Pressure (CPAP) in Adults** |
| **Status:** | **Group Prior Approval** |

M&SECCGs commissions Continuous Positive Airway Pressure (CPAP) on a restrictive basis for patients with moderate or severe Obstructive Sleep Apnoea/Hypopnoea Syndrome (OSAHS) in Adults (≥15 hypopnoea events/hour per night)

CPAP is the first choice therapy for patients with moderate or severe OSAHS that is sufficiently symptomatic to require intervention.

Persistent low CPAP use (less than two hours per night) over six months, following efforts to improve patient comfort, should lead to a review of treatment.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Duputyren’s Contracture** |
| **Status:** | **Individual Prior Approval** |

Duputyren’s Contracture is nodular or cord-like thickening of the palmar fascia causing a tethering of the digits and a loss of range of extension.

Surgical treatment for Duputyren’s contracture is commissioned by M&SECCGs on a restricted basis. Cases will only be funded if they meet the criteria below:

* Metacarpophalangeal joint (MCPJ) joint contracture of 30° or more and/or proximal interphalangeal joint contracture of 20°or more (inability to place hand flat on table)

**OR**

Severe thumb contractures

**AND**

* Where such condition (either MCPJ or PIPJ) is severely impacting on activity of daily living.

**OR**

* Young patients with early onset disease (25-40) +/- family history, who may benefit from early assessment.

The use of Collagenase clostridium histolyticum (Xiapex®) is only supported in line with NICE TA459

* People who meet the inclusion criteria for the ongoing clinical trial (HTA-15/102/04), comparing collagenase clostridium histolyticum (CCH) with limited fasciectomy, are encouraged to participate in the study.
* For people not taking part in the ongoing clinical trial, CCH is recommended as an option for treating Duputyren’s contracture with a palpable cord in adults only if all of the following apply:
* There is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° or first web contracture) plus up to 2 affected joints.
* Limited fasciectomy is considered appropriate by the treating hand surgeon.
* The choice of treatment (CCH or limited fasciectomy) is made on an individual basis after discussion between the responsible hand surgeon and the patient about the risks and benefits of the treatments available.
* One injection is given per treatment session by a hand surgeon in an outpatient setting. ME&SCCGs will not fund any activity/treatments costs associated with administration of CCH in any other circumstances. **Individual funding approval is required for each injection (High Cost Drug proforma).**

For audit purposes the referral letter must detail loss of extension and functional impairment.

**The following surgery/treatments are considered to be a low clinical priority and are not routinely funded.**

* Needle aponeurotomy (also known as percutaneous needle fasciotomy)
* Radiation therapy for early Duputyren’s contracture
* Simple nodules in the palm

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

References:

<https://www.nice.org.uk/Guidance/IPG43>

<https://www.nice.org.uk/guidance/IPG368>

<https://www.nice.org.uk/guidance/indevelopment/gid-tag364>

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| **Policy statement:** | **Dynamic Lycra Splinting** |
| **Status:** | **Not Funded** |

Dynamic Lycra Splinting is provided for a small cohort of people with cerebral palsy as part of some commissioned community health care services, but is not funded separately.

**Background**

Lycra splints are made-to-measure and consist of sections of lycra stitched together using specific tension, direction of pull, type of material (e.g. water absorbent for under the arms) and thickness. Boning can be included to give extra support. Splints range from hand splints to full body garments. The closeness and tightness of the splint fitting increases proprioception and helps to increase spatial awareness. In turn, this aids the reduction of any excessive tone and relaxes the patient with possible improvements in posture and gait.

Dynamic lycra splinting is not suitable for patients who have fixed deformities of a bony nature which are not amenable to change.

Compliance has a significant role to play in determining outcome, as it does for all therapy and medical interventions. Problems with comfort, toileting issues, level of support needed to put on and take off the garments and carer / patient’s willingness to comply with treatment have been reported. The patient and family or carers, who may be assisting them to apply the splints, must be made fully aware of the commitment required to ensure success.

**Evidence of effectiveness**

There has been very little research into the effectiveness of dynamic splinting. A Technology Scoping Report from Healthcare Improvement Scotland published in May 2013 concluded that

* There is limited clinical and cost-effectiveness evidence available
* Splinting may improve functional ability in some children with cerebral palsy
* There is no evidence relating to adults

Expert opinion suggests that younger children with athetoid disorders, those with quadriplegic palsy and those with neuromuscular disorders benefit the most.

Funding for patients outside commissioned services will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**Reference:**

[http://www.pencru.org/media/universityofexeter/general/training/pdfdocuments/Lycra orthoses\_April\_2013.pdf](http://www.pencru.org/media/universityofexeter/general/training/pdfdocuments/Lycra%20orthoses_April_2013.pdf)

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| **Policy statement:** | **Dysthyroid Eye Disease (Proptosis)** |
| **Status:** | **Individual Prior Approval** |

Surgery for proptosis is commissioned on a restricted basis.

Funding will be provided to treat proptosis, arising from thyroid disease, as a result of enlargement of muscles in the socket and increased fatty tissue or abnormality of position of eyelid which causes extra exposure to the eye surface.

Surgery will only be offered for abnormality of the eyelid position after artificial tears have been tried for at least 6 months and failed

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Ear Microsuction/Wax Removal** |
| **Status:** | **Group Prior Approval** |

M&SECCGs commission ear micro suction on a restricted basis for patients who meet one of the following criteria:

1. Patients with contraindications to syringing (tympanic perforation, previous ear surgery, history of otitis externa following syringing, young children uncooperative to ear irrigation)
2. Acute or chronic otitis externa with excessive debris or swollen external meatus not settling after initial topical treatment or who require regular microsuction to prevent recurrent episodes
3. The patient has a cleft palate (repaired or not).
4. Wax unresponsive to ear irrigation. Ear irrigation must have been attempted and documented as failed on at least two occasions before referral for ear micro-suction on each occasion.
5. Ear foreign body extraction
6. Regular mastoid cavity de-waxing

Routine repeated ear micro-suctioning to prevent ear wax build up will not be funded.

Patients not meeting the above criteria will only be funded on exceptional clinical circumstances.

For more information <http://www.nhs.uk/conditions/earwax/pages/introduction.aspx>

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Endoscopic Laser Spinal Surgery** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund endoscopic laser spinal surgery for chronic back pain.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

This restriction applies to the following procedures:

* Laser lumbar disectomy considered when there is nerve compression or persistent symptoms that are unresponsive to conservative treatment. Laser disectomy can be performed when the prolapse is contained. It is one of several minimally invasive surgical techniques which are alternatives to open repair procedures such as open lumbar disectomy or laminectomy.(IPG027)
* Endoscopic laser surgery for aminoplasty for chronic back and leg pain from a variety of causes. (IPG031)
* Percutaneous endoscopic laser thoracic disectomy is used to treat symptomatic thoracic disc hemiation. (IPG061)
* Endoscopic division of epidural adhesions for lower back pain, particularly when radiculopathy (a disorder of the spinal nerve roots) is present. (IPG088)
* Percutaneous intradiscal electrothermal therapy for discogenic back pain. (IPG081)

**Rationale:**

Endoscopic laser spinal surgery for chronic back pain is of unproven benefit. Referral and treatment should only be considered under exceptional circumstances, in settings which meet the requirements of NICE guidance (IPG027, IPG031, IPG061 and IPG088).

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Exogen® Bone healing ultrasound system** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission EXOGEN® ultrasound bone healing system for non-union in long bone (defined as humerus, ulna, radius, femur, tibia and fibula) fracture on a restricted basis.

The case for adopting the EXOGEN® ultrasound bone healing system to treat long bone fractures with non-union- i.e. failure to heal after 9 months is supported by the clinical evidence, which shows high rates of fracture healing.

On this basis M&SECCGs only fund EXOGEN® in patients meeting ALL the following criteria:

* Patients with non-union fractures in long bones which have failed to heal after 9 months.
* Patient age ≥18 years
* Patient does not have fractures related to or secondary to malignancy
* The bones are well aligned and the inter-fragment gap is < 10mm.
* The patient has been screened and referred by a Consultant Radiologist/Consultant Orthopaedic Surgeon following review on at least two occasions at least 90 days apart to allow examination of serial x-rays.
* The patient has received a further assessment in a non-union clinic by surgeon with expertise of dealing with non-union of long bones AND appropriateness of EXOGEN® has been determined through agreement of two specialist non-union Consultants.
* The patient has been counselled and has the ability to comply with usage protocol and criteria in line with the EXOGEN International\* Performance Program which includes a 90% minimum adherence to the treatment regimen.

Only patients registered on the EXOGEN® International Performance Program meeting the above criteria and who successfully heal will be funded. **It is the provider’s responsibility to confirm that the patient is eligible for the ‘money-back guarantee’**

Providers must fund this treatment themselves initially and may only claim reimbursement from M&SECCGS when healing has occurred, and on the basis that individual prior approval was obtained before treatment commences and evidence is provided to M&SECCGS to support the application. For treatment failures, it is the provider’s responsibility to claim reimbursement in accordance with the manufacturers “money back guarantee” arrangement; M&SECCGs do not fund these patients.

M&SECCGs do not commission the use of EXOGEN® in patients with delayed healing fractures that have no radiological evidence of healing between 3 and 9 months.

M&SECCGs do not commission the use of EXOGEN® for any other indications

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality. Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **[Facial Surgery](file:///M:\\Exceptional%20Cases%20Panel\\SRP%20Comparisions%20docs%20April%202016\\v2%20from%20Paula\\ESRSRP2016003AestheticFacialSurgery.docx" \l "Index)- Aesthetic (Cosmetic)** |
| **Status:** | **Not Funded** |

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M&SECCGs do not fund aesthetic (cosmetic) facial surgical procedures including (but not limited to) face lifts (rhytidectomy), brow lifts, neck lifts, nose reshaping (rhinoplasty), split earlobe correction, eye bag reduction and upper eye lid surgery.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGS and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Facial Surgery (non aesthetic)** |
| **Status:** | **Group Prior Approval** |

M&SECCGs commission non-aesthetic facial surgery on a restricted basis for the treatment of:

* Congenital craniofacial abnormalities
* Facial palsy (congenital or acquired paralysis)
* As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis
* To correct the consequences of trauma

All patients must be advised that requests for surgery to address concerns about appearance or to treat the natural ageing process are considered to be cosmetic and as such will not be funded.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Flash Glucose Scanning** |
| **Status:** | **Group (Notification) / Individual Prior Approval** |

Flash Glucose Scanning systems monitor blood glucose levels using interstitial fluid levels rather than capillary blood glucose from finger prick testing. It consists of a handheld reader and a sensor, which is sited on the arm. When the reader unit is passed over the sensor, the reader shows a reading based on interstitial fluid glucose levels. The sensor lasts for up to 14 days and then needs to be replaced. The reader can show a trace for the last 8 hours and displays an arrow showing the direction the glucose reading is heading.

Flash Glucose Scanning is not the same as continuous glucose monitoring (CGM).

At present there is only one product where prescribing on the NHS is supported- FreeStyle Libre®. The following policy therefore applies only to this product and funding for any other flash glucose scanning products is not currently available.

**Group Prior Approval**

M&SECCGs commission use of FreeStyle Libre**®** on a restricted basis, and only for people with diabetes on insulin, aged 4 and above, attending specialist care using multiple daily injections or insulin pump therapy, who have been assessed by the specialist diabetes clinician and deemed to meet one or more of the following criteria:

* Patients with Type 1 diabetes with poorly controlled Hba1c (>8.5% or >69 mmol/mol) requiring self-monitoring blood glucose testing nine times or more daily to achieve safe control as demonstrated on a meter download/review over the past 3 months anddetermined by those with clinical responsibility for their diabetes care and where they are satisfied that the patient’s clinical history support this (supported by NICE TA151, NG17 & NG18)
* Patients with Type 1 diabetes with multiple episodes of diabetic ketoacidosis (DKA) and/ or severe hypoglycaemic episodes (i.e. needing external support) and/ or multiple admissions due to poor glycaemic control, requiring self-monitoring blood glucose testing nine times or more daily (supported by NICE TA151, NG17 & NG18)
* Patients with Type 1 or Type 2 diabetes on haemodialysis and on insulin with poorly controlled Hba1c (>8.5% or >69 mmol/mol) requiring self-monitoring blood glucose testing nine times or more dailyas demonstrated on a meter download/review over the past 3 months
* Diabetes associated with cystic fibrosis on insulin treatment
* Pregnant women with Type 1 or Type 2 diabetes requiring insulin – this will only be funded for 12 months in total inclusive of post-delivery period
* Patients with Type 1 diabetes who the specialist diabetes multi-disciplinary team determines have occupational (e.g. working in insufficiently hygienic conditions to safely facilitate finger-prick testing) or psychosocial circumstances that warrant a 6 month trial of FreeStyle Libre® with appropriate adjunct support.
* Patients with Type 1 unable to routinely self-monitor blood glucose at home due to severe mental or physical disability. Evidence must be provided that they require carers to directly support glucose monitoring and insulin management, and that these carers struggle to manage simple blood glucose monitoring.
* Patients with Type 1 diabetes previously self-funding Flash Glucose Scanning where those with clinical responsibility for their diabetes care are satisfied that their clinical history suggests that they
  + would have satisfied one or more of the above criteria prior to them commencing use of Flash Glucose Scanning had these criteria been in place prior to April 2019

**AND**

* has shown improvement in HbA1c over a period of 6 months since using the self-funded sensors.

**Additional Requirements**

In addition all patients (or carers) must be willing to:

* + undertake training in the use of FreeStyle Libre**®**
  + agree to scan glucose levels no less than 8 times a day and use the sensor for more than 70% time
  + agree to regular reviews with the local specialist clinical team
  + complete a Type 1 diabetes structured education programme (DAFNE, BERTIE or equivalent). Previously completed approved courses will be recognised.

The decision to start FreeStyle Libre**®** will only be made by the diabetes specialist team and will initially be for a 6 month trial period.

Use will only be continued at the discretion of the diabetes specialist if there is sustained benefit in patient outcomes whilst they are using the device as demonstrated by one or more of the following:

* Reduction in severe / non-severe hypoglycaemia episodes
* Reduction in HbA1c of 0.5%/5mmol/mol or more within 6 months
* Agreed reduction in use of self-monitoring blood glucose test strips
* Reduction in episodes of DKA
* Reductions in admission to hospital
* In severe disability to ensure clear benefit to the carer support for the patient

If there has not been sufficient improvement in one or more of the above areas over a 6 month period then the use of FreeStyle Libre**®** under NHS prescription will be discontinued and an alternative method of monitoring should be used.

**Individual Prior Approval**

Patients with Type 1 Diabetes with recurrent severe loss of hypoglycaemia awareness or impaired awareness of hypoglycemia may be considered for Flash Glucose Scanning on a case by case basis. These patients ideally do not need FreeStyle Libre® but will need a different Continuous Glucose Monitoring system with an alarm component - requested on a named patient basis- see VBCP- **Continuous Glucose Monitoring**

NICE suggests that Continuous Glucose Monitoring with an alarm is the standard. Other evidence-based alternatives with NICE guidance or NICE TA support are pump therapy, psychological support, structured education, islet transplantation and whole pancreas transplantation. (supported by NICE TA151, NG17 & NG18)

Any patient individually approved for FreeStyle Libre® must also meet the **additional requirements** listed in section above.

Patients not meeting the above criteria will only be funded where there are exceptional clinical circumstances.

Further information on applying for funding in exceptional clinical circumstances can be found by clicking the link below.

[Value Based Commissioning Policies](http://midessexccg.nhs.uk/about-us/the-library/service-restriction-policies-1)

**Additional Information**

Under national criteria and this policy the following groups do not currently meet the criteria for NHS funding:

* Any Type 2 diabetes patient unless **on insulin** **and** pregnant **or** on haemodialysis requiring more than 8 tests daily.
* Otherwise well Type 1 diabetes patients with no major disabling symptoms, recurrent hospital admissions, psychosocial issues, severe disabilities, poor Hba1c or any other of the criteria stated above
* Poor engagement or compliance with glucose testing- no evidence use of FreeStyle Libre® solves this

Patients who by choice self-fund FreeStyle Libre® will continue to be supported (and data viewed) in routine NHS clinics.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**References**

Flash Glucose Monitoring: National Arrangements for Funding of Relevant Diabetes Patients

Issued by NHS England March 2019

<https://www.england.nhs.uk/publication/flash-glucose-monitoring-national-arrangements-for-funding-of-relevant-diabetes-patients/>

Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus July 2008

<https://www.nice.org.uk/guidance/ta151>

Type 1 diabetes in adults: diagnosis and management July 2016

<https://www.nice.org.uk/guidance/ng17>

Diabetes (type 1 and type 2) in children and young people: diagnosis and management November 2016

<https://www.nice.org.uk/guidance/ng18>

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| **Policy statement:** | **Functional Electrical Stimulation** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund Functional Electrical Stimulation (FES) for the treatment of dropped foot / foot drop in patients with neurological conditions.

Providers of services for patients who were funded by the NHS prior to the introduction of this policy, who require on-going funding for maintenance and support, must seek Individual approval on an annual basis and the following criteria apply:

* The patient will have objectively demonstrated (using validated tools) that the use of FES is still clinically appropriate, e.g. by
  + foot drop which impedes gait and evidence that this is not satisfactorily controlled using ankle–foot orthoses
  + gait improvement from its use

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGS and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Gall Stones/Cholecystectomy** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission cholecystectomy on a restricted basis.

Cholecystectomy is routinely commissioned for **symptomatic gallstones** as a day‑case laparoscopic cholecystectomy for people having it as an elective planned procedure, unless their circumstances or clinical condition make an inpatient stay necessary.

M&SECCGs **do not routinely fund cholecystectomy** for **asymptomatic** gallstones because the risks of surgery outweigh the benefits.

Asymptomatic gallstones are defined as the presence of gallstones detected incidentally in patients who do not have any abdominal symptoms, or have symptoms that are not thought to be due to gallstones.

The following tables indicate appropriateness of indication versus risk due to patient co-morbidity.

**Indications for cholecystectomy:**

|  |  |  |
| --- | --- | --- |
| **Indication** | **Investigative Findings** | **Comorbidity** |
| Vague Symptoms | Stone in CBD | No+low |
| Single attack of biliary colic | Stone(s) in GB or CBD or non-functioning GB | No+low |
| Multiple attacks of biliary colic | Stone(s) in GB or CBD or non-functioning GB | No+low |
| Confirmed acute cholecystitis | Stone(s) in GB or CBD or non-functioning GB | No+low |
| Suspected acute cholecystitis | Stone(s) in GB or CBD | No+low |
| Porcelain gall bladder | Stone(s) in GB or CBD | No |
| Silent onset of jaundice | Stone in CBD or dilated CBD | No+low |
| Acute pancreatitis with and without appreciable alcohol intake | Stone(s) in GB or CBD | No+low |
| Acute recurrent pancreatitis – no significant alcohol intake | Stone(s) in GB or CBD | No, low +med |
| Acute recurrent pancreatitis – appreciable alcohol intake | Stone in CBD | No + low |
| Incidental cholecystectomy + compatable symptoms |  | No |

**Inappropriate Indications for cholecystectomy:**

|  |  |  |
| --- | --- | --- |
| **Indication** | **Investigative Findings** | **Comorbidity** |
| Vague Symptoms | Stone in GB or chronic cholecystitis  Any | Med+high  High |
| Single attack of biliary colic | Stone(s) in GB or non-functioning GB | High |
| Suspected acute cholecystitis | No Stones  Stones but no complications | High  High |
| Porcelain gall bladder |  | High |
| Silent onset of jaundice | No Stones  Stones in GB only  Stone in CBD only | All  Low+med  High |
| Acute pancreatitis with and without appreciable alcohol intake | No Stones  Stones in GB only | All  High |
| Acute recurrent pancreatitis – no significant alcohol intake | No Stones | Med+high |
| Acute recurrent pancreatitis – appreciable alcohol intake | No Stones  Stones in GB only | All  High |
| Incidental cholecystectomy + Asymptomatic |  | Med + high |
| Long term TPN | Symptoms only  Stones only  Symptoms + stones  Incidental findings | Med + high  Med + high  High  Med + high |
| Asymptomatic cholecyternteric fistula |  | Med+high |

**Exceptions** to this policy could include patients with asymptomatic gallstones **and**

* Sickle cell disease.
* Calcified 'porcelain' gallbladder or a family history of gallbladder carcinoma immunosuppression, as they would be at higher risk if they develop an infective complication i.e. cholecystitis or cholangitis.

<https://www.nice.org.uk/guidance/CG188>

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Ganglion/Mucoid cysts** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission surgical removal of ganglion/mucoid cysts on a restricted basis.

A ganglion is a non-cancerous fluid-filled lump which can occur near joints or tendons. Ganglion cysts are the commonest cause of discrete swelling around the wrist. The cyst can range from the size of a pea to the size of a golf ball. Ganglions can occur alongside any joint in the body, but are most common on the wrist (particularly the back of the wrist), and the hand and fingers. Ganglions can also be present on the ankles and feet.

This policy applies to ganglion in all locations.

Ganglions are harmless, but can sometimes be painful. If they do not cause any pain or discomfort, they can be left alone and may disappear without treatment, although this can take a number of years. There are no long term consequences from leaving the ganglion untreated.

Reassurance should be the first therapeutic for most patients with ganglion cyst (and all children) because of the high rate of spontaneous resolution and because it avoids the potential complications of invasive therapy.

The two main treatment options for a ganglion cyst are:

* Draining fluid out of the cyst with a needle and syringe – the medical term for this is aspiration
* Cutting the cyst out using surgery.

Aspiration or surgery will remove the ganglion in the short term, however recurrence rates are high.

There is no indication for the routine excision of simple or asymptomatic ganglia; these should not be referred.

Surgical removal of ganglion will only be funded when they meet the criteria specified below:

* Seed ganglia at base of digits with significant pain and functional impairment which persist or recur after puncture/aspiration

**OR**

* Mucoid cysts that are causing significant nail deformity or have recurrent spontaneous discharge (risk of septic arthritis in distal inter-phalangeal joint)

**OR**

* Surgery for ganglion of the wrist where:
  + there are symptoms associated with the ganglia such as pain, loss of sensation in certain parts of the hand, neurological loss or weakness of the wrist with the ganglion, and where the ganglion has resulted in functional impairment which prevents the individual from fulfilling activities of daily living, but has not responded to all appropriate conservative1 treatments over a minimum period of 3 months

**OR**

* The patient is unable to wear typical ‘off the shelf’ footwear due to the size and location of ganglion.

**OR**

* Ganglion of the foot with significant functional impairment.

**OR**

* Surgery for ganglia will be funded where painful lump causing significant pain and is restricting activities of daily living and/or work

1Conservative treatments include:

* Reassurance-35-45% of wrist ganglia resolve with no treatment at all.
* Aspiration – There is a significant recurrence rate after a single aspiration (using wide bore needle) but after 3 serial aspirations the recurrence rate is only 12-15% which is comparable with surgery

For audit purposes, the referral letter and hospital records should include detail on:

* Precise location of ganglion e.g. flexor tendon
* Size in cm/inches (length and width)
* How function of the area is impaired? i.e. what is the patient unable to do as a result of the ganglion?
* Degree of pain
* How long it has existed plus dates of 3 serial aspirations

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Grommets** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission grommet insertion on a restricted basis.

**Group Prior Approval**

**Children**

All children must have a specialist audiology and ENT assessment. Providers should ensure that glue ear has not resolved once a date for surgery has been agreed, with tympanometry as a minimum.

Children will be funded for grommet (ventilation tube) insertion if they meet the following criteria:

* Children with severe hearing loss-i.e. persistent bilateral otitis media with effusion (OME) documented over a period of 3 months with a hearing level in the better ear of 25–30 dBHL or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available)

**OR**

* Children who have had at least 5 occurrences\* of acute otitis media in the last year with additional complications such as perforations, persistent discharge, febrile convulsions, sensor neural deafness or cochlear implantation.

The persistence of bilateral OME and hearing loss needs to be confirmed over a period of **3 months before** surgical intervention will be considered. The child’s hearing should be re-tested at the end of this time. During this active observation period of 3 months, advice on educational and behavioural strategies to minimise the effects of the hearing loss should be offered.

\*GPs should provide details of infection occurrences at the time of referral.

**Individual prior approval**

Children will be **considered** for funding if they meet one of the following criteria and individual prior approval for funding must be obtained:

* A child with persistent bilateral OME with a hearing level better than 25–30 dBHL where the impact of the hearing loss on a child’s developmental, social or educational status is judged to be significant by a specialist with expertise in child development. For children under 5 years of age overall hearing level applies
* Children with **Down’s Syndrome** as an alternative to hearing aids for treating persistent bilateral OME with hearing loss and/or significant impact on child’s developmental, social or educational status as judged by a specialist with expertise in child development.

For children with Down’s syndrome, the following factors need to be considered before the intervention is offered:

* the severity of hearing loss
* the age of the child
* the practicality of ventilation tube insertion
* the risks associated with ventilation tubes
* the likelihood of early extrusion of ventilation tubes

Funding for children on the Cleft Lip/Palate Clinical care management pathway is through NHS England- Specialised Commissioning and therefore is not funded by the CCG.

**Individual Prior Approval**

**Adjuvant adenoidectomy** will only be funded inchildren with Otitis Media with Effusion (OME) who meet the above criteria for ventilation tubes (grommets) **and** in the presence of persistent and/or frequent upper respiratory tract infections.

**Adenoidectomy as a separate procedure will not be funded.**

**Group Prior Approval**

**Adults**

Grommet insertion is only funded for adults with disabling conductive hearing loss due to middle ear effusions, who meet the following criteria:

* Treatment for Meniere’s disease where other non-surgical treatments have not resolved the problem over a period of 3 months.

**OR**

* Severe retraction of the tympanic membrane, who have not responded to non-surgical intervention over a period of 3 months if the clinician feels this may be reversible and reversing may help avoid erosion of the ossicular chain or the development of cholesteatoma

**OR**

* Persistent bilateral Otitis Media with effusion (OME) documented over a period of 3 months **WITH**
* A hearing level in the better ear of 25-30 dBHL or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available) **AND**
* The persistence of bilateral OME causing conductive hearing loss has been confirmed at 3 months through audiologist assessment **AND**
* Investigation and treatment of underlying causes has been completed without improvement in hearing

**OR**

* Unilateral hearing loss as part of post nasal space biopsy procedure, where deemed clinically necessary by the surgeon
* Patients with unilateral hearing loss should be referred for review of post nasal space

Myringotomy with or without grommet insertion is commissioned where middle ear ventilation is an essential feature of **specialist investigation** for management of:

* Underlying malignancy
* acute or chronic otitis media with complications: facial palsy or intracranial infection e.g. meningitis
* eustachian tube dysfunction that prevents the commencement or completion of hyperbaric oxygen treatment as commissioned by NHS England <https://www.england.nhs.uk/wp-content/uploads/2017/10/prescribed-specialised-services-manual-2.pdf>

The CCGs **do not commission:**

* Balloon dilatation of the Eustachian tube as per NICE IPG 409
* Myringotomy with or without grommet insertion for treatment of hearing loss or other symptoms of otitis media in adults as there is insufficient research evidence of long term benefits compared with conservative management

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**Patient Information Leaflet:**

<https://www.nhs.uk/conditions/glue-ear/>

**References:**

1. Lous J, Burton MJ, Felding JU, Ovesen T, Rovers MM, Williamson I, 2005, Grommets for hearing loss associated with otitis media with effusion. Cochrane Systematic Review , 2005

2. NICE Clinical Guidance 60, Surgical Management Of OME, by the Collaborating Centre for Women’s and Children’s Health

3. McDonald Stephen, Langton Hewer Claire D, Nunez Desmond A, 2008, Grommet (ventilation tubes) for recurrent acute otitis media in children. Cochrane Systematic Review

4. South, Central, and West Commissioning Support Unit. Grommet insertion in adults with otitis media with effusion (OME) Secondary Care Prior Approval Policy. Version 1617.v3

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| **Policy statement:** | **Gynaecomastia** |
| Status: | **Not Funded** |

Procedures to treat gynaecomastia ***will not be*** funded.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Haemorrhoids** |
| **Status:** | **Individual Prior Approval** |

**This policy does not apply to referrals for suspected cancer and acute, profuse rectal bleeding**

Haemorrhoidectomy will be funded for patients with first or second degree haemorrhoids who do not respond to:

* Conservative treatment (e.g. lifestyle changes and pharmacological treatment)
* Other techniques (e.g. rubber band ligation, sclerotherapy, or infra-red photocoagulation).

Haemorrhoidectomy will be funded for patients with third or fourth-degree haemorrhoids that are either too large for other measures or have not responded to them.

* Grade 1 are small swellings on the inside lining of the anal canal. They cannot be seen or felt from outside the opening of the back passage (anus). Grade 1 piles are common. In some people they enlarge further to grade 2 or more.
* Grade 2 are larger. They may be partly pushed out from the anus when you go to the toilet, but quickly spring back inside again.
* Grade 3 hang out from the anus when you go to the toilet. You may feel one or more as small, soft lumps that hang from the anus. However, you can push them back inside the anus with a finger.
* Grade 4 permanently hang down from within the anus, and you cannot push them back inside. They sometimes become quite large.

Ref: <https://patient.info/health/rectal-bleeding-blood-in-faeces/piles-haemorrhoids>

Funding will not be made available outside the above criteria unless there are clinical exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Hair Depilation/Hirsutism** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund hair depilation procedures or medication (e.g. Vaniqa®) or laser treatment for Hirsutism.

This service/procedure/treatment has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Heavy Menstrual Bleeding (including uterine fibroids) Hysterectomy/Myomectomy/Uterine Artery Embolisation** |
| **Status:** | **Group Prior Approval – Hysterectomy/Endometrial Ablation** |
| **Status:** | **Not funded – Myomectomy/Uterine Artery Embolisation** |

Hysterectomy for heavy menstrual bleeding will only be funded by M&SECCGs when the following criteria are met:

Heavy Menstrual Bleeding (HMB) is defined as excessive menstrual blood loss which interferes with the woman’s physical, emotional, social and material quality of life, and which can occur alone or in combination with other symptoms. **The policy does not apply to post-menopausal, inter-menstrual or post-coital bleeding.**

Hysterectomy for heavy menstrual bleeding will only be funded when:

* There has been a trial with a levonorgestrel-releasing intrauterine system LNG-IUS, e.g. Mirena®, unless contraindicated, for at least 12 months and this has not successfully relieved symptoms or has produced unacceptable side effects. Contraindications to the levonorgestrel intrauterine system are:
  + Distorted or small uterine cavity (with proven ultrasound measurements; uterocervical canal length < 5cm)
  + Genital malignancy
  + Active trophoblastic disease
  + Active pelvic inflammatory disease
  + Large cavity over 10cm length

**AND**

* At least **two** of the following drug treatments **(for at least 3 months each)** have failed to relieve symptoms (unless contraindicated or inappropriate):
  + Alternative hormonal treatment in keeping with NICE guidance e.g. combined or progestogen only oral contraceptives, injected progesterone, Gn-RH analogues
  + NSAIDs
  + Tranexamic Acid

For those who for ethical reasons cannot accept the use of Mirena®, they should have tried at least two of the alternative treatments.

**AND**

where ultrasound shows small fibroids <3cms; uterus <12 wks gestation AND severe impact on quality of life and

* Endometrial Ablation or Resection has been unsuccessful (unless contraindicated or inappropriate) as first line surgical treatment for women with heavy menstrual bleeding who do not wish to conceive in the future.

Women offered hysterectomy should have a full discussion of the implication of the surgery before a decision is made. The discussion should include: sexual feelings, fertility impact, bladder function, need for further treatment, treatment complications, the woman's expectations, alternative surgery and psychological impact.

Women offered hysterectomy should be informed of the increased risk of serious complications (such as intraoperative haemorrhage or damage to other abdominal organs) associated with hysterectomy when uterine fibroids are present.

Women should be informed of the risk of possible loss of ovarian function and its consequences, even if their ovaries are retained during hysterectomy.

Taking into account the need for individual assessment, the route of hysterectomy should be considered in the following order: first line vaginal; second line abdominal or laproscopic.

NICE guidelines state that removal of healthy ovaries at the time of hysterectomy should not be undertaken; however prophylactic removal of fallopian tubes may be considered to reduce the risk of ovarian cancer. Ovary removal should be discussed with the patient on an individual basis and the age of the patient should also be taken into account. Ovary removal should only be undertaken with the expressed wish and consent of the woman.

**Interventions not funded by M&SECCGS**

Myomectomy and Uterine Artery Embolisation (UAE) are **not funded** by M&SECCGS.

NICE published update guidance in 2010 for UAE NICE interventional procedure guidance [IPG367] stating that ‘Current evidence on uterine artery embolisation (UAE) for fibroids shows that the procedure is efficacious for symptom relief in the short and medium term for a substantial proportion of patients’. However re-intervention rates are significantly higher after UAE than after surgery with up to 32% re-intervention rates for either symptom recurrence or complication by 5 years (4% for surgery). Myomectomy has a higher re-intervention rate than UAE.

The evidence for fertility and pregnancy outcomes after myomectomy and after UAE is poor. Currently it is not possible to make an evidence based recommendation about treatment (myomectomy or UAE) for women with fibroids who wish to maintain their fertility. Surgical treatments for fibroids in women of childbearing age who wish, or might wish to become pregnant in the future should be offered only after fully informed discussion.

There is limited evidence on the role of other interventions such as uterine artery ligation, Magnetic Resonance guided Focussed Ultrasound (MRgFUS) and myolysis. NICE assessment of MRgFUS indicates that although the procedure appears effective in the short term, there is a lack of evidence for its longer term effectiveness. **These procedures are not funded.**

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**References:**

NICE Heavy Menstrual Bleeding –Clinical Guideline March 18

<https://www.nice.org.uk/guidance/ng88/resources>

Clinical recommendations on UAE in management of fibroids

<https://www.rcog.org.uk/globalassets/documents/guidelines/23-12-2013_rcog_rcr_uae.pdf>

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| **Policy statement:** | **Hernia (surgical treatment)** |
| **Status:** | **Individual Prior Approval** |

**This policy does not include situations where emergency treatment is required e.g. strangulation is suspected-refer direct to secondary care**

**Femoral: All suspected femoral hernias should be referred to secondary care due to the increased risk of incarceration/strangulation**

M&SECCGs commission surgical treatment of hernias on a restrictive basis for patients meeting the defined criteria below. This policy covers the management of inguinal, umbilical, ventral and incisional hernias, with criteria for referrals/treatment.

**Inguinal:**

For asymptomatic or minimally symptomatic hernias, a watchful waiting approach is advocated with informed consent.

Surgical treatment should only be offered when one of the following criteria is met:

* Symptomatic i.e. symptoms are such that they interfere with work or activities of daily living OR
* The hernia is difficult or impossible to reduce, OR
* Inguino-scrotal hernia, OR
* The hernia increases in size month on month OR
* The patient is currently asymptomatic but works in a heavy manual occupation (for e.g. in removal firms lifting heavy weights) and there is an increased risk of strangulation and future complications.

**Umbilical:**

Surgical treatment should only be offered when one of the following criteria is met:

* Pain/discomfort severely impacting on activity of daily living with a demonstrable significant detrimental impact on daily activities with functional limitation OR
* increase in size month on month OR
* to avoid incarceration or strangulation of bowel OR
* The patient is currently asymptomatic but works in a heavy manual occupation (for e.g. in removal firms lifting heavy weights) and there is an increased risk of strangulation and future complications

**Incisional/Ventral:**

Surgical treatment should only be offered when BOTH of the following criteria are met:

* Pain/discomfort severely impacting on activity of daily living with a demonstrable significant detrimental impact on daily activities with functional limitation.

**AND**

* Appropriate conservative management has been tried first e.g. weight reduction where appropriate

OR

* The patient is currently asymptomatic but works in a heavy manual occupation (for e.g. in removal firms lifting heavy weights) and there is a risk of strangulation and future complications.

**Diastases/Divarication of recti** is a separation between the left and right side of the rectus abdominis muscle, and causes a protrusion in the midline, but is not a '' hernia and does not carry the risk of bowel becoming trapped within it and thus does not require repair.

Evidence suggests that divarication does not carry the same risks as that of actual herniation.

**M&SECCGs consider repair of diastasis/divarication of recti to be a cosmetic procedure and a low clinical priority and as such do not fund.**

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Hip Joint Injections** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission hip joint injections under imaging guidance on a restricted basis.

Current evidence on the safety and efficacy does not appear adequate to routinely recommend hip joint injections.

M&SECCGs only fund hip injections in the following circumstances:

* Diagnostic aid
* To introduce contrast medium to the joint as part of hip arthrogram
* Investigation of infection in biological and replaced hips.
* Adults with inflammatory arthropathy

**Individual prior approval approval is required.**

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**References:**

Intraarticular Hip Injection and Early Revision Surgery Following Total Hip Arthroplasty: A Retrospective Cohort Study 23 September 2014. <https://doi.org/10.1002/art.38886>

Is Anesthetic Hip Joint Injection Useful in Diagnosing Hip Osteoarthritis? A Meta-Analysis of Case Series June 2014: <https://doi.org/10.1016/j.arth.2013.12.008>

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| **Policy statement:** | **Hip Joint Replacement** |
| **Status:** | **Group Prior Approval** |

M&SECCGs commission surgery for hip joint replacement on a restricted basis as defined overleaf.

Referral to secondary care for consideration of elective hip joint replacement should only be made when there is clinically significant functional limitation resulting in significant diminished quality of life and management of other pre-existing medical conditions has been optimised, and, except for patients with severe functional limitation (as defined in table below), an extended course (at least 6 months) of non-surgical management to manage moderate to severe persistent pain has been exhausted and failed. This will include weight reduction and changing activity -which NICE considers core treatments, use of NSAIDs and other analgesics, and introducing a walking aid. There must be radiological features of joint damage and a narrowing of the joint space on radiograph.

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The Oxford Hip Score must be completed in Primary Care prior to referral for consideration of surgical hip joint replacement. The completed tool in full (not just the score) should be attached to the referral. The tool can be found at <http://www.orthopaedicscore.com/scorepages/oxford_hip_score.html>

The Oxford Hip Score tool should be used in conjunction with other information to help a patient make an informed decision as whether to proceed to surgery or not. This, together with the Shared Decision Making leaflet - **Deciding what to do about osteoarthritis of the hip-,** should form the basis for this discussion between GP / triage referral service and patient.



The patient must be willing to have surgery and, if relevant, had any risks associated with smoking or obesity explained to them. This must be discussed this with the patient before referring for surgical opinion for surgery.

Grading for the Oxford Hip Score

0 -19 May indicate severe hip arthritis. It is likely that some form of surgical intervention is required. Offer referral to a consultant orthopaedic surgeon for consideration of surgery.

20 - 29 May indicate moderate to severe hip arthritis. Consider seeking advice and guidance from consultant orthopaedic surgeon.

30 - 39 May indicate mild to moderate hip arthritis. Patients may benefit from non-surgical treatment, such as exercise, weight loss, and /or anti-inflammatory medication.

40 – 48 May indicate satisfactory joint function. May not require any formal treatment

**M&SECCGs will only fund hip joint replacement surgery if:**

* The patient complains of **severe** joint pain\* **AND** has radiological features of **severe** disease including a narrowing of the joint space on radiograph **AND** has **severe** functional limitation\* irrespective of whether non-surgical treatments\* have been trialled,

**OR**

* The patient complains of **severe** joint pain\* **AND** has radiological features of **severe** disease including a narrowing of the joint space on radiograph **AND** has **moderate** functional limitation\*, despite the use of non-surgical treatments\* such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.

**OR**

* The patient complains of **moderate** joint pain\* **AND** has radiological features of **severe** disease including a narrowing of the joint space on radiograph **AND** has **severe** functional limitation\*, despite the use of non-surgical treatments\* such as adequate doses of NSAID analgesia, weight control treatments and physical therapies **AND** is **assessed to be at low surgical risk**. Surgical risk divided into; Low (ASA 1 to 3); High (ASA 4)

**\***Please refer to the tables defining appropriate non-surgical treatments and the classification of pain levels and functional limitations to comply with policy.

**In all cases:-**

* Shared decision making must take place with respect to all management. This includes presenting the patient with information on all treatment options, and a clear description of the risks and benefits of each treatment, including surgery where indicated. Emphasis should be on dialogue enabling patients’ to realise they have a choice, understand the options available to them, and make a decision as to which option to choose.
* Evidence that the patient has been fully involved in the decision to have joint surgery, and including evidence of shared decision making i.e. a full record of the discussion with the patient in their notes, and including risk/benefits of all treatment options offered.
* There must be documented supporting clinical diagnostics and other assessments to support the decision to perform joint surgery.

Prostheses for total hip replacement are recommended as a treatment option for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years.

Evidence suggests that the following patients would be INAPPROPRIATE candidates for hip joint replacement surgery and will therefore **not be funded:**

* Where the patient complains of mild joint pain **AND** has minor or moderate functional limitation
* Where the patient complains of moderate to severe joint pain **AND** has minor functional limitation **AND** has not previously had an adequate trial of conservative management as described above

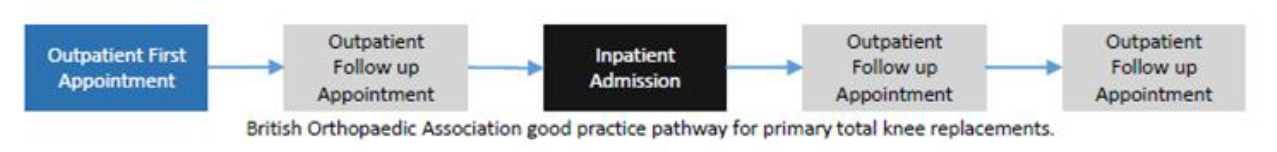
Patients who are inappropriate for hip joint replacement surgery must not be listed for surgery and will not be funded.

[**Hip Replacement - Classification of Pain Levels and Functional Limitations**](file:///C:\Users\racanderson\AppData\Local\Microsoft\Windows\Temporary%20Internet%20Files\Content.Outlook\CJOM4JSW\Hip%20Replacement%20-%20Classification%20of%20Pain%20Levels%20and%20Functional%20Limitations%20table.docx)

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| **Variable** | **Definition** |
| **Pain Level** | |
| Mild | Pain interferes minimally on an intermittent basis with normal activities of daily living. Not related to rest or sleep. Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin/paracetamol at regular doses. |
| Moderate | Pain occurs daily with movement and interferes with normal activities of daily living. Vigorous activities cannot be performed. Not related to rest or sleep. Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin/paracetamol at regular doses |
| **Severe** | **Pain is constant and interferes with most normal activities of daily living. Pain at rest or interferes with sleep. Pain not controlled, even by narcotic analgesics.** |
| **Previous non-surgical treatments** | |
| **Correctly Done** | **NSAIDs, paracetamol, aspirin or narcotic analgesics at regular doses over a period of at least 6 months without achieving management of pain; provision of weight management advice and support if overweight with patient engagement, physical therapies done.** |
| Incorrectly Done | NSAIDs, paracetamol, aspirin or narcotic analgesics at regular doses over a period of less than 6 months without achieving management of pain; no provision of weight management advice and support if overweight with or without patient engagement, no physical therapies done**.** |
| **Functional Limitations** | |
| Minor | Functional capacity adequate to conduct normal activities of daily living and self-care.  Walking capacity of more than one hour.  No aids needed. |
| Moderate | Functional capacity adequate to perform only a few or none of the normal activities of daily living and self-care.  Walking capacity of about one half hour.  Aids such as a cane are needed. |
| **Severe** | **Largely or wholly incapacitated.** **The quality of life is significantly compromised.**  **Walking capacity of less than half hour or unable to walk or bedridden.**  **Aids such as a cane, a walker or a wheelchair are required.** |

M&SECCGs commission Primary Hip Replacements based on good clinical practice pathways as identified by the British Orthopaedic Association and Monitor1.

The CCGs commission Hip replacement in line with the British Orthopaedic Association good practice pathway:



Defined as

* a first outpatient appointment,
* a follow-up outpatient appointment,
* an inpatient admission and
* two outpatient follow-up appointments maximum only.

Further long term routine ongoing follow up is considered to be a **low clinical priority** and not funded.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Procedure** | **OPCS4 codes** |
| **Primary total hip replacement with or without cement** | W3712  W371 , W379 , W381 , W389, W391, W399, W931, W939, W941, W949, W951, W959 |
| **Total prosthetic replacement of the hip, with or without cement, bilateral** | All above codes with Z941  As in primary hip replacement with code Z941 for bilateral operations |
| **Complex primary total hip replacement (including bone grafting or femoral osteotomy)** | W3713 |

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| OPCS codes | WF01A, WF02A.  Treatment function code 330. |

**References:**

NICE CG177 Osteoarthritis: care and management <https://www.nice.org.uk/guidance/cg177>

British Orthopaedic Association-2017 Commissioning Guide: Pain Arising from the Hip in Adults

<https://www.boa.ac.uk/wp-content/uploads/2017/11/Pain-Arising-from-the-Hip-Guide-Final.pdf>

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| **Policy statement:** | **Hip Resurfacing** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commissions hip resurfacing on the following restricted basis.

M&SECCGs will only fund those patients who would qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements as restricted by NICE Guidance Hip disease - metal on metal hip resurfacing (TA44).

Hip resurfacing is not generally considered the best option for women over the age of 65. Clinicians applying for funding approval should provide full clinical rationale for choice.

Prostheses for resurfacing arthroplasty are recommended as a treatment option for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years.

<https://www.nice.org.uk/guidance/ta304/resources/total-hip-replacement-and-resurfacing-arthroplasty-for-endstage-arthritis-of-the-hip-review-of-technology-appraisal-guidance-2-and-44-82602365977285>

Issued: February 2014

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Hyperhidrosis (Botox)** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commissions specialist treatment for hyperhidrosis only when carried out in line with the following pathway:<http://midessexccg.nhs.uk/your-health-services/medicines-optimisation/clinical-pathways-and-medication-guidelines/chapter-13-skin-3/1593-hyperhydrosis-pathway-jan-2016/file>

Patients with generalised hyperhidrosis should not be referred to secondary care but managed in accordance with the above pathway.

Patients with localised hyperhidrosis should not be referred to specialist without having tried

* self- funded topical strong antiperspirants **AND**
* self-funded iontophoresis with tap water for at least six months.

Tap-water iontophoresis is non-invasive and is appropriate for axillary, palmar, plantar and craniofacial hyperhidrosis.

Iontophoresis with glycopyrronium bromide is not funded as the level of evidence for adding glycopyrronium bromide solution is weak and costs in primary care is prohibitive

**Patient Information Leaflet-** <http://midessexccg.nhs.uk/your-health-services/medicines-optimisation/clinical-pathways-and-medication-guidelines/chapter-13-skin-3/795-excessive-sweating-self-management-leaflet-may-2015-1/file>

M&SECCGs do not commission Endoscopic Thoracic Sympathectomy (ETS) due to weak evidence and significant risk of morbidity

**Individual prior approval** for funding for use of botulinium toxin is required. Treatments must not be repeated more frequently than once every 6 months.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Hysteroscopy/ Dilatation and Curettage (D&C)** |
| **Status:** | **Group Prior Approval** |

M&SECCGs commissions Dilatation and Curettage/Hysteroscopy on a restricted basis.

M&SECCGS only funds D&C and hysteroscopy when used in line with NICE guidance (NG88)

Hysteroscopy will only be funded for the investigation and management of heavy menstrual bleeding when it is carried out:

* as an investigation for structural and histological abnormalities where suspected

submucosal fibroids, polyps or endometrial pathology

OR

* immediately prior to the ablative procedure to ensure correct placement of the device where endometrial ablation is required.

The CCGs will not fund D&C:

* as a diagnostic tool for heavy menstrual bleeding; or
* as a therapeutic treatment for heavy menstrual bleeding.

Postmenopausal women who have had a pelvic scan and endometrial biopsy and who present with further bleeding 6 months later should be offered hysteroscopy to be sure no small cancer has been missed without a mandatory preliminary scan.

Hysteroscopy for the majority of women should be performed as an outpatient procedure.

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**References:**

Heavy menstrual bleeding: assessment and management

NICE guideline [NG88] Published date: March 2018

<https://www.nice.org.uk/guidance/ng88/resources>

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| **Policy statement:** | **Ingrown Toe Nail Surgery** |
| **Status:** | **Group Prior Approval/Individual Prior Approval** |

M&SECCGs commission surgery for ingrown toe nails on a restricted basis.

**Group Prior Approval**

Nail surgery for ingrowing toenails will only be funded for patients with moderate to severe symptoms when primary care management has failed and when delivered by a commissioned community provider.

Moderate-Severe Symptoms include:

* Increased pain and inflammation of the toe
* Purulent drainage
* Bleeding
* Recurrent Infection
* Severe and disabling pain
* Substantial erythema and inflammation
* Severe infection
* Chronic inflammation and granulation
* Nail fold hypertrophy

**Individual Prior Approval**

Surgery for ingrown toe nails is not routinely commissioned in a secondary care setting unless future orthopaedic surgery would be compromised- for example a recurrent infected ingrown toenail requiring treatment prior to joint replacement surgery. Individual prior approval must be sought.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Insulin Pump Therapy- continuous subcutaneous insulin infusion** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission the use of continuous subcutaneous insulin infusion (CSII) or ‘insulin pump' therapy as a treatment for adults and children 12 years and over with type 1 diabetes mellitus where:

* attempts to reach target haemoglobin A1c (HbA1c) levels with multiple daily injections result in the person having ‘disabling hypoglycaemia', **OR**
* HbA1c levels have remained high (8.5% or above) with multiple daily injections (including using long-acting insulin analogues if appropriate) despite the person and/or their carer carefully trying to manage their diabetes **AND**
* The person has attended and completed a CCG approved diabetes educational course for example DAFNE.

CSII therapy is commissioned as a treatment option for children younger than 12 years with type 1 diabetes mellitus provided that:

* Multiple Daily Injection (MDI) therapy is considered to be impractical or inappropriate, **and**
* Children on insulin pumps would be expected to undergo a trial of therapy between the ages of 12 and 18 years.

Insulin pump therapy should only be started by a trained specialist team. This team should include a doctor who specialises in insulin pump therapy, a diabetes nurse and a dietitian (someone who can give specialist advice on diet). This team should provide structured education programmes and advice on diet, lifestyle and exercise that is suitable for people using insulin pumps.

Following initiation in adults and children 12 years and older, CSII therapy should only be continued if it results in a sustained improvement in glycaemic control, evidenced by a fall in HbA1c levels, or a sustained decrease in the rate of hypoglycaemic episodes. Appropriate targets for such improvements should be set by the responsible physician, in discussion with the person receiving the treatment or their carer, and notified to the commissioner. Patients must be reviewed against these targets at least annually. Continuation of funding will be dependent upon demonstrating sustained improvement and management in glycaemic control as above. .

Insulin pump therapy is not routinely funded for people with type 2 diabetes mellitus

In accordance with NICE principles and the ethos of NICE clinical guideline Type 1 diabetes in adults: diagnosis and management ([nice.org.uk/guidance/ng17](https://www.nice.org.uk/guidance/ng17)), M&SECCGs support funding of the insulin pump with the lowest acquisition cost that meets the clinical needs of the patient, and without consideration of a patient’s desire to self-fund CGM. Co-funding, which involves both private and NHS funding for a single episode of care, is not permitted for NHS care. The choice of pump in very young children should take into account the ability to deliver a very low basal rate

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**References:**

(NICE Technology Appraisal 151: <https://www.nice.org.uk/Guidance/TA151>).

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| **Policy statement:** | **Irritable Bowel Syndrome** **Diagnostic Colonoscopy/Flexible Sigmoidoscopy-Calprotectin** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission colonoscopy/flexible sigmoidoscopy for the diagnosis of Irritable Bowel Syndrome on a restricted basis.

Calprotectin is a protein biomarker which is used in the differentiation of inflammatory bowel disease (IBD) from irritable bowel syndrome (IBS). This test supports the differentiation of those with IBS, who can be managed in primary care, and facilitates appropriate referral to secondary care of patients with IBD.

This policy does not cover those patients with the following red flag symptoms, who should be referred via a 2 week wait referral.

* Unintentional weight loss
* Family history of bowel or ovarian cancer
* Age >60 and a change in bowel habits lasting >6weeks
* Symptoms suggestive of ovarian pathology

Requests for endoscopy to diagnose IBS will not be funded unless the below process has been followed and evidenced in the Individual Prior Approval application and referral.

Patients presenting with the following symptoms should be offered a calprotectin test:

* Abdominal pain relieved by defecation
* Altered bowel frequency or consistency
* Symptoms for at least 6months.
* No red flag symptoms
* Normal examination and blood tests

Patients with calprotectin levels <30ug/g should be managed as IBS patients in primary care.

Patients with calprotectin levels between 30-75ug/g should have a repeat test in 4 weeks. If the repeat test shows a calprotectin level of <30ug/g, the patient should be managed, as an IBS patient, in the primary care setting.

If the first test shows calprotectin level >75ug/g, or if the repeat test shows levels >30ug/g the patient should be referred to secondary care for inflammatory bowel disease.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**References:**

<https://www.nice.org.uk/Guidance/DG11>

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| **Policy statement:** | **Knee Joint Replacement** |
| **Status:** | **Group Prior Approval** |

M&SECCGs commission surgery for knee joint replacement on a restricted basis.

Referral for consideration of elective knee joint replacement surgery should only be made when the patient has intense or severe joint symptoms (pain, stiffness and reduced function) that have a substantial impact on their quality of life **AND** are refractory to non-surgical treatment\* for at least 6 months **AND** has radiological features of severe disease. Plain radiographs, with standing AP (or long-leg) and a lateral view may be taken for initial diagnosis but are not essential in patients over 45. Skyline and Rosenberg views may also be requested. Note that standard radiographs are required on all patients prior to referral to secondary care.

Non-Surgical Treatment\*-Prior to referral patients must have **received and engaged** in **all** core non-operative treatments AND **at least one** additional non-operative therapy for at least 6 months.

* Core treatments for all patients:
* Accurate verbal and written information to enhance understanding of the condition and its management and to counter misconceptions, such as that it inevitably progresses and cannot be treated. Ensure that information sharing is an ongoing, integral part of the management plan rather than a single event at time of presentation
* Exercise irrespective of age, comorbidity, pain severity or disability. Exercise should include local muscle strengthening and general aerobic fitness.
* Interventions to achieve weight loss if the patient is overweight. Weight maintenance also has a role in managing symptoms.
* Advice on appropriate footwear (including shock-absorbing properties)
* Individualised self-management strategies with the person with osteoarthritis. Ensure that positive behavioural changes, such as exercise, weight loss, use of suitable footwear and pacing, are appropriately targeted
* Additional non-operative therapies include: manual therapy (e.g. physiotherapy), supports and braces, local heat and cold therapy, non-steroidal anti-inflammatory medication (topical or oral) or COX-2 inhibitors with a proton pump inhibitor, opioid medication, and intra-articular corticosteroid knee injections.

**The Oxford Knee Score should be completed in Primary Care prior to referral for consideration of surgical knee joint replacement. The completed tool in full (not just the score) should be attached to the referral**. The tool can be found at

<http://www.orthopaedicscore.com/scorepages/oxford_knee_score.html>

The Oxford Knee Score tool should be used in conjunction with other information to help a patient make a sensible decision as whether to proceed to surgery or not. This, together with the Shared Decision Making leaflet - **Deciding what to do about osteoarthritis of the knee-,** should form the basis for this discussion between GP/triage referral service and patient.



Grading for the Oxford Knee Score

0 -19 May indicate severe knee arthritis. It is likely that some form of surgical intervention is required- Offer referral to a consultant orthopaedic surgeon for consideration of knee surgery.

20 - 29 May indicate moderate to severe knee arthritis. Consider seeking advice and guidance (eRS) from consultant orthopaedic surgeon.

30 - 39 May indicate mild to moderate knee arthritis. Patients may benefit from non-surgical treatment, such as exercise, weight loss, and /or anti-inflammatory medication.

40 – 48 May indicate satisfactory joint function. May not require any formal treatment

**M&SECCGs will only fund knee joint replacements if:**

* The patient complains of intense or severe symptomatology **AND** has radiological features of severe disease **AND** has demonstrated disease within all three compartments of the knee (tri-compartmental) or localised to one compartment plus patello-femoral disease (bi-compartmental).

**OR**

* The patient complains of intense or severe symptomatology **AND** has radiological features of moderate disease **AND** limited mobility or stability of the knee joint is severely impacting on activities of daily living. Information demonstrating the severity of the impact on activities of daily living must be included in the referral letter.

\*Please refer to the table overleaf for classification of pain levels and functional limitations to comply with policy.

**In all cases:-**

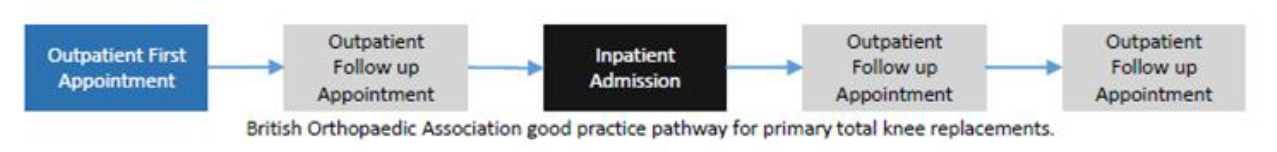
* Shared decision making must take place with respect to all management. This includes presenting the patient with information on all treatment options, and a clear description of the risks and benefits of each treatment, including surgery where indicated. Emphasis should be on dialogue enabling patients’ to realise they have a choice, understand the options available to them, and make a decision as to which option to choose.
* Evidence that the patient has been fully involved in the decision to have joint surgery, and including evidence of shared decision making i.e. a full record of the discussion with the patient in their hospital notes, and including risk/benefits of all treatment options offered.
* There must be documented supporting clinical diagnostics and other assessments to support the decision to perform joint surgery.

[**Knee Joint Replacement - Classification of Pain Levels and Functional Limitations**](file:///C:\Users\racanderson\AppData\Local\Microsoft\Windows\Temporary%20Internet%20Files\Content.Outlook\CJOM4JSW\Hip%20Replacement%20-%20Classification%20of%20Pain%20Levels%20and%20Functional%20Limitations%20table.docx)

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| **Variable** | **Definition** |
| **Mobility and Stability** | |
| Preserved mobility and stable joint | Preserved mobility is equivalent to minimum range of movement from 0o to 90o.  Stable or not lax is equivalent to an absence of slackness of more than 5mm in the extended joint. |
| Limited mobility and/or stable joint | Limited mobility is equivalent to a range of movement less than 0o to 90o unstable or lax is equivalent to the presence of slackness of more than 5mm in the extended joint. |
| **Symptomatology** | |
| Slight | Sporadic pain.  Pain when climbing/descending stairs.  Allows daily activities to be carried out (those requiring great physical activity may be limited).  Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects. |
| Moderate | Occasional pain.  Pain when walking on level surfaces (half an hour, or standing).  Some limitation of daily activities.  Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects. |
| Intense | Pain of almost continuous nature.  Pain when walking short distances on level surfaces or standing for less than half an hour.  Daily activities significantly limited.  Continuous use of NSAIDs for treatment to take effect.  Requires the sporadic use of support systems walking stick, crutches). |
| Severe | Continuous pain.  Pain when resting.  Daily activities significantly limited constantly.  Continuous use of analgesics - narcotics/NSAIDs with adverse effects or no response.  Requires more constant use of support systems (walking stick, crutches). |
| **Radiology** | |
| Slight | Ahlback grade I. |
| Moderate | Ahlback grade II and III. |
| Severe | Ahlback grade IV and V. |
| **Localisation** | |
| Unicompartmental | Excluded patello-femoral isolated. |
| Bicompartmental | Unicompartmental plus patello-femoral. |
| Tricompartmental | Disease affecting all three compartments of the knee. |

M&SECCGs commission Primary Knee Replacements based on good clinical practice pathways as identified by the British Orthopaedic Association and Monitor1.

The CCGs commission knee replacement in line with the British Orthopaedic Association good practice pathway:



Defined as

* a first outpatient appointment,
* a follow-up outpatient appointment,
* an inpatient admission and
* two outpatient follow-up appointments maximum only.

Further long term routine ongoing follow up is considered to be a **low clinical priority** and not routinely funded.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**References**:

NICE CG177 Osteoarthritis: care and management <https://www.nice.org.uk/guidance/cg177>

British Orthopaedic Association -2017 Commissioning Guide: Painful Osteoarthritis of the Knee

<https://www.boa.ac.uk/wp-content/uploads/2014/01/Painful-OA-Knee-Guide-Final-.pdf>

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| **Policy statement:** | **[Labial Reduction / Refashioning](#Index) / Vaginoplasty / Cliteroplasty** |
| **Status:** | **Individual Prior Approval** |

This policy does not apply to genital reconstruction for gender dysphoria as CCGs are not the responsible commissioners. NHS England is responsible for commissioning gender identity disorder services from Specialist Gender Identity Disorder Clinic Centres.

M&SECCGs **do not fund** elective vaginal labia reduction/refashioning or hymenorrhaphy or vaginoplasty or cliteroplasty as these are considered to be cosmetic procedures.

M&SECCGs fund in the following circumstances:

* vaginoplasty for congenital absence, significant developmental/endocrine abnormalities of the vaginal canal or post-traumatic vaginal stenosis
* reconstructive surgery for patients who have undergone female genital mutilation or cutting

**Labia repair-trauma**

Repair of labia at the time of trauma will be routinely funded.

Post immediate trauma applications will not be funded unless there are **exceptional clinical circumstances.**

In all circumstances medical photography is required with the funding request submission.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Lymphoedema Services** |
| **Status:** | **Group Prior Approval** |

M&SECCGs commission lympoedema services on a restricted basis. M&SECCGs do not fund intensive acute hospital inpatient therapy or treatment in specialist units outside local CCG community commissioned pathways.

Treatment of lymphoedema by specialist units **will only be funded in exceptional clinical circumstances**.

**Definition:**

Lymphoedema is swelling due to excess accumulation of fluid in the tissues caused by inadequate lymphatic drainage. It can affect any part of the body, but most commonly affects the arms and legs. There is no agreement on the quantitative definition of Lymphedema.

Lymphoedema can be classified as primary or secondary. Primary lymphoedema is due to abnormality intrinsic to the lymphatic system. Secondary Lymphoedema is due to damage/obstruction of the lymphatic system. This can be caused by cancer or cancer treatment, but there are a variety of other, non-cancer causes. Historically, lymphoedema services have often developed in relation to cancer services and have extended their scope to treat other types of lymphoedema.

Lymphoedema is essentially incurable as it represents end-stage failure of lymph drainage and will invariably progress unless controlled. Skin infections occur which can necessitate hospital admissions and there is increasing lack of mobility if patients are untreated.

Symptoms include the weight and discomfort of the affected limb, recurrent inflammation and infection, and the psychological distress caused by the appearance on the limb.

Once correct diagnosis has been established, the patient should be referred on to a local CCG commissioned lymphedema service.

**Criteria for referral:**

As lymphoedema is only one cause of oedema, the GP should ensure

* the correct diagnosis -remembering that most causes of peripheral oedema are cardiac, renal, hepatic or venous in origin, rather than lymphoedema.
* the oedema is persistent or greater than 3 months duration; or
* Patient is at known risk of lymphoedema.
* Patient must have tried and failed all available conservative management options before referral to a community based lymphoedema service.

GPs must include evidence of meeting these requirements and confirm before referral to a community based lymphoedema service.

Where children or younger adults present with limb swelling, the GP may wish to refer to the appropriate specialist to exclude diagnosis such as malignant or vascular causes, dependant on the exact clinical picture. If lymphoedema is diagnosed following investigation, these patients should be regarded as high priority by local lymphoedema services, to prevent avoidable deterioration.

Patients who are restricted from having treatment for an unrelated condition that is usually available on the NHS, and has the effect of increasing life-expectancy or quality life years as a direct result of the lymphoedema will be offered treatment for their lymphoedema.

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Monogenetic Diabetes Testing (MODY)** |
| **Status:** | **Individual Prior Approval** |

Monogenetic Diabetes (Maturity Onset Diabetes of the Young) results from the inheritance of a mutation in a single gene, and accounts for 1-2% of the population in the UK with diabetes. Around 90% of cases are misdiagnosed as T1D or T2D

When to suspect a diagnosis of Type 1 may not be correct

* A diagnosis of diabetes before 6 months
* Family history of diabetes with a parent affected
* Evidence of endogenous insulin production outside the ‘honeymoon’ phase with detectable C peptide
* When pancreatic islet autoantibodies are absent, especially if measured at diagnosis

When to suspect a diagnosis of Type 2 may not be correct

* Not markedly obese or diabetic family members who are normal weight
* Acanthosis nigricans not detected
* Ethnic background from a low prevalence Type 2 diabetes race e.g. European Caucasian
* No evidence of insulin resistance with fasting C peptide within the normal range

M&SECCGs commission monogenetic diabetes testing for those patients where the outcome of the test is going to change clinical management.

Funding will be made available for patients where the GP has:

* Identified the test being requested
* Provides a report documenting the outcome of the genetic nurse assessment/discussion with Monogenetic diabetes team in Exeter as to whether patient would benefit from testing and test recommended
* Name of monogenetic nurse with whom the discussion took place with (in case of further contact required)
* Assessment for the patient using the link/calculator and documentation of the outcome: <http://diabetesgenes.org/content/mody-probability-calculator>

Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Myopia – laser eye surgery** |
| **Status:** | **Not Funded** |

M&SECCGs do not commission laser eye surgery for the correction of Myopia.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGS and will not be funded unless there are **exceptional clinical circumstances.**

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Nipple Inversion** |
| **Status:** | **Not funded** |

M&SECCGs do not commission surgery to correct nipple inversion.

Nipple inversion may occur as a result of underlying breast malignancy. If the inversion is newly developed, it requires 2 week wait/urgent referral and assessment.

In all other circumstances; this service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Open/Wide-bore MRI** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission open/wide bore MRIs on a restricted basis.

Funding will only be made available if the patient meets at least one of the criteria below:

* Morbidly obese patients unable to access local MRI services because of their size
* Patients with co-morbidities which mean that the patient will be at significant increased clinical risk if they were to have a standard MRI.

Patients with claustrophobia **are not eligible** for open/wide-bore MRI scans unless either of the above criteria also applies.

It is the responsibility of the referring clinician to provide evidence to support the application. Decisions on funding are made based solely on the information provided.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Orthoses/Orthotics** |
| **Status:** | **Group Prior Approval/Individual Prior Approval** |

M&SECCGs commission assessment and supply of orthoses on a restricted basis.

Referrals for assessment for orthoses will only be accepted in the following circumstances

1. Neurodisability

2. Talipes equinovarus

3. Adolescent tendinopathy at risk of developmental compromise

4. Post operative patients

5. Congenital skeletal abnormality

6. Burns

M&SECCGs do not fund ‘off-the shelf’ orthoses/‘in-shoe’ appliances. Patients who have been funded for ‘off-the-shelf’ /’in-shoe’ orthoses by M&SECCGs in the past will **no longer be funded** on this basis alone.

M&SECCGs only fund customised orthoses for patients with circumstances as listed above and where the clinical needs of a patient cannot be met using an ‘off-the-shelf’ orthoses.

Patients with **structural/flexible flat foot** requiring arch supports/pronation control orthoses **should not be referred** but advised to purchase ‘off-the-shelf’ /’in-shoe’ orthoses if required.

**Cervical Soft Collars**

M&SECCGS does not routinely fund cervical soft collars.

**Lumbar Supports**

M&SECCGs do not routinely fund lumbar support orthoses other than custom moulded back braces when prescribed following consultation with NHS commissioned spinal specialist surgeons for which **individual prior approval is required.**

Funding outside these criteria will only be provided in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Photodynamic therapy for age related macular degeneration** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund Photodynamic therapy for age related macular degeneration.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Pinnaplasty/Otoplasty** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission Pinnaplasty/Otoplasty surgery on a restricted basis.

Patients will be considered for surgery on a case by case basis where both the following criteria are met:

* Patient is aged between 10 and 16 years of age and has expressed concern about their appearance
* There is very significant ear deformity or asymmetry.

**All applications for funding must be accompanied by photographs.**

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Plagiocephaly- Positional** |
| **Status:** | **Not Funded** |

Craniosynostosis, which results from the premature closure of one of more of the cranial sutures, carries a significant risk of raised intracranial pressure, therefore requiring interventional surgery.  **Interventions of craniosynostosis are commissioned by NHS England.**

Nonsynostotic or positional plagiocephaly has not been shown to be associated with any long term developmental problems and treatment has been described as entirely cosmetic.

M&SECCGs do not fund treatments for non-synostotic or positional plagiocephaly

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGS and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Platelet Rich Plasma Injections for Tendinopathy** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund Platelet Rich Plasma (autologous blood) Injections for Tendinopathy

The evidence on autologous blood injection for tendinopathy raises no major safety concerns. However the evidence on efficacy remains inadequate, with few studies available that use appropriate comparators.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**References:**

<https://www.nice.org.uk/guidance/ipg438/>

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| **Policy statement:** | **[Repair of Ear Lobes](#Index)** |
| **Status:** | **Group Prior Approval – Immediate** |
| **Status** | **Not Funded – Post immediate trauma applications** |

M&SECCGs commission surgical repair of ear lobes on a restricted basis.

This is only funded when primary suture post trauma occurs immediately after the time of trauma i.e. the patient is automatically eligible for emergency treatment when he/she presents for repair at A&E at the time of trauma.

**Post immediate trauma applications are not funded.**

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement** | **[Reversal of Sterilisation](#Index)** |
| **Status:** | **Not funded** |

M&SECCGs do not fund reversal of sterilisation in men or women.

Sterilisation procedures are undertaken on the understanding that it is an irreversible procedure. Patients are informed and written consent is sought before the operation is carried out. Provider clinical governance systems should continue to embrace good practice guidelines from the Royal Colleges regarding the giving of information and informed consent prior to sterilisation.

Sterilisation is a procedure by which a person is rendered permanently unable to produce children. This is called a vasectomy in men and operative occlusion of the fallopian tubes in women. Reversal of sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes in women and vas deferens in men.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Rhinophyma** |
| **Status:** | **Not funded** |

M&SECCGs do not fund laser or surgical treatments for Rhinophyma.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **[Riser Recliner Chairs](#RiserRecliner)** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs provide funding for riser recliner chairs on a restricted basis.

In the majority of cases specialist adaptations can be made to fit the existing seating in a patient’s home to achieve correct postural management or pressure relief. It is recognised that not all standard domestic chairs are suitable for adaptations-e.g. pressure relieving overlays may render a chair too high for transfers and that some patients will need to buy suitable standard furniture. Riser recliner chairs are considered to be furniture and are available to purchase from high street stores.

NHS funding for a riser recliner will not usually be made available when there is a profiling bed in-situ or provision planned, or only because a patient has unsuitable furniture, and will not be funded for personal comfort alone. Specialist height adjustments, use of a footstool, posture management or pressure relieving solutions can be added to existing furniture to meet specific needs. Patients with oedematous legs or specific pressure care needs will not automatically be eligible.

M&SECCGs will only fund a riser recliner chair where no other solution can safely meet a genuine healthcare need, so that the patient can sit out for periods of two hours or more and is required to support mobilisation and maintain a level of independence.

It is the responsibility of the applying clinician to provide full information to support the application for funding, demonstrating that the patient:

* has a genuine healthcare need for a riser recliner which cannot be safely met by any other solution, **AND**
* can sit out for periods of two hours or more **AND**
* the riser recliner is required to support mobilisation and maintain a level of independence; **AND**
* the patient agrees to use the chair regularly to optimise their health outcomes.

Applications for funding will be considered on a case by case basis upon receipt of a fully completed proforma.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **[Sacral](#RiserRecliner) Nerve Modulation** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund sacral nerve modulation for any condition.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

N.B. NHS England is the responsible commissioner for sacral nerve stimulation for urinary and faecal incontinence.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Scar revision** |
| **Status:** | **Individual Prior Approval / Not Funded** |

M&SECCGs commission scar revision surgery on a restricted basis only in patients where ALL of the following criteria apply:

* The scarring is a consequence of previous surgery, burns or trauma; **AND**
* The scarring is causing adverse clinical consequences (due to contraction, tethering or recurrent breakdown); significant functional impairment (for example obstruction of orifice or vision); bleeding or suspicion of malignancy; **AND**
* Where clinically appropriate, proactive conservative/’over the counter’ therapies (e.g. almond oil, steroid injections, silicone therapy, pressure garments, medication or massage) aimed at arresting the development of adverse, keloid or hypertrophic scarring have been tried but have not been effective; **AND**
* At least 2 years of the natural healing process has passed

GPs should not refer unless the above criteria apply and referrals must include objective information to demonstrate this.

M&SECCGs do not commission scar therapy e.g. laser or surgery, including skin resurfacing, for any of the categories listed below:

* + Hypertrophic or keloid scars that are not causing adverse consequences or functional impairments (e.g.. keloid scarring after ear piercing)
  + Scarring / ulceration from chronic tattoo breakdowns
  + Post-acne scarring
  + Scars resulting from self-harm
  + Scar treatment for skin rejuvenation or other cosmetic purposes

Photographs will be required to support any application for funding

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**References:**

1. Information for Commissioners of Plastic Surgery Services - Referrals and Guidelines in Plastic Surgery (NHS Modernisation Agency) London

http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2

2 Juckett G, Hartman-Adams H; Management of keloids and hypertrophic scars. Am Fam Physician. 2009 Aug 1;80 (3):253-60. https://www.aafp.org/afp/2009/0801/p253.html

3 Leventhal D et al. Treatment of keloids and hypertrophic scars: a meta-analysis and review of the literature. Arch Facial Plast Surg. 2006 Nov-Dec;8(6):362-8. <http://www.ncbi.nlm.nih.gov/pubmed/17116782?dopt=Abstract>

4 Viera MH et al; Innovative therapies in the treatment of keloids and hypertrophic scars. J Clin Aesthet Dermatol. 2010 May; 3 (5):20-6. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2922716/pdf/jcad_3_5_20.pdf>

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| **Policy statement:** | **Scotopic Sensitivity Syndrome** **(Mears-Irlen Syndrome) and Coloured Filters/Tinted Lenses** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund provision of colorimetry and coloured filters/tinted lenses for specific reading difficulty (SRD), dyslexia, Scotopic Sensitivity Syndrome (SSS), visual stress or Mears Irlen Syndrome. There is insufficient evidence of efficacy on this treatment.

Scotopic Sensitivity Syndrome (SSS) is said to cause visual discomfort in a subgroup of people with dyslexia. It consisted of six major categories of symptoms:

* Photophobia: sensitivity to light.
* Background distortion.
* Visual resolution: the inability to see print clearly and free from distortions.
* Scope of focus: the inability to perceive groups of letters, notes, numerals, or words at the same time.
* Sustained focus: the inability to maintain focus except with the employment of inordinate energy and effort.
* Depth perception/gross motor activities: the inability to judge distance accurately.

Sufferers from SSS are diagnosed by a set of questions constituting the Irlen Differential Perceptual Schedule (IDPS) test and treated with coloured lenses specific to each individual.

An update from the Royal College of Ophthalmologists issued in Autumn 2002 stated that “no scientific evidence to support the existence of such a syndrome has been found. The symptoms elicited by the IDPS are vague and medically would have very little diagnostic significance. Although SSS may not exist, interest in coloured filters or overlays as a treatment for dyslexia has persisted. Much of the literature is uncontrolled or poorly planned, but some good studies have supported it”.

There are no proven documented risks to health for the use of individually prescribed coloured overlays or tinted lenses. Pending further high quality research, provision of coloured filters/tinted lenses for specific reading difficulty (SRD) is considered low priority.

[Coloured filters for reading disability: A systematic review WMHTAC 2008](http://www.birmingham.ac.uk/Documents/college-mds/haps/projects/WMHTAC/REPreports/2008/ColouredfiltersforreadingdisabilityFINALVERSION.pdf)

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Septoplasty** |
| **Status:** | **Individual Prior Approval** |

The nose is partitioned in the middle by the nasal septum, dividing it into two nostrils. The nasal septum is made of cartilage and bone. Sometimes, due to injury or simply because it has grown that way, the septum may be bent, buckled or deviated to one (or both) sides, causing blockage by reducing the area available for air to flow through. The operation of Septoplasty is used to correct this abnormality in order to allow air to pass through either nostril more easily

Rhinoplasty aims to improve the cosmetic appearance of the nose. When rhinoplasty is performed in combination with septoplasty it is called septorhinoplasty. Nasal surgery to improve cosmetic appearance of the nose, including Rhinoplasty and Septorhinoplasty, is not routinely funded by M&SECCGs-see Aesthetic Facial Surgery

Primary care must obtain **prior approval** before referring patients to secondary care providers and secondary care providers must satisfy themselves that the patient has funding secured prior to seeing the patient. This is to ensure inappropriate out-patient appointments are avoided and patient expectations are properly managed.

NB: This policy does not apply to:

* Immediate post trauma nasal manipulation which normally occurs two to three weeks after the trauma and not restricted.
* To facilitate sinus surgery access

M&SECCGs commissions septoplasty on a restricted basis for which **individual prior approval** is required.

Requests for septoplasty will be considered where the patient has:

* A deviated septum causing significant and persistent nasal blockage. This includes post-traumatic nasal injury associated with septal/bony deviation of the nose which is causing significant and persistent nasal blockage.

**OR**

* Nasal deformity secondary to a congenital craniofacial deformity causing significant functional impairment-

**OR**

* Part of reconstructive head and neck surgery.

Septorhinoplasty will only be funded when a septoplasty alone will not improve functional impairment.

Note: Cleft lip/palate patients are funded through NHS England commissioned Cleft Lip/Palate clinical management pathway and not funded by M&SECCGs.

M&SECCGs will not approve funding for patients who are unhappy with the outcome of previous surgeries including immediate post-trauma corrections (whether provided by the NHS or private providers) or for snoring unless they meet the criteria above.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Skin contouring/Body contouring/ Liposuction/Tumescent Liposuction/Liposculpture** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund liposuction/tumescent liposuction/liposculpture/skin contouring surgical procedures except apronectomy/abdominoplasty in defined circumstances- see separate policy.

Body contouring is any procedure that alters the shape of different areas of the body to reduce excess skin or remove fat.

Liposuction, which is sometimes known as liposculpture, is the removal of unwanted body fat using a surgical vacuum and is a form of cosmetic surgery.

Skin excision for contouring including the lifting of buttock, arm and/or thigh is regarded as a cosmetic procedure and as such is not funded.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Sleep Studies including Diagnostic Investigations and Treatments for Obstructive Sleep Apnoea/Hypopnoea Syndrome (OSAHS) in Adults** |
| **Status:** | **Individual Prior Approval** |
| **Status** | **Not Funded – Surgical Procedure for OSAHS** |
| **Status** | **Not Funded – Snoring – see separate policy** |

M&SECCGs commission sleep studies for adults (over 18 years of age) with suspected sleep apnoea, complex sleep disorders or where necessary to confirm a diagnosis of narcolepsy.

NHS England commissions sleep studies for children and young people from Specialist Paediatric Respiratory Centres.

**Oral Appliances/Mandibular Advancement Devices**

Oral appliances have been shown to improve OSAHS and, in comparison with continuous positive airway pressure (CPAP), no conclusive difference in daytime sleepiness was shown. There is large cost, convenience, and adherence implications for the use of CPAP and, for some patients, oral appliances may be of benefit. Therefore, oral applications (self-funded) should be promoted in primary care to avoid where possible the need for CPAP**.**

**Driving**

It is the responsibility of people who are sleepy during the day (regardless of the cause) to cease driving until their symptoms resolve. If the symptoms are severe enough to affect driving performance and are due or very likely due to a medical condition (including OSAHS) the driver must inform the DVLA. Although clinicians are not required to inform the DVLA about the patient’s symptoms, they are responsible for advising the patient appropriately.

Vocational drivers of Heavy Goods Vehicles (HGVs) or Public Service Vehicles (PSVs) meeting the referral criteria of this policy may be referred for investigation with oximetry/polysomnography without attempted lifestyle modification and, if diagnosed with OSAHS at any level of severity may be offered oral devices or CPAP as initial options. For vocational drivers, if a diagnosis of OSAHS has been made or is strongly suspected adequate symptom control should be confirmed by a specialist before driving resumes and annual licensing review is required.

**Limited Sleep Studies**

M&SECCGs commission limited sleep studies (pulse oximetry) for patients with suspected sleep apnoea where other causes of day time sleepiness have been excluded e.g. insufficient sleep, psychological conditions and sedating drugs.

If obstructive sleep apnoea is suspected the patient should have attempted lifestyle modification i.e. weight loss, stop smoking, reduce alcohol consumption- as appropriate **before referral.**

The following criteria must be met prior to referral for limited sleep studies:

* Patient ≥ 18
* Patient snores
* Daytime sleepiness (rather than tiredness) assessed by Epworth scale with score ≥11

**AND** one or more of the following

* + Witnessed regular or frequent nocturnal apnoeic episodes of stopping breathing
  + Waking with sensations of choking/obstruction
  + Neck circumference ≥17ins in a man or > 15ins in a woman
  + Significant retrognathia
  + Small oedematous pharynx on visual inspection

**Polysomnograpy**

Patient has ≥5 <15 hyponea events/hour per night measured by pulse oximetry

**OR**

Patients who have typical symptoms of excessive daytime somnolence but no objective evidence of obstructive sleep apnoea on limited sleep study.

**OR**

Patient has suspected narcolepsy and confirmation of diagnosis is required.

M&SECCGs do not commission surgical procedures for OSAHS.

M&SECCGs do not commission sleep studies for parasomnia, periodic limb movement disorder, chronic insomnia or snoring.

M&SECCGs do not commission procedures for snoring where this is the sole problem- see [Snoring](#SnoringandsnoringENTreferrals)

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Snoring and Snoring ENT referrals** |
| **Status:** | **Not Funded / Group Prior Approval** |

**Snoring**

M&SECCGs do not fund procedures for simple snoring where this is the sole problem. This includes but is not limited to surgical procedures and related treatments in adults to remove, refashion or stiffen the tissues of the soft palate.

Surgical interventions and related treatments for simple snoring **will not be funded**: Such interventions include, but may not be limited to, the following:

Uvulopalatopharyngoplasty (UP3 or UPPP)

Laser assisted uvulopalatoplasty (LAUP)

Radiofrequency ablation (RFA)

Soft palate implants

If associated with sleep apnoea - see Sleep Studies

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

**Snoring ENT referrals**

**In circumstances where a cancer is suspected, the 2 week wait referral process should be used.**

A referral for an assessment to exclude other sinister pathology will be funded when all the following conservative measures have been tried prior to referral

* Weight reduction if BMI is over 35
* Use of therapies such as nasal sprays or strips
* Use of ear plugs whilst asleep
* Reduction of alcohol
* Stop smoking
* Self-training to alter their sleep position to avoid lying on their back. Please indicate in any referral, how the patient has altered sleep position
* Use of a mandibular device (not funded by the NHS)

See also Septoplasty, Facial Aesthetic-Rhinoplasty and Snoring Value Based Commissioning Policies.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Sperm, Embryo or Oocyte Cryopreservation** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission Sperm, Embryo or Oocyte cryopreservation on a restricted basis.

Funding for fertility preservation will be offered to patients who have a disease or a condition requiring *urgent medically necessary treatment* that has a significant likelihood of making them infertile and those whose medical treatment may compromise fertility.

The following fertility preservation methods will be considered for funding:

• Sperm retrieval and cryo-storage

• Ovarian stimulation, egg collection and either egg or embryo cryo-storage

The following fertility preservation methods will be considered for funding: -

* Sperm retrieval and cryostorage
* Ovarian stimulation. egg collection and either egg or embryo cryostorage

Patients must meet the following criteria:

* Commenced puberty and be aged up to 43 years old.
* Women need to be well enough to undergo ovarian stimulation and egg collection but this should not worsen their condition and sufficient time is available prior to starting treatment.

Embryo or oocycte cryostorage will not be available where a woman:

* Chooses to undergo medical or surgical treatment whose primary purpose is that it will render her infertile, such as sterilisation
* Requests cryostorage for personal lifestyle reasons, such as wishing to delay trying to conceive.

One cycle of egg collection and up to two separate collections of semen will be funded.

Surgical sperm recovery is not funded.

At the time of fertility preservation treatment, patients **do not need** to demonstrate they comply with the criteria below (although where applicable patients must meet criteria in force at the time for subsequent IVF treatment);

1. be a non-smoker
2. have a BMI between >19 - <30
3. have a documented history of unexplained infertility

Fertility preservation treatment must take place prior to the treatment likely to affect fertility.

M&SECCGs will fund storage of embryo, eggs and sperm (whose harvest was funded under this policy)

* + until the age of 25 if harvested before 20th birthday
  + for 5 years if harvested between her 20th and 38th birthday
  + until 43rd birthday if harvested after the age of 38
  + six months post a live birth (as a result of either stored material or natural conception)

Patients can choose to fund storage themselves beyond the NHS funded period.

If the patient dies whilst their embryos, eggs and sperm are in storage the CCGs will only fund storage 3 months from the date of the person dying. Extended storage beyond this time may be funded privately if applicable.

If the person is already deceased the 3 months commences on 1 August 2018.

**NHS Funding for use of stored material for assisted conception** in line with patient’s CCG policy. Any further costs e.g. use of sperm/oocytes in private fertility treatment or transport to another clinic etc would need to be met by the patient.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

*It should be noted that M&SECCGs are not the responsible commissioner for Pre-implantation Genetic Diagnosis and associated IVF/ICSI. This service is commissioned by NHS England.*

*Specialist fertility services for members of the Armed Forces are commissioned separately by NHS England.*

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| **Policy statement:** | **Spinal Cord Stimulators** |
| **Status:** | **Not funded** |

M&SECCGs do not fund spinal cord stimulators.

Patients requiring spinal cord stimulators, including previously managed patients requiring e.g. battery changes should be referred to an NHS England commissioned specialised pain centre.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**References:**

Ref: Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin

NICE technology appraisal guidance [TA159] Published date: October 2008

<https://www.nice.org.uk/guidance/ta159>

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| **Policy statement:** | **Spinal Injections for Low Back Pain and Radicular Leg Pain** |
| **Status:** | **Therapeutic/Low Back Pain – Not funded** |
| **Status:** | **Therapeutic/Radicular – Individual Prior Approval** |
| **Status:** | **Diagnostic – Individual Prior Approval** |
| **Status:** | **Radiofrequency Denervation – Individual Prior Approval** |

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M&SECCGs commission spinal injections on a restricted basis.

**Non specific low back pain**

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

Spinal injections include:

* Facet joint injections
* Therapeutic medial branch blocks
* Intradiscal therapy
* Prolotherapy
* Trigger Point Injections with any agent, including botulinum toxin
* Any other spinal injections not specifically mentioned above

Epidural, sacro-iliac and nerve root injections are **not funded** for the treatment of non-specific low back pain.

**Epidural, sacro-iliac and nerve root injections for radicular leg pain - Individual Prior Approval**

Epidural, sacro-iliac and nerve root injections for radicular leg pain (caudal epidural, lumbar epidural, transforaminal epidural or nerve root injections) will only be funded in accordance with the criteria specified below. Nerve root injections should only be performed under imaging.

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

OR

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

AND

* Moderate to severe and persistent radicular leg pain despite participation in comprehensive back pain programme (e.g. analgesia, physical therapy, modified activity, etc.).

Under these circumstances, a total of **up to two injections** will be funded per episode. The interval between two injections must be at least 6 months. Individual prior approval is required for each injection.

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

**Diagnostic assessment - Individual Prior Approval**

Medial branch blocks are only commissioned for diagnostic assessment when **one procedure will be funded for one particular level or side** in each patient being assessed for radiofrequency denervation/surgical management of chronic spinal pain e.g. neck pain; low back pain; leg pain. Patients must have had the pain for more than one year and other conventional options have failed to resolve the pain (oral analgesics and physiotherapy).

Diagnostic assessment for radiofrequency denervation for chronic non-specific low back pain will only be funded if the following criteria (which apply to radiofrequency denervation) are met:

* Comprehensive non-surgical treatment as stated above including community pain pathway has not been successful

AND

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

AND

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

Progression to medial branch block radiofrequency denervation will only be commissioned (funded) where there is evidence of pain relief of ≥80% at time of the medial branch block injection and the pain starts to recur within 72 hours.

**Radiofrequency denervation (rhizolysis) - Individual Prior Approval**

The procedure called ‘radiofrequency denervation’ involves sealing off some of the nerves to the joints of the spine to stop the nerves transmitting pain signals. It aims to achieve longer-term pain relief and allow rehabilitation in people with spinal pain who experience significant but short-term relief after a diagnostic block by injection of local anaesthetic.

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

* Comprehensive non-surgical treatment including community pain pathway has not been successful

AND

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

AND

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

AND

* Positive response to a diagnostic medial branch block.

AND

* The interval to the last radiofrequency denervation (in the same location) must be at least 12 months

Funding for patients not meeting the condition and relevant criteria set out above will not be granted unless there are clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**Reference:**

[Low back pain and sciatica in over 16s: assessment and management NICE guideline [NG59] Published date: November 2016](https://www.nice.org.uk/guidance/NG59/chapter/Recommendations)

**Do not offer** spinal injections for managing low back pain.

**Do not offer** ultrasound for managing low back pain with or without sciatica.

**Do not offer** PENS for managing low back pain with or without sciatica.

**Do not offer** TENS for managing low back pain with or without sciatica.

**Do not offer** interferential therapy for managing low back pain with or without sciatica.

**Do not offer** traction for managing low back pain with or without sciatica.

**Do not offer** belts or corsets for managing low back pain with or without sciatica.

**Do not offer** foot orthotics for managing low back pain with or without sciatica.

**Do not offer** rocker sole shoes for managing low back pain with or without sciatica

**Do not offer** disc replacement in people with low back pain.

**Do not offer** spinal fusion for people with low back pain unless as part of a randomised controlled trial.

National Back Pain and Radicular Pain Pathway <https://docs.wixstatic.com/ugd/dd7c8a_caf17c305a5f4321a6fca249dea75ebe.pdf>

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| **Policy statement:** | **Spinal Surgery for Non-Acute Lumbar Conditions** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs commission spinal surgery for non-acute lumbar conditions on a restricted basis.

Funding will only be available under the following circumstance:

* Surgical discectomy (standard or microdiscectomy) in selected patients with sciatica secondary to disc prolapse where conservative management for at least 4-6 weeks has failed.

or

* Lumbar decompression for sciatica with nerve root compression or severe central spinal stenosis with claudication symptoms in one of both legs.

M&SECCGs do not accept requests to fund spinal surgery for low back pain.

[NICE Guidance- Low back pain and sciatica in over 16s: assessment and management (2016)](http://pathways.nice.org.uk/pathways/low-back-pain-and-sciatica)

M&SECCGs will not fund and therefore advises that clinicians:

**Do not offer** spinal injections for managing low back pain.

**Do not offer** ultrasound for managing low back pain with or without sciatica.

**Do not offer** PENS for managing low back pain with or without sciatica.

**Do not offer** TENS for managing low back pain with or without sciatica.

**Do not offer** interferential therapy for managing low back pain with or without sciatica.

**Do not offer** traction for managing low back pain with or without sciatica.

**Do not offer** belts or corsets for managing low back pain with or without sciatica.

**Do not offer** foot orthotics for managing low back pain with or without sciatica.

**Do not offer** rocker sole shoes for managing low back pain with or without sciatica

**Do not offer** disc replacement in people with low back pain.

**Do not offer** spinal fusion for people with low back pain unless as part of a randomised controlled trial.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Surrogacy** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund surrogacy.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Tattoo Removal** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund procedures for the removal of tattoos.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGS and will not be funded unless there are **exceptional clinical circumstances.**

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Temporomandibular Joint Replacement** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund temporomandibular joint replacement.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGS and will not be funded unless there are **exceptional clinical circumstances.**

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Temporomandibular Joint (TMJ) Retainers and Appliances** |
| **Status:** | **Group Prior Approval** |

M&SECCGs fund TMJ retainers and appliances on a restricted basis only when used within specialist services e.g. management of patients with head and neck cancers and funded as part of national tariff. e.g. Therabite.

These appliances will not be separately funded. GPs should not accept requests to prescribe such appliances on FP10s. Supplies to patients will be made by specialist services.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Tinnitus** |
| **Status:** | **Group Prior Approval** |

M&SECCGs provide funding for investigation of tinnitus on a restricted basis.

Investigation is funded if the patient has:

* unilateral tinnitus or pulsatile bilateral tinnitus for over 2 months,
* bilateral or central tinnitus with hearing loss for over 2 months
* intrusive bilateral or central tinnitus without hearing loss for over 6 months

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Tonsillectomy/Adenoidectomy** |
| **Status:** | **Individual Prior Approval** |

**Suspected or confirmed malignancy – should be referred via a two week pathway. Tonsillectomies required as part of treatment for malignancy do not need prior funding approval. No prior approval required for patients with tonsillar asymmetery or diagnostic tonsillectomy for suspicion of cancer.**

M&SECCGs commission tonsillectomies on a restrictive basis for those patients who meet criteria as outlined in SIGN Guidance 117 (April 2010) or one of the conditions listed below:

**Individual prior approval for funding is required in all cases**. GPs should not refer unless the criteria below have been met, and referrals must include objective information to demonstrate this.

**A period of 6 months watchful waiting by the GP** is recommended prior to tonsillectomy to establish firmly the pattern of symptoms and allow the patient to consider fully the implications of operation. For recurrent tonsillitis in children <16 years old, before referral to secondary care, the GP should discuss with patient/parents or carers the benefits and risks of tonsillectomy vs. active monitoring. Sign post patients to relevant information and reassurance given if no further treatment or referral for tonsillectomy is deemed necessary at this stage. The Right Care Shared Decision Aid for recurrent sore throats should be used



(http://sdm.rightcare.nhs.uk/pda/).

This discussion should be documented.

**Patients must meet the following criteria:  
(the answers to 1 and 2 must be ‘Yes’ and then the answer to any one criteria 3-6 must be ‘Yes’):**

1. Sore throats that are due to acute tonsillitis

**AND**

1. Episodes of sore throat that are disabling and prevent normal functioning

**AND**

1. Seven or more well documented clinically significant, adequately treated sore throats in the preceding year.

**OR**

1. Five or more such episodes in each of the preceding two years.

**OR**

1. Three or more such episodes in each of the preceding three years.  
   **OR**
2. Failure to thrive in paediatric patients where recurrent tonsillitis is considered a contributory factor.

**OR**

**the patient should have one of the following conditions:**

* intractable cough with a high level of streptococcal antibody for longer than one year-test results to be included with referral;
* severe halitosis which has been demonstrated to be due to tonsil crypt debris for longer than one year (diagnosed by an ENT surgeon).
* peritonsillar abscess not responding to antibiotics and incisional drainage.

ME&SCCGs commission tonsillectomy with or without concurrent adenoidectomy for Obstructive sleep apnoea (OSA) in

* adults who has been diagnosed by sleep study/overnight polysomnography, in the presence of large tonsils-see also Sleep Studies policy
* children where OSA is demonstrated by sleep study or diagnosed clinically in the presence of excessively large tonsils and adenoids with documented evidence of failure to thrive as assessed using NICE guidance NG75.

**Adenoidectomy as a separate procedure will not be funded**. See also Grommets.

Once a decision is made for tonsillectomy, this should be performed as soon as possible, to maximise the period of benefit before natural resolution of symptoms might occur (without tonsillectomy).

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding for these procedures can be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**Rationale**

This policy has been developed using the criteria within the Royal College of Surgeons commissioning guide for tonsillectomy. Evidence for the benefits of tonsillectomy is poor. In children surgery may be beneficial in selected cases. In adults, limited evidence suggests that tonsillectomy may benefit people with recurrent infection. (NICE evidence summaries).

The potential benefits of tonsillectomy in reducing recurrent or chronic throat infection need to be weighed against complications and operative risks and the possibility that the throat infections may resolve without intervention (watchful waiting). A period of watchful waiting is more appropriate for children with mild sore throats (SIGN 2010).

The Royal College of Surgeons advise that before referral to secondary care a discussion should take place of the benefits and risks of tonsillectomy vs. watchful waiting for both recurrent tonsillitis and sleep disordered breathing. Information to be provided and reassurance given if no further treatment or referral for tonsillectomy is deemed necessary at this stage. This discussion should be documented (Royal College of Surgeons 2013).

For recurrent tonsillitis in children <16 years old the Right Care Shared Decision Aid for recurrent sore throats should be used before referral into secondary care (<http://sdm.rightcare.nhs.uk/pda/>).

Information to be provided and reassurance given if no further treatment or referral for tonsillectomy is deemed necessary at this stage. This discussion should be documented (Royal College of Surgeons 2013).

The impact of recurrent tonsillitis on a patient’s quality of life and activities of daily living should be taken into consideration. A fixed number of episodes, as described above, may not be appropriate for adults with severe or uncontrolled symptoms, or if complications (e.g. quinsy) have developed (Royal College of Surgeons 2013).

There is a lack of published evidence demonstrating the benefit of performing tonsillectomy for the treatment of tonsilloliths (evidence review April 2015) and therefore this has not been included as an indication for tonsillectomy

**References**:

SIGN guidance

Commissioning guide:Tonsillectomy

<https://www.entuk.org/sites/default/files/files/ENT%20UK%20Tonsillectomy%20revised%20commissioning%20guide%202016%20PUBLISHED.pdf>

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| **Policy statement:** | **Lens Implants – Astigmatism** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund toric intraocular lens implants as there is insufficient evidence to demonstrate safety, clinical and cost effectiveness. Toric IOLs refer to astigmatism correcting intraocular lenses used at the time of cataract surgery to decrease post-operative astigmatism. The Toric IOLs are the so called ‘premium lens’ however these come at a greater cost than the standard.

The standard IOLs design used for cataract surgery in the NHS is the monofocal IOLs. Intraocular lens implants for cataracts will continue to be commissioned in accordance with the Cataracts SRP.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances**.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Transcranial Magnetic Stimulation** |
| **Status:** | **Not Funded** |

M&SECCGs do not fund Transcranial Magnetic Stimulation for any indication.

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Trigger Finger** |
| **Status:** | **Individual Prior Approval** |

Surgery for trigger finger is commissioned by M&SECCGs on a restricted basis. Cases will only be funded if they meet the criteria below:

* Patients who experience interference with activities of daily living or significant pain.

**AND**

* Who fail to respond to all appropriate conservative1 treatments for a minimum of 6 months.

**OR**

* Patients who have had 2 other trigger digits unsuccessfully treated with non-operative methods
* The finger is permanently locked in the palm

Conservative1 treatments include:

* Reassurance – up to 83% have been found to resolve spontaneously after a few months.
* Steroid injections – 50-80% will resolve after a single injection and a second injection should be carried out after 6 weeks if no response to first injection. Patients should not be referred until they have tried two steroid injections unless contra-indicated. An interval of 6 weeks should elapse before surgery is considered.

For audit purposes, the referral letter and hospital records must include evidence that the patient meets the criteria, including the dates of the corticosteroid injections and any other conservative management.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Vaginal/Uterine Prolapse** |
| **Status:** | **Individual Prior Approval** |

M&SECCGs will only fund surgical interventions for Uterovaginal Prolapse in the following circumstances:

* In cases of mild to moderate symptomatic cystoceles where trial of a pessary has failed.
* In cases of mild to moderate symptomatic rectoceles.
* In severe cases of prolapse or precedentia

Initially, patients should be assessed and managed conservatively in primary care. **Also refer to sections below on vaginal pessaries and surgery.**

1. **Watchful waiting**, with observation for the development of new symptoms or complications is appropriate if the prolapse is minimal (Stage I), or asymptomatic

2. **Conservative treatment options**

2.1 Lifestyle modification

* Treatment of conditions that increase intra-abdominal pressure: constipation, chronic cough, overweight/obesity; reduction of heavy lifting (while POP has been associated with these factors, the role of lifestyle modification in prevention/treatment has not been investigated)

2.2. Pelvic floor muscle exercises

* Role in managing prolapse unclear; probably not useful if the prolapse ex ends to or beyond the vaginal introitus.
* Cochrane review 2006: concluded evidence was insufficient (from 3 randomised trials) to judge the value of conservative management of POP, & that further trials were needed
* The pilot study for the Pelvic Organ Prolapse Physiotherapy (POPPY) multi-centre trial suggested that pelvic floor muscle training delivered by a physiotherapist to symptomatic Stage I or II POP women in an outpatient setting may reduce the severity of prolapse

Local (vaginal) oestrogen creams and oral treatments-For information on criteria for funding, please see the Medicines Optimisation section of M&SECCGs websites.

3. **Vaginal pessary insertion** – those participating in active vaginal intercourse should be offered surgery once occult urodynamic stress incontinence has been explored.

* Cochrane review 2004: no RCTs of pessary use in women with prolapse; there is no consensus on the use of different types of device, the indications, nor the patterns of replacement & follow-up care; evidence or pessary selection and management is incomplete so trial and error, expert opinion, and experience remain the best guides for use and management of the pessary
* Although not supported by definitive evidence, current opinion is that pessaries are effective1 & should be considered before surgery in women who have symptomatic prolapse; they can be attempted in all POP cases irrespective of stage
  + For short-term relief before surgery, or in the long-term if surgery is not wanted or recommended
  + To predict surgical outcomes or unmask occult urodynamic stress incontinence before surgery, as part of the investigation of continent women with POP (so that the decision to perform a concomitant continence procedure along with pelvic reconstruction can then be individually tailored)
* Risk factors for unsuccessful fitting include: short vaginal length <6 cm and wide introitus fingerbreadths; local oestrogens may play a role in successful fitting
* Failure to retain the pessary has been associated with increasing parity and previous hysterectomy; and discontinuation with history of hysterectomy or prolapse surgery, and stress incontinence;
* Follow-up: no clear consensus on how often to follow up1 ; after 3 months & then every 6 months, if there are no complications, has been suggested;
* Complications tend to occur in women who are not regularly followed up1; self- care of pessary is also important to minimise adverse events16; however, many patients find insertion & removal of most pessary types challenging

4. **Surgery -** those participating in active vaginal intercourse should be offered use of pessaries prior to surgical intervention for those women who have symptomatic prolapse. Or to unmask occult urodynamic stress incontinence before surgery **Refer to section on use of vaginal pessaries above**

* Assessed as effective, but with a close risk/benefit in mild cases; a combination of procedures may be required and reoperation is required in 29% of cases
* Types of repair surgery vary depending on type of POP & associated symptoms, whether the woman is sexually active & her fitness for surgery

4.1. Reconstructive surgery (abdominal or vaginal approach)

* 2010 Cochrane review of surgical management of POP: found 40 RCTs with a variety of types of POP5
  + - There was not enough evidence on most types of common prolapse surgery nor about the use of mesh or grafts in vaginal prolapse surgery
    - Impact of POP surgery on bowel, bladder and sexual function can be unpredictable and may make symptoms worse or result in new symptoms such as leakage of urine (unmask occult SI) or problems with intercourse
    - Uterine/vaginal vault prolapse: abdominal sacral colpopexy may be better than vaginal sacrospinous colpopexy – it was associated with a lower rate or recurrent vault prolapse and dyspareunia; these benefits must be balanced against a longer operating time, longer time to return to activities of daily living and increased cost of the abdominal approach
    - Posterior vaginal wall prolapse/rectocele: posterior vaginal wall repair may be better than transanal repair in terms of recurrence of prolapse (limited evidence)
    - Value of the addition of a continence procedure to a prolapse repair operation in women who are dry before operation remains to be assessed
    - Use of mesh/graft inlays (synthetic):
    - 2010 Cochrane review: use of mesh or grafts at the time of anterior vaginal wall repair reduces the risk of recurrent anterior wall prolapse on examination; however, evidence of benefit to the woman, including symptoms and quality of life improvement, is lacking for the use of grafts over native tissue repairs
    - 2008 NICE guidance: surgical repair of vaginal wall prolapse using mesh

4.2 Obliterative Surgery

* Corrects POP by moving the pelvic viscera back into the pelvis & closing of the vaginal canal; vaginal intercourse is no longer possible

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| **Clinical scenarios where surgery**  **will not be routinely funded** | **Clinical scenarios where referral for**  **specialist assessment is necessary to**  **determine suitability for surgery** |
| Asymptomatic pelvic organ prolapse | Failure of pessary |
| Mild pelvic organ prolapse (unless  combined with urinary/faecal  incontinence) | Women with symptomatic prolapse (including those combined with urethral sphincter incompetence or faecal incontinence) |
|  | Prolapse combined with urethral sphincter  incompetence/ urinary incontinence or faecal  incontinence |
| Women with moderate to severe prolapse who want definitive treatment |

**Recommendations**

* Initially, patients should be assessed and managed conservatively in primary care
* All patients should have a trial of ring pessary, including suitable candidates for surgery, as part of the investigation of continent women with prolapse; the decision to perform a concomitant continence procedure along with pelvic reconstruction can then be individually tailored

**Patient information:**

<http://www.nhs.uk/conditions/Prolapse-of-the-uterus/Pages/Introduction.aspx> Policy (continued) Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Vagus Nerve Stimulation** |
| **Status:** | **Not Funded** |

Vagus nerve stimulation (VNS) is a medical treatment that involves delivering electrical impulses to the vagus nerve. It is used as an add-on treatment for certain types of intractable epilepsy and treatment-resistant depression. More recently, it has been used to treat headaches.

**M&SECCGs do not fund vagus nerve stimulation for any indication.**

This service/procedure has been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**The East of England Priorities Advisory Committee (PAC) Statement - May 2019**

gammaCore® vagus nerve stimulator for the treatment of headaches

**PAC interim recommendations**

* Commissioning of gammaCore® for any indication is not currently recommended
* Recommendations will be reviewed on publication of new NICE guidance and/or further information on proposed NHS England funding route.

**Key points:**

* gammaCore® is a handheld, patient-controlled, non-invasive vagus nerve stimulator approved for use for primary headache (migraine, cluster headache and hemicrania continua) and medication overuse headache in adults.
* In May 2019, NHS England announced that funding will be made available for gammaCore® for the treatment of cluster headaches, as part of The [NHS Long Term Plan](https://www.longtermplan.nhs.uk/). The innovation is being funded as part of a scheme to fast track specific innovations into the NHS. No details were published alongside the announcement describing how the funding would be made available.
* NICE published a Medtech Innovation Briefing [MIB 162] in October 2018, and gammaCore® for cluster headache and an Interventional Procedures Guidance [IPG 552], Transcutaneous stimulation of the cervical branch of the vagus nerve for cluster headache and migraine, in March 2016
* NICE are developing Medical technology guidance for gammaCore® for cluster headache which is expected to be published in November 2019.
* The clinical and cost effectiveness and place in therapy of this technology has yet to be established, therefore commissioning of gammaCore® is not currently recommended for any indication.
* These recommendations will be reviewed on the publication of new NICE guidance or further information on proposed NHS England funding route.

**References**

1. NICE Medical technology guidance gammaCore for cluster headache [GID-MT523]. Final scope. Expected publication date: 22 November 2019

<https://www.nice.org.uk/guidance/indevelopment/gid-mt523>

1. gammaCore® website <http://gammacore.co.uk/>
2. NICE Interventional procedures guidance [IPG552] Transcutaneous stimulation of the cervical branch of the vagus nerve for cluster headache and migraine. Published March 2016 <https://www.nice.org.uk/guidance/ipg552>
3. gammaCore® for cluster headache Medtech Innovation Briefing [MIB162] Published October 2018

<https://www.nice.org.uk/advice/mib162>

1. NHS England press release 7th May 2019 <https://www.england.nhs.uk/2019/05/nhs-funds-handheld-headache-busting-device-as-part-of-long-term-plan/>
2. Electronic drug tariff. NHS Business Services Authority. Accessed 20/05/2019 <http://www.drugtariff.nhsbsa.nhs.uk/#/00446515-DC_2/DC00446511/Home>
3. National tariff payment system 2019/2020. Annex A: The national tariff workbook. <https://improvement.nhs.uk/resources/national-tariff/#h2-annexes>

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| **Policy statement:** | [**Varicose Veins**](#Index) |
| **Status:** | **Individual Prior Approval** |

Conservative management is the first line of treatment and applications will not normally be accepted without evidence that conservative management of asymptomatic and symptomatic varicose veins has been tried, and failed, for a period of at least six months.

Prior to consideration for intervention patients should be given information regarding

* Weight loss if they have a raised BMI
* Light to moderate physical activity
* Avoiding factors which are known to make their symptoms worse, if possible
* Use of compression stockings for a 6 month duration, where this is considered appropriate
* When and where to seek further medial help

**M&SECCGS commissions treatment or surgery for varicose veins on a restrictive basis.**

**Funding for treatment or surgery will only be made available for Grade III and above Varicose Veins.**

**Grade III: Varicose veins with complications, including bleeding, recurrent phlebitis or eczema.**

* Patients who have had bleeding associated with varicose veins should be referred urgently.
* Patients with recurrent thrombophlebitis and persistent varicose veins may be referred, especially if phlebitis has affected veins above the knee.
* Patients with eczema near the ankle or associated with varicose veins below the knee should be referred for specialist advice.

*VARICOSE ECZEMA STASIS GRAVITATIONAL ECZEMA*

Interventional treatment should be in line with NICE guidance which identifies endothermal ablation as the first line intervention where suitable.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

**References:**

*In drafting this policy it was noted that NICE CG 168 recommends that all symptomatic varicose veins should be referred for investigation and, where appropriate, treatment. Current resources cannot meet the demand that this would generate either in commissioning costs or in the capacity to undertake Doppler examinations etc. This policy is intended as a holding position until resources are available and the required pathway and contracting changes have been made to enable full adoption of NICE CG 168.*

[*http://www.nice.org.uk/guidance/CG168/chapter/introduction*](http://www.nice.org.uk/guidance/CG168/chapter/introduction)

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| **Policy statement:** | **Vision Therapy/Vision Training/Behavioural Optometry** |
| **Status:** | **Not Funded** |

M&SECGGs do not fund provision of vision therapy, behavioural optometry or vision training, including for the following conditions.

* exotropia (eye deviates outward)
* nystagmus (involuntary movement of the eyeballs)
* dyslexia and other learning and reading disabilities
* learning disability or language disorder including developmental delay

If the cause of the condition is orthoptic e.g amblyopia (lazy eye), patients should be assessed and treated with orthoptic treatment by Orthoptists as part of commissioned services within the CCGs.

Vision therapy may also be referred to as eye exercise therapy, visual therapy, visual training, vision training, or optometric vision therapy. Vision therapy may include elements of a wide range of optometric treatment modalities, with the therapeutic goal of correcting or improving specific dysfunctions of the vision system. This may include the use of special lenses, prisms, filters, and other appropriate materials, methods, equipment, and procedures, including eye exercises and behavioural modalities that are used for eye movement and fixation training to eliminate or improve conditions.

Vision therapy has been assessed as a Low Clinical Priority by the CCGs and will not be funded unless there are **exceptional clinical circumstances.**

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.

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| **Policy statement:** | **Wigs and Hair Pieces/Hair Systems/Transplantation** |
| **Status:** | **Wigs and Hair Pieces – as per National Regulations** |
| **Status:** | **Hair Systems/Transplantation – Not Funded** |

Wigs are available on the NHS, but patients will be charged for them unless they qualify for help with charges. <http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Wigsandfabricsupports.aspx>

Hair pieces and wigs for patients experiencing total or severe hair loss as a result of alopecia totalis, cancer treatment, previous surgery or trauma, are available from local NHS Trusts within tariff through commissioned pathways.

Patients requiring reconstruction of the eyebrow following cancer or trauma will be treated within existing contracts.

M&SECCGs do **not fund** treatments for the correction of male or female pattern baldness as it is a normal process of ageing.

M&SECCGs do **not fund** hair transplantation or the use of the ‘Interlace’ or other hair systems, regardless of gender. Patients who were initially funded by the NHS will not be funded for ongoing maintenance and support

These services/procedures have been assessed as a **Low Clinical Priority** by M&SECCGs and will not be funded unless there are **exceptional clinical circumstances.**

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Applications for funding in such circumstances should be made to the Exceptional Case Team but should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs’ website.