Procedures of Lower Clinical Value

Procedures of Lower Clinical Value Policy

Walsall Clinical Commissioning Group

April 2019

Name of Responsible Board /Committee for Ratification: Walsall CCG Commissioning Committee

Date Issued: 2019 v1.0

Review Date: April 2020

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<th>Type of Change</th>
<th>Date</th>
<th>Description of change</th>
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<tr>
<td>0.1</td>
<td>Update - D. Whatton</td>
<td>07/02/19</td>
<td>Replacement of 17 existing procedures in policy with NHSE Evidence Based Interventions;</td>
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<td>1. Surgery for Snoring</td>
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<td>2. D&amp;C for HMB</td>
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<td>3. Knee Arthroscopy</td>
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<td>4. Joint injection-non-specific Back Pain</td>
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<td>5. Breast reduction</td>
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<td>6. Removal of Benign Skin Lesions</td>
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<td>(small amendment to NHSE wording to make policy clearer; ref: NHSE email 3/5/19)</td>
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<td>7. Grommets</td>
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<td>8. Tonsillectomy</td>
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<td>9. Haemorrhoids</td>
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<td>10. Hysterectomy for HMB</td>
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<td>11. Chalazia removal</td>
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<td>12. Shoulder Decompression</td>
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<td>13. Carpal Tunnel syndrome release</td>
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<td>14. Dupuytren’s Contracture release</td>
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<td>15. Ganglion excision</td>
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<td>16. Trigger finger release</td>
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<td>17. Varicose vein surgery</td>
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INTRODUCTION

The purpose of this policy is to describe the access and exclusion criteria which the CCGs listed below will apply to Procedures of Lower Clinical Value (PoLCV).

The term ‘Procedures of Lower Clinical Value’, refers to procedures that are of value, but only in the right clinical circumstances.

The main objective for having PoLCV policies is to ensure that:

• Patients receive appropriate health treatments in the right place and at the right time

• Treatments with no or a very limited evidence base are not used

• Treatments with minimal health gain are restricted.

The procedures this relates to are listed in the “Scope” section below.

BACKGROUND

CCGs have limited budgets; these are used to commission healthcare that meets the reasonable requirements of its patients, subject to the CCG staying within the budget it has been allocated. By using these policies, we can prioritise resources using the best evidence about what is clinically effective, to provide the greatest proven health gain for the whole of the CCG’s population. Our intention is to ensure access to NHS funding is equal and fair, whilst considering the needs of the overall population and evidence of clinical and cost effectiveness.

We recognise there may be exceptional circumstances where it is clinically appropriate to fund each of the procedures listed in this policy and these will be considered on a case-by-case basis. Funding for cases where either; a) the clinical threshold criteria is not met, or b) the procedure is not routinely funded, will be considered by the CCGs following application to the CCG’s Individual Funding Request Panel, whereby the IFR process will be applied.

This position is supported by each CCG’s Ethical Framework which can be found on the respective CCG website.
Procedures of Lower Clinical Value

PRINCIPLES

Commissioning decisions by CCG Commissioners are made in accordance with the commissioning principles set out below, and in the Birmingham, Black Country and Solihull CCGs’ Individual Funding Request Policy:

1. CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.

2. CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment.

3. The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor.

4. CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.

5. CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.

6. CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance.

7. Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered.

SCOPE

The following policies and procedures are within the scope of this policy.

Each policy is categorised as either ‘not routinely funded’ or ‘restricted’ these are defined as follows:

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

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

<table>
<thead>
<tr>
<th>Policy</th>
<th>Treatment</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenoidectomy</td>
<td></td>
<td>Restricted</td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>Abdominoplasty / Apronectomy</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>Thigh Lift, Buttock Lift and Arm Lift, Excision of</td>
<td>Not routinely commissioned</td>
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<tr>
<td></td>
<td>Redundant Skin or Fat</td>
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<td>Cosmetic Surgery</td>
<td>Liposuction</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>Breast Augmentation a) Non breast cancer b) Breast</td>
<td>a) Not routinely commissioned</td>
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<tr>
<td></td>
<td></td>
<td>b) Restricted</td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>Breast Reduction</td>
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<tr>
<td>Cosmetic Surgery</td>
<td>Mastopexy (Breast Lift)</td>
<td>Not routinely commissioned</td>
</tr>
</tbody>
</table>
## Procedures of Lower Clinical Value

<table>
<thead>
<tr>
<th>Policy</th>
<th>Treatment</th>
<th>Category</th>
</tr>
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<tbody>
<tr>
<td>Cosmetic Surgery</td>
<td>Inverted Nipple Correction</td>
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<td>Gynaecomastia (Male Breast)</td>
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<td>Cosmetic Surgery</td>
<td>Labiaplasty</td>
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<td>Cosmetic Surgery</td>
<td>Vaginoplasty</td>
<td>Restricted</td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>Pinnaplasty</td>
<td>Not routinely commissioned</td>
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<tr>
<td>Cosmetic Surgery</td>
<td>Repair of Ear Lobes</td>
<td>Not routinely commissioned</td>
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<tr>
<td>Cosmetic Surgery</td>
<td>Rhinoplasty</td>
<td>Restricted</td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>Face Lift or Brow Lift</td>
<td>Restricted</td>
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<td>Cosmetic Surgery</td>
<td>Hair Depilation (Hirsutism)</td>
<td>Restricted</td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>Alopecia (Hair Loss)</td>
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<td>Cosmetic Surgery</td>
<td>Removal of Tattoos / Surgical correction of body piercings and correction of respective</td>
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<td>Cosmetic Surgery</td>
<td>Removal of Lipomata</td>
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<td>Cosmetic Surgery</td>
<td>Removal of Benign or Congenital Skin Legions</td>
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<td>Medical and Surgical Treatment of Scars and Keloids</td>
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<td>Cosmetic Surgery</td>
<td>Botulinum Toxin</td>
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<td>Cosmetic Surgery</td>
<td>Treatment for Viral Warts</td>
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<td>Cosmetic Surgery</td>
<td>Thread / Telangiectasis / Reticular Veins</td>
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<td>Cosmetic Surgery</td>
<td>Rhinophyma</td>
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<td>Resurfacing Procedures: Dermabrasion, Chemical Peels and Laser Treatment</td>
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<td>Other Cosmetic Procedures</td>
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<td>Cosmetic Surgery</td>
<td>Revision of Previous Cosmetic</td>
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<tr>
<td>Non Specific, Specific and Chronic Back Pain</td>
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<td>Cataracts</td>
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<td>Cholecystectomy for AS gallstones</td>
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<td>Male Circumcision</td>
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<td>Dilation and Curettage (D&amp;C) for HMB</td>
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<td>Eyelid Surgery (Upper and Lower) – Blepharoplasty inc Chalazia</td>
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<td>Ganglion</td>
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<td>Restricted</td>
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<tr>
<td>Groin Hernia Repair</td>
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<td>Restricted</td>
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<tr>
<td>Grommets</td>
<td></td>
<td>Restricted</td>
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<tr>
<td>Haemorrhoidectomy</td>
<td></td>
<td>Restricted</td>
</tr>
<tr>
<td>Hip Replacement Surgery</td>
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<table>
<thead>
<tr>
<th>Procedure</th>
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<tr>
<td>Hysterectomy for Heavy Menstrual Bleeding</td>
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<td>Hysteroscopy for Menorrhagia</td>
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<td>Knee Replacement Surgery</td>
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<td>Sub acromial Decompression</td>
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<tr>
<td>Tonsillectomy</td>
<td>Restricted</td>
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<tr>
<td>Trigger Finger</td>
<td>Restricted</td>
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<tr>
<td>Varicose Veins</td>
<td>Restricted</td>
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<tr>
<td>Dupuytren’s Disease</td>
<td>Restricted</td>
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<tr>
<td>Carpal Tunnel Syndrome</td>
<td>Restricted</td>
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<tr>
<td>Spinal fusion surgery for chronic low back pain</td>
<td>Restricted</td>
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<tr>
<td>Lumbar spinal epidural injections</td>
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<tr>
<td>Diagnostic arthroscopy of the knee</td>
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<tr>
<td>Knee arthroscopy for patients with osteoarthritis</td>
<td>Restricted</td>
</tr>
<tr>
<td>Joint injections</td>
<td>Restricted</td>
</tr>
<tr>
<td>Bunions and hallux valgus corrective surgery</td>
<td>Restricted</td>
</tr>
<tr>
<td>Ear wax removal</td>
<td>Restricted</td>
</tr>
<tr>
<td>Routine Ear Irrigation</td>
<td>Not routinely commissioned</td>
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<tr>
<td>Adult Snoring Surgery</td>
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<td>Autologous Cartilage Transplant</td>
<td>Not routinely commissioned</td>
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<tr>
<td>Reversal of Male Sterilisation</td>
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<tr>
<td>Reversal of Female Sterilisation</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Laser Surgery for Myopia</td>
<td>Not routinely commissioned</td>
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<td>BotTox for Spasticity</td>
<td>Restricted</td>
</tr>
<tr>
<td>EST for Refractory Plantar Fasciitis</td>
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</tr>
<tr>
<td>EST - Refractory Achilles Tendinopathy</td>
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<tr>
<td>Inpatient CBT (Residential Placements) for CFS/ME</td>
<td>Not routinely commissioned</td>
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IMPLEMENTATION

Commissioners, GPs, service providers and clinical staff treating registered patients of the CCGs are expected to implement this policy. When procedures are undertaken on the basis of meeting the criteria specified within the policy, this should be clearly documented within the clinical notes. Failure to do so will be considered by the CCGs as lack of compliance.

Patients with problems or conditions that might require treatments included in this policy should be referred to a consultant or specialist only;

- After a clinical assessment is made by the GP or Consultant; AND
Procedures of Lower Clinical Value

- The patient meets all the criteria set out in the policy.

GP s wishing to seek a specialist opinion for patients who meet the above criteria should ensure the essential clinical information is included in the referral letter confirming the patient has been assessed in line with this policy.

GP s, Consultants in secondary care and provider finance departments need to be aware that the CCG will not pay for the procedures listed in this policy unless the patient meets the criteria outlined in this policy.

The CCGs recognise there will be exceptional, individual or clinical circumstances when funding for treatments designated as low priority will be appropriate.

Where a treatment is either not routinely funded, or the patient does not meet the specified clinical criteria, this means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Individual Funding Requests should only be sent to the respective NHS.net account as below. Guidance regarding IFRs and an application form can be found on the CCGs websites.

IFR contact information follows, however please refer to the CCG IFR policy for more information

Individual Funding Request Case Manager
Floor Two, Kingston House
438 High Street
West Bromwich West Midlands B70 9LD

Telephone: 0121 611 0470
Email addresses for Individual Funding Request teams at CCGs (Ctrl+Click required address to send email):

- Birmingham & Solihull CCG    ifr.bsol1@nhs.net
- NHS Sandwell and West Birmingham CCG  ifr.swb@nhs.net
- NHS Walsall CCG        ifr.walsall@nhs.net
- NHS Wolverhampton CCG  ifr.wolv@nhs.net

MONITORING AND REVIEW

This policy will be subject to continued monitoring using a mix of the following approaches:

- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding clinical and cost effectiveness.
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COPIES OF THIS POLICY

Electronic copies of this policy can be found on the websites of Walsall CCG.
https://walsallccg.nhs.uk/publications/commissioning-individual-funding-request/1370-policy-for-procedures-of-lower-clinical-value-2  Alternatively, you may contact the CCG and ask for a copy of the Policy for Procedures of Lower Clinical Value.

GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>TERM</th>
<th>MEANING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominoplasty/Apronectomy</td>
<td>A procedure to reduce excess skin and fat, improve abdominal contours and scars, and tighten muscles. This is sometimes called a ‘tummy tuck’.</td>
</tr>
<tr>
<td>Adenoidectomy</td>
<td>A procedure to remove the adenoids – lumps of tissue at the back of the nose.</td>
</tr>
<tr>
<td>Aesthetics</td>
<td>These are procedures which relate to cosmetic procedures which are intended to restore or improve a person’s appearance</td>
</tr>
<tr>
<td>Alopecia</td>
<td>Hair loss</td>
</tr>
<tr>
<td>Analgesics</td>
<td>Painkillers</td>
</tr>
<tr>
<td>Asymptomatic</td>
<td>Without symptoms</td>
</tr>
<tr>
<td>Augmentation</td>
<td>Increasing in size, for example breast augmentation</td>
</tr>
<tr>
<td>Benign</td>
<td>Does not invade surrounding tissue or spread to other parts of the body; it is not a cancer</td>
</tr>
<tr>
<td>Binocular vision</td>
<td>Vision in both eyes</td>
</tr>
<tr>
<td>Body Mass Index (BMI)</td>
<td>Body Mass Index - a measure that adults can use to see if they are a healthy weight for their height.</td>
</tr>
<tr>
<td>Cataract</td>
<td>When the lens of an eye becomes cloudy and affects vision</td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>Removal of the gall bladder</td>
</tr>
<tr>
<td>Chronic</td>
<td>Persistent</td>
</tr>
<tr>
<td>Co-morbidities</td>
<td>Other risk factors alongside the primary problem</td>
</tr>
<tr>
<td>Congenital</td>
<td>Present from birth</td>
</tr>
<tr>
<td>Conservative treatment</td>
<td>The management and care of a patient by less invasive means, these are usually non-surgical</td>
</tr>
<tr>
<td>Depilation</td>
<td>Removal, For example hair depilation</td>
</tr>
<tr>
<td>Eligibility/Threshold</td>
<td>Whether someone qualifies. In this case, the minimum criteria to access a procedure</td>
</tr>
<tr>
<td>Exceptional clinical circumstances</td>
<td>A patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients, with the same medical condition and at the same stage of progression as the patient.</td>
</tr>
<tr>
<td>Functional health</td>
<td>Difficulty in performing, or requiring assistance from another to perform, one or more activities of daily living.</td>
</tr>
<tr>
<td>Ganglion</td>
<td>A non-cancerous fluid filled lump</td>
</tr>
<tr>
<td>Gynaecomastia</td>
<td>Benign enlargement of the male breast</td>
</tr>
<tr>
<td>Haemorrhoidectomy</td>
<td>A procedure to cut away haemorrhoids, sometimes called piles</td>
</tr>
<tr>
<td>Histology</td>
<td>The structure of cells or tissue under a microscope</td>
</tr>
</tbody>
</table>
## Procedures of Lower Clinical Value

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperhidrosis</td>
<td>Excess sweating</td>
</tr>
<tr>
<td>Hysteroscopy</td>
<td>A procedure used to examine the inside of the womb</td>
</tr>
<tr>
<td>Individual Funding Request (IFR)</td>
<td>A request received from a provider or a patient with explicit support from a clinician, which seeks funding for a single identified patient for a specific treatment</td>
</tr>
<tr>
<td>Irreducible</td>
<td>Unable to be reduced</td>
</tr>
<tr>
<td>Labiaplasty</td>
<td>A procedure to reduce and/or reshape the labia</td>
</tr>
<tr>
<td>Lipomata</td>
<td>Fat deposits under the skin</td>
</tr>
<tr>
<td>Liposuction</td>
<td>A procedure using a suction technique to remove fat from specific areas of the body.</td>
</tr>
<tr>
<td>Malignant/malignancy</td>
<td>Harmful</td>
</tr>
<tr>
<td>Mastopexy</td>
<td>A reconstructive procedure to lift the breast</td>
</tr>
<tr>
<td>Menorrhagia</td>
<td>Abnormally heavy or prolonged bleeding at menstruation</td>
</tr>
<tr>
<td>Monocular vision</td>
<td>Vision in one eye only</td>
</tr>
<tr>
<td>Multi-disciplinary</td>
<td>Involving several professional specialisms for example in a Multi-disciplinary team (MDT).</td>
</tr>
<tr>
<td>NICE guidance</td>
<td>The guidance published by the National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>Not routinely funded (a procedure)</td>
<td>This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
<tr>
<td>NSAIDS</td>
<td>Non-steroidal anti-inflammatory drugs – medication that reduces pain, fever and inflammation</td>
</tr>
<tr>
<td>Paediatric(ian)</td>
<td>Medical care concerning infants, children and adolescents usually under 18.</td>
</tr>
<tr>
<td>Pathology/pathological</td>
<td>The way a disease or condition works or behaves. This may for example include examination of bodily fluids or tissue e.g. blood testing.</td>
</tr>
<tr>
<td>Pinnaplasty</td>
<td>A procedure to pin or correct deformities the ear</td>
</tr>
<tr>
<td>Precipitates</td>
<td>Brings about/triggers</td>
</tr>
<tr>
<td>Prophylactic</td>
<td>Preventative or prevention</td>
</tr>
<tr>
<td>Rationale</td>
<td>Explanation of the reason why</td>
</tr>
<tr>
<td>Restricted (a procedure)</td>
<td>This means CCG will fund the treatment if the patient meets the stated clinical threshold for care.</td>
</tr>
<tr>
<td>Rhinophyma</td>
<td>A condition causing development of a large, bulbous, ruddy (red coloured), nose</td>
</tr>
<tr>
<td>Rhinoplasty</td>
<td>A procedure to shape the size and/or shape of the nose</td>
</tr>
<tr>
<td>Rhytidectomy</td>
<td>A procedure to restore facial appearance or function. These are sometime called face or brow lifts.</td>
</tr>
<tr>
<td>Symptomatic</td>
<td>Something causing or exhibiting symptoms</td>
</tr>
<tr>
<td>Tonsillectomy</td>
<td>A procedure to remove the tonsils</td>
</tr>
<tr>
<td>Vaginoplasty</td>
<td>A procedure to reconstruct the vaginal canal</td>
</tr>
</tbody>
</table>
Procedures of Lower Clinical Value

Adenoidectomy

Category: Restricted

Applicable OPCS Codes: E20.1

An adenoidectomy is an operation to remove the adenoids – small lumps of tissue at the back of the nose, behind the palate.

Adenoids are part of the immune system, which helps fight infection and protects the body from bacteria and viruses. Adenoids are only present in children. They start to grow from birth and are biggest when your child is approximately three to five years old.

But by age seven to eight they start to shrink and by the late teens, are barely visible. By adulthood, the adenoids will have disappeared completely.

The adenoids disappear because – although they may be helpful in young children – they are not an essential part of an adult's immune system.

Eligibility Criteria:

Adenoidectomy will only be funded if undertaken in conjunction with Tonsillectomy and/or Grommets (Please refer to policies for Tonsillectomy and/or Grommets).

This is because of the clinical inter-dependency of adenoidectomy and tonsillectomy when tonsils and adenoids become enlarged and block the upper airway, leading to breathing difficulty. They are also removed when recurrence of tonsil infections or strep throat cannot be successfully treated by antibiotics. The surgery is most often performed on children.

This means (for patients who do not require tonsillectomy and/or grommets) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Guidance:


This guide has been prepared for commissioners by the Royal College of Surgeons following a review of the latest research evidence.

Cosmetic surgery is often carried out to change a person’s appearance in order to achieve what they perceive to be a more desirable look. Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely funded by the CCG Commissioner.

1. CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
2. CCG Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
3. The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor.
4. CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
5. CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
6. CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance.
7. Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered.


### Specific Procedure Referral Criteria

**Applicable OPCS Codes**

S02.1/.2/.8/.9

<table>
<thead>
<tr>
<th>Intervention:</th>
<th>1. Abdominoplasty/Apronectomy (sometimes called ‘tummy tuck’)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Eligibility Criteria</td>
<td>Abdominoplasty and apronectomy are surgical procedures performed to remove excess fat and skin from the mid and lower abdomen. Many people develop loose abdominal skin after pregnancy or substantial weight loss, whether it be due to surgical or dietary weight loss. Abdominoplasty is not routinely commissioned. This is because purely removal of surplus skin or fat irrespective of site on body is deemed to be cosmetic and does not meet the principles laid out in this policy. This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>
Procedures of Lower Clinical Value

Guidance:
Royal College of Surgeons - Cosmetic Surgery Categorisation

Royal College of Surgeons – Abdominoplasty Guide
Weblink: https://www.rcseng.ac.uk/members/resources/pre-op-leaflets/Cosmetic/Abdominoplasty.pdf/view

Applicable OPCS Codes S03.1/.2/.3/.8/.9

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Minimum Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat</td>
<td>Skin or Fat are surgical procedures performed to remove loose skin or excess fat to reshape body contours. As with abdominoplasty / apronectomy theses procedures are not routinely commissioned.</td>
</tr>
<tr>
<td></td>
<td>This is because purely removal of loose skin or excess fat irrespective of site on body is deemed to be cosmetic and does not meet the principles laid out in this policy. This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>

Guidance:
Royal College of Surgeons - Cosmetic Surgery Categorisation

Royal College of Surgeons – Liposuction Guide
Weblink: http://www.rcseng.ac.uk/members/resources/pre-op-leaflets/Cosmetic/Liposuction.pdf/at_download/file

Applicable OPCS Codes: S62.1/.2

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Minimum Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Liposuction</td>
<td>Liposuction (also known as liposculpture) is a surgical procedure performed to improve body shape by removing unwanted fat from areas of the body such as abdomen, hips, thighs, calves, ankles, upper arms, chin, neck and back. Liposuction is sometimes done as an adjunct to other surgical procedures, such as cancer procedures. Liposuction is not routinely commissioned.</td>
</tr>
<tr>
<td></td>
<td>This is because purely removal of unwanted fat from the above areas is deemed to be cosmetic and does not meet the principles laid out in this policy. This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>
Procedures of Lower Clinical Value

Guidance:
Royal College of Surgeons - Cosmetic Surgery Categorisation


Applicable OPCS Codes: B30.1/.8/.9; B31.2; B37.5

<table>
<thead>
<tr>
<th>Intervention</th>
<th>4. Breast Augmentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Eligibility Criteria</td>
<td>a) Breast Augmentation/enlargement involves inserting artificial implants behind the normal breast tissue to improve its size and shape. Breast Augmentation is not routinely commissioned, except for patients with breast cancer. This is because breast augmentation for non-cancer reasons is deemed to be cosmetic and does not meet the principles laid out in this policy. This means (for patients who do not have breast cancer) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
<tr>
<td></td>
<td>b) For patients with Breast Cancer, this procedure is restricted. The CCG will fund this treatment if the patient meets the following criteria:</td>
</tr>
<tr>
<td></td>
<td>• Treatment of the unaffected breast following cancer surgery will not be routinely commissioned, however reconstructive surgery on the affected breast will be commissioned for patients as part of the original treatment plan. This is because breast augmentation on the breast not at risk of being affected by cancer reasons is deemed to be cosmetic and does not meet the principles laid out in this policy. This means (for breast cancer patients who DO NOT meet the above criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>

Guidance:
Royal College of Surgeons - Cosmetic Surgery Categorisation

Weblink:

Royal College of Surgeons – Breast Augmentation Guide Weblink:
http://www.rcseng.ac.uk/members/resources/pre-op-leaflets/Breast/Breast%20Augmentation.pdf/at_download/file

DW 03/05/19 v 1.0
**Procedures of Lower Clinical Value**

**Applicable OPCS Codes: B31.1**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>5. Breast Reduction <em>(NHSE EBI report 2018)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Updated description of the intervention</td>
<td>The evidence highlights that breast reduction is only successful in specific circumstances and the procedure can lead to complications - for example not being able to breast feed permanently. However in some cases breast reduction surgery is necessary where large breasts impact on day to day life, for example ability to drive a car. Therefore, breast reduction should only be undertaken under specific criteria. Wearing a professionally fitted bra, losing weight (if necessary), managing pain and physiotherapy often work well to help with symptoms like back pain from large breasts.</td>
</tr>
<tr>
<td>Summary of intervention</td>
<td>Breast reduction surgery is a procedure used to treat women with breast hyperplasia (enlargement), where breasts are large enough to cause problems like shoulder girdle dysfunction, intertrigo and adverse effects to quality of life.</td>
</tr>
</tbody>
</table>
Procedures of Lower Clinical Value

<table>
<thead>
<tr>
<th>Criteria</th>
<th>The NHS will only provide breast reduction for women if all the following criteria are met:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain.</td>
</tr>
<tr>
<td></td>
<td>• In cases of thoracic/shoulder girdle discomfort, a physiotherapy assessment has been provided</td>
</tr>
<tr>
<td></td>
<td>• Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps).</td>
</tr>
<tr>
<td></td>
<td>• Breast reduction planned to be 500gms or more per breast or at least 4 cup sizes.</td>
</tr>
<tr>
<td></td>
<td>• Body mass index (BMI) is &lt;27 and stable for at least twelve months.</td>
</tr>
<tr>
<td></td>
<td>• Woman must be provided with written information to allow her to balance the risks and benefits of breast surgery.</td>
</tr>
<tr>
<td></td>
<td>• Women should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking.</td>
</tr>
<tr>
<td></td>
<td>• Women should be informed that breast surgery for hypermastia can cause permanent loss of lactation.</td>
</tr>
</tbody>
</table>

Unilateral breast reduction is considered for asymmetric breasts as opposed to breast augmentation if there is an impact on health as per the criteria above. Surgery will not be funded for cosmetic reasons. Surgery can be approved for a difference of 150 - 200gms size as measured by a specialist. The BMI needs to be <27 and stable for at least twelve months.

Resection weights, for bilateral or unilateral (both breasts or one breast) breast reduction should be recorded for audit purposes.

This recommendation does not apply to therapeutic mammoplasty for breast cancer treatment or contralateral (other side) surgery following breast cancer surgery, and local policies should be adhered to. The Association of Breast Surgery support contralateral surgery to improve cosmesis as part of the reconstruction process following breast cancer treatment.

Gynaecomastia: Surgery for gynaecomastia is not routinely funded by the NHS. This recommendation does not cover surgery for gynaecomastia caused by medical treatments such as treatment for prostate cancer.
## Procedures of Lower Clinical Value

### Rationale

One systematic review and three non-randomized studies regarding breast reduction surgery for hypermastia were identified and showed that surgery is beneficial in patients with specific symptoms. Physical and psychological improvements, such as reduced pain, increased quality of life and less anxiety and depression were found for women with hypermastia following breast reduction surgery.

Breast reduction surgery for hypermastia can cause permanent loss of lactation function of breasts, as well as decreased areolar sensation, bleeding, bruising, and scarring and often alternative approaches (e.g. weight loss or a professionally fitted bra) work just as well as surgery to reduce symptoms. For women who are severely affected by complications of hypermastia and for whom alternative approaches have not helped, surgery can be offered. The aim of surgery is not cosmetic; it is to reduce symptoms (e.g. back ache).

### References


2. Royal College of Surgeons –


### References (continued)

<table>
<thead>
<tr>
<th></th>
<th>Authors</th>
<th>Title</th>
<th>Journal</th>
<th>Date</th>
<th>Volume</th>
<th>Pages</th>
<th>DOI</th>
<th>PubMed ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><a href="https://www.nhs.uk/conditions/breast-reduction-on-the-nhs/">https://www.nhs.uk/conditions/breast-reduction-on-the-nhs/</a></td>
</tr>
</tbody>
</table>

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**Procedures of Lower Clinical Value**

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**NHS Walsall Clinical Commissioning Group**

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**DW 03/05/19 v 1.0**
### Procedures of Lower Clinical Value

**Applicable OPCS Codes B31.3**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>6. Mastopexy</th>
</tr>
</thead>
</table>
| Policy Statement | a) Mastopexy refers to the surgical correction of breasts that sag or droop. This can occur as part of the natural aging process, or pregnancy, lactation and substantial weight loss. Mastopexy is not routinely commissioned, except for patients with breast cancer. This is because the procedure is deemed to be cosmetic and does not meet the principles laid out in this policy. This means (for patients who do not have breast cancer) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

b) For patients with Breast Cancer, this procedure is restricted. The CCG will fund this treatment if the patient meets the following criteria.

- Treatment of the unaffected breast following cancer surgery will not be routinely commissioned, however reconstructive surgery on the affected breast will be commissioned for patients as part of the original treatment plan.

This is because Mastopexy on the breast not at risk of being affected by cancer reasons is deemed to be cosmetic and does not meet the principles laid out in this policy.

This means (for breast cancer patients who DO NOT meet the above criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |

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**Guidance:**

Royal College of Surgeons - Cosmetic Surgery Categorisation

Procedures of Lower Clinical Value
Applicable OPCS Codes: B35.4/.6

<table>
<thead>
<tr>
<th>Intervention</th>
<th>7. Inverted Nipple Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Statement</td>
<td>Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded. This policy explicitly relates to correction of inverted nipples for cosmetic reasons. Inverted Nipple Correction is not routinely commissioned. This is because correction of inverted nipples is deemed to be cosmetic and does not meet the principles laid out in this policy. This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>

Guidance:
Royal College of Surgeons - Cosmetic Surgery Categorisation

Applicable OPCS Codes: B31.1

<table>
<thead>
<tr>
<th>Intervention</th>
<th>8. Surgery for Gynaecomastia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Statement</td>
<td>Gynaecomastia is enlargement of the male breast tissue. It is defined as the presence of &gt;2 cm of palpable, firm, subareolar gland and ductal breast tissue. It may occur at any time and there are a number of causes, some physiological and others pathological. Pathological causes involve an imbalance between the activity of androgens and oestrogens - the former is decreased compared with the latter. Surgery for Gynaecomastia is not routinely commissioned. This is because surgery for reduction of male breast tissue is deemed to be cosmetic and does not meet the principles laid out in this policy. <strong>This policy does not cover surgery for gynaecomastia caused by medical treatments such as treatment for prostate cancer (NHSE EBI 2018)</strong> This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>

Guidance:
Royal College of Surgeons - Cosmetic Surgery Categorisation
Procedures of Lower Clinical Value

Applicable OPCS Codes: P05.5/.6/.7

<table>
<thead>
<tr>
<th>Intervention</th>
<th>9. Labiaplasty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td>A labiaplasty is a surgical procedure to reduce the size of the labia minora – the flaps of skin either side of the vaginal opening. This procedure is restricted. The CCG will fund this treatment if the patient meets the eligibility criteria below.</td>
</tr>
<tr>
<td>Eligibility criteria</td>
<td>Where repair of the labia is required after trauma.</td>
</tr>
<tr>
<td>This means (for patients who DO NOT meet the above criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
<td></td>
</tr>
</tbody>
</table>

Guidance:
NHS Choices – Guide to Labiaplasty Weblink:
http://www.nhs.uk/Conditions/labiaplasty/Pages/Introduction.aspx#cosmetic

Applicable OPCS Codes: P21.3

<table>
<thead>
<tr>
<th>Intervention</th>
<th>10. Vaginoplasty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td>Vaginoplasty is a reconstructive plastic surgery and cosmetic procedure for the vaginal canal and its mucous membrane, and of vulvo-vaginal structures that might be absent or damaged because of congenital disease (e.g., vaginal hypoplasia) or because of an acquired cause (e.g., childbirth physical trauma, cancer). The term vaginoplasty generally describes any such cosmetic reconstructive and corrective vaginal surgery, and the term neovaginoplasty specifically describes the procedures of either partial or total construction or reconstruction of the vulvo-vaginal complex. Vaginoplasty and genital procedures are restricted. The CCG will fund this treatment if the patient meets the eligibility criteria below. This is because Vaginoplasty is deemed to be cosmetic and does not meet the principles laid out in this policy.</td>
</tr>
</tbody>
</table>
Procedures of Lower Clinical Value

<table>
<thead>
<tr>
<th>Eligibility criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Congenital (present from birth) absence or significant developmental/endocrine abnormalities of the vaginal canal</td>
</tr>
<tr>
<td>• Where repair of the vaginal canal is required after trauma.</td>
</tr>
</tbody>
</table>

This means (for patients who DO NOT meet the above criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Applicable OPCS Codes: P03.3

<table>
<thead>
<tr>
<th>Intervention</th>
<th>11. Pinnaplasty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Statement</td>
<td>Pinnaplasty is an operation to reshape the ears and make them less prominent. This can be done from the age of approximately 6 years depending on the thickness of the cartilage. This operation can be performed under local anaesthetic for adults but better under general anaesthetic for children. The surgery is performed as a day case. Pinnaplasty is not routinely commissioned.</td>
</tr>
<tr>
<td></td>
<td>This is because there are no known links to high quality clinical guidelines/decision support tools for Pinnaplasty.</td>
</tr>
<tr>
<td></td>
<td>This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>

Guidance:
Procedures of Lower Clinical Value

Applicable OPCS Codes: D06.2

<table>
<thead>
<tr>
<th>Intervention</th>
<th>12. Repair of Ear Lobes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Statement</td>
<td>Ear lobe surgery includes:</td>
</tr>
<tr>
<td></td>
<td>• Congenital Deformity - birth deformities of the earlobe surgery include a simple repair of a congenital cleft or with a significant abnormality, cartilage grafts and skin grafts may be required in one or more stages.</td>
</tr>
<tr>
<td></td>
<td>• Split Earlobes - earlobes are often split by heavy earrings gradually enlarging a piercing over many years. On other occasions, when an earring is forcefully pulled the earlobe can split acutely. Repair is usually performed under local anaesthetic, is simple and repiercing is normally possible within a few weeks.</td>
</tr>
<tr>
<td></td>
<td>• Earlobe Reduction - correction of droopy earlobes is designed to rejuvenate the ear.</td>
</tr>
<tr>
<td></td>
<td>• Facelift Earlobe - the earlobe is pulled down.</td>
</tr>
<tr>
<td></td>
<td>• Earlobe Keloids - Keloids are scars growing in an uncontrolled manner. Repair of split ear lobes are not routinely commissioned. This is because repair of split ear lobes is deemed to be cosmetic and does not meet the principles laid out in this policy.</td>
</tr>
</tbody>
</table>

This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Applicable OPCS Codes: E02.3/.4/.5/.6; E07.3

<table>
<thead>
<tr>
<th>Intervention</th>
<th>13. Rhinoplasty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Statement</td>
<td>Rhinoplasty, commonly known as a ‘nose job’, is a plastic surgery procedure for correcting and reconstructing the form, restoring the functions, and aesthetically enhancing the nose by resolving nasal trauma (blunt, penetrating, blast), congenital defect, respiratory impediment, or a failed primary rhinoplasty.</td>
</tr>
<tr>
<td></td>
<td>a) Rhinoplasty is not routinely commissioned for cosmetic reasons. b) Rhinoplasty is restricted for non-cosmetic/other reasons e.g. asepoplasty. The CCG will fund this treatment if the patient meets the eligibility criteria below.</td>
</tr>
</tbody>
</table>

DW 03/05/19 v 1.0
### Procedures of Lower Clinical Value

<table>
<thead>
<tr>
<th><strong>Rationale</strong></th>
<th>This is because if you have a blocked nose because your nasal bones are crooked or damaged, or the bone and cartilage between your nostrils is deviated (bent) a septoplasty can improve how you breathe.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimum Eligibility Criteria</strong></td>
<td>The CCG will fund this treatment if the patient meets the following criteria:</td>
</tr>
<tr>
<td></td>
<td>• Documented medical problems caused by obstruction of the nasal airway OR</td>
</tr>
<tr>
<td></td>
<td>• Correction of complex congenital conditions e.g. Cleft lip and palate</td>
</tr>
<tr>
<td></td>
<td>This means (for patients who DO NOT meet the above criteria or require the procedure for cosmetic reasons) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>

**Guidance:**

Royal College of Surgeons - Cosmetic Surgery Categorisation


Royal College of Surgeons – Rhinoplasty Guide Weblink:

[http://www.rcseng.ac.uk/members/resources/pre-op-leaflets/Ear%20Nose%20Throat/Rhinoplasty.pdf/at_download/file](http://www.rcseng.ac.uk/members/resources/pre-op-leaflets/Ear%20Nose%20Throat/Rhinoplasty.pdf/at_download/file)
### Procedures of Lower Clinical Value

**Applicable OPCS Codes: S01.1/2./3./4./5./6./8./9**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>14. Face Lift or Brow Lift (Rhytidectomy)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy Statement</strong></td>
<td>A facelift, technically known as a rhytidectomy, is a type of cosmetic surgery procedure used to give a more youthful facial appearance. There are multiple surgical techniques. It usually involves the removal of excess facial skin, with or without the tightening of underlying tissues, and the redraping of the skin on the patient’s face and neck. Facelifts are effectively combined with eyelid surgery (blepharoplasty) and other facial procedures</td>
</tr>
<tr>
<td>a)</td>
<td>Rhytidectomy is not routinely commissioned for cosmetic reasons.</td>
</tr>
<tr>
<td>b)</td>
<td>Rhytidectomy is restricted for non-cosmetic/other reasons. The CCG will fund this treatment if the patient meets the minimum eligibility criteria below.</td>
</tr>
</tbody>
</table>

| **Rationale** | This is because there are many changes to the face and brow as a result of ageing that may be considered normal. However, there are a number of specific conditions for which these procedures may form part of the treatment to restore appearance and function. |

<table>
<thead>
<tr>
<th><strong>Minimum Eligibility Criteria</strong></th>
<th>Recognised diagnosis of Congenital (present from birth) facial abnormalities OR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Facial palsy (congenital or acquired paralysis) OR</td>
</tr>
<tr>
<td></td>
<td>As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis OR</td>
</tr>
<tr>
<td></td>
<td>To correct the consequences of trauma OR</td>
</tr>
<tr>
<td></td>
<td>For significant deformity following corrective surgery. However funding will not be approved to improve previous cosmetic surgery</td>
</tr>
</tbody>
</table>

This means (for patients who DO NOT meet the above criteria or require the procedure for cosmetic reasons) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

**Guidance:**

Royal College of Surgeons - Cosmetic Surgery Categorisation


Royal College of Surgeons – Facelift Guide Weblink: [http://www.rcseng.ac.uk/members/resources/pre-op-leaflets/Cosmetic/Facelift.pdf/at_download/file](http://www.rcseng.ac.uk/members/resources/pre-op-leaflets/Cosmetic/Facelift.pdf/at_download/file)
Procedures of Lower Clinical Value
Applicable OPCS Codes S60.6/.7

<table>
<thead>
<tr>
<th>Intervention</th>
<th>15. Hair Depilation (removal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Statement</td>
<td>Hair depilation can be used for excess hair (hirsuitism) in a normal distribution pattern, or for abnormally placed hair. It is usually achieved permanently by electrolysis or laser therapy.</td>
</tr>
<tr>
<td></td>
<td>Hirsutism essentially means that an individual, usually female, grows too much body or facial hair in a male pattern. Although hirsutism sometimes occurs in males, it is more difficult to detect because of the wide range of normal hair growth in men. Hirsutism affects approximately 10% of women in Western societies and is commoner in those of Mediterranean or Middle-Eastern descent.</td>
</tr>
<tr>
<td></td>
<td>The British Association of Dermatologists advises that there are a range of treatment options:</td>
</tr>
<tr>
<td></td>
<td>• Self-care: shaving, waxing, depilatories (hair removal creams) and bleaching creams;</td>
</tr>
<tr>
<td></td>
<td>• Physical treatments: electrolysis, or Laser and intense pulsed light (IPL) treatments;</td>
</tr>
<tr>
<td></td>
<td>• Medical treatments: Eflornithine cream, or a range of Anti-androgens.</td>
</tr>
<tr>
<td>Rationale</td>
<td>Hair depilation is restricted. The CCG will fund this treatment if the patient meets the minimum eligibility criteria below.</td>
</tr>
<tr>
<td>Minimum Eligibility Criteria</td>
<td>The CCG will fund this treatment if the patient meets the following criteria:</td>
</tr>
<tr>
<td></td>
<td>• Has undergone reconstructive surgery leading to abnormally located hair-bearing skin OR</td>
</tr>
<tr>
<td></td>
<td>• Is undergoing treatment for pilonidal sinuses to reduce recurrence</td>
</tr>
<tr>
<td></td>
<td>This means (for patients who DO NOT meet the above criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>

Guidance:
British Association of Dermatologists - hirsuitism patient information leaflet
## Applicable OPCS Codes:


### Intervention

<table>
<thead>
<tr>
<th>16. Alopecia (Hair Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy Statement</strong></td>
</tr>
<tr>
<td>Treatment for Alopecia will not be routinely commissioned.</td>
</tr>
<tr>
<td>This is because surgical treatment for hair loss is deemed to be cosmetic and does not meet the principles laid out in this policy. The British Association Dermatologists state ‘Leaving alopecia areata untreated is a legitimate option for many patients. Spontaneous remission occurs in up to 80% of patients with limited patchy hair loss of short duration (&lt; 1 year).’</td>
</tr>
<tr>
<td>Such patients may be managed by reassurance alone, with advice that regrowth cannot be expected within 3 months of the development of any individual patch.’</td>
</tr>
<tr>
<td>The NHS Choices guidance below provides a range of non-surgical options for hair loss, including prescription medication from your GP.</td>
</tr>
<tr>
<td>This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>

### Guidance:

### Procedures of Lower Clinical Value

**Applicable OPCS Codes:** S09.1/.2; S10.8/.9; S60.1/.2

<table>
<thead>
<tr>
<th>Intervention</th>
<th>17. Removal of Tattoos/Surgical correction of body piercings and correction of respective problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Statement</td>
<td>Tattoo fading involves using a laser to target tattoo ink in the skin. The laser heats the ink particles, so they break up and allow the body to absorb them. The amount of treatment needed varies, depending on the individual tattoo. However, it can take up to 12 sessions to treat a professional tattoo, which usually takes place once every eight weeks. The results can vary, depending on the individual tattoo and the type or colour of ink used. Indian ink tattoos are usually easier to treat, and black and red inks tend to fade better. Some inks do not respond to treatment at all. Removal of Tattoos/Surgical correction of body piercings and correction of respective problems is not routinely commissioned. This is because surgical treatment for removal of tattoos/surgical correction of body piercings and correction of respective problems is deemed to be cosmetic and does not meet the principles laid out in this policy. This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>

**Guidance:**

NHS Choices – Guide to Non-surgical cosmetic procedures

**Weblink:**

### Procedures of Lower Clinical Value

Applicable OPCS Codes: S06.1/.2/.3/.4/.5/.8/.9; S08.1/.2/.3/.8/.9; S09.1/.2/.3/.8; S10.1/.2; S11.1/.2; D02.1/.2/.8/.9

<table>
<thead>
<tr>
<th>Intervention</th>
<th>18. Removal of Benign (non-cancerous) or Congenital Skin Lesions (NHSE EBI 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Updated description of the intervention</td>
<td>Removal of benign skin lesions cannot be offered for cosmetic reasons. It should only be offered in situations where the lesion is causing symptoms according to the criteria outlined below. Risks from the procedure can include bleeding, pain, infection, and scarring.</td>
</tr>
<tr>
<td>Summary of intervention</td>
<td>Removal of benign skin lesions means treating asymptomatic lumps, bumps or tags on the skin that are not suspicious of cancer. Treatment carries a small risk of infection, bleeding or scarring and is not usually offered by the NHS if it is just to improve appearance. In certain cases, treatment (surgical excision or cryotherapy) may be offered if certain criteria are met. A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be treated or referred according to NICE skin cancer guidelines. This policy does not refer to pre-malignant lesions and other lesions with potential to cause harm.</td>
</tr>
<tr>
<td>Rationale</td>
<td>There is little evidence to suggest that removing benign skin lesions to improve appearance is beneficial. Risks of this procedure include bleeding, pain, infection and scarring. Though in certain specific cases as outlined by the criteria above, there are benefits for removing skin lesions, for example, avoidance of pain and allowing normal functioning.</td>
</tr>
<tr>
<td>Criteria</td>
<td>This policy refers to the following benign lesions when there is diagnostic certainty;</td>
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<tr>
<td></td>
<td>• benign moles (excluding large congenital naevi)</td>
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<tr>
<td></td>
<td>• solar comedones</td>
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<tr>
<td></td>
<td>• corn/callous</td>
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<tr>
<td></td>
<td>• dermatofibroma</td>
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<tr>
<td></td>
<td>• lipomas</td>
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<tr>
<td></td>
<td>• milia</td>
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<td></td>
<td>• molluscum contagiosum (non-genital)</td>
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<tr>
<td></td>
<td>• epidermoid &amp; pilar cysts (sometimes incorrectly called sebaceous cysts)</td>
</tr>
<tr>
<td></td>
<td>• seborrhoeic keratoses (basal cell papillomata)</td>
</tr>
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<td></td>
<td>• skin tags (fibroepithelial polyps) including anal tags</td>
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<tr>
<td></td>
<td>• spider naevi (telangiectasia)</td>
</tr>
<tr>
<td></td>
<td>• non-genital viral warts in immunocompetent patients</td>
</tr>
<tr>
<td></td>
<td>• xanthelasmata</td>
</tr>
<tr>
<td></td>
<td>• neurofibromata</td>
</tr>
</tbody>
</table>
Procedures of Lower Clinical Value

**AND** they must meet at least **ONE** of the following criteria to be removed;

- The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires 2 or more courses of antibiotics (oral or intravenous) per year
- There is repeated infection requiring 2 or more antibiotics per year
- The lesion bleeds in the course of normal everyday activity
- The lesion causes regular pain
- The lesion is obstructing an orifice or impairing field vision
- The lesion significantly impacts on function e.g. restricts joint movement
- The lesion causes pressure symptoms e.g. on nerve or tissue
- If left untreated, more invasive intervention would be required for removal
- Facial viral warts
- Facial spider naevi in children causing significant psychological impact
- Lipomas on the body > 5cms, or in a sub-facial position, with rapid growth and/or pain. These should be referred to Sarcoma clinic.

The following are outside the scope of this policy recommendation:

- Lesions that are suspicious of malignancy should be treated or referred according to NICE skin cancer guidelines.
- Any lesion where there is diagnostic uncertainty, pre-malignant lesions (actinic keratoses, Bowen disease) or lesions with pre-malignant potential should be referred or, where appropriate, treated in primary care.
- Removal of lesions other than those listed above.

Referral to 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.
- Requests for treatment where a patient meets the criteria do not require prior approval or an IFR.
- This policy applies to all providers, including general practitioners (GPs), GPs with enhanced role (GPwer), independent providers, and community or intermediate services.
For further information, please see:

- https://www.nice.org.uk/guidance/csg8
- https://www.nice.org.uk/guidance/ng12

This means (for patients who either DO NOT meet the above criteria or require treatment for cosmetic reasons) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

**References**


**Applicable OPCS Codes:** There are no appropriate OPCS Codes since Lipomata lie subcutaneously. ICD 10 Codes for lipoma are D17 and E88.2, but there are no appropriate ICD 10 Codes for the clinical criteria.

**Intervention 19. Removal of Lipomata**

**Policy Statement**

Lipomata are fat deposits underneath the skin. They are usually removed on cosmetic grounds, although patients with multiple subcutaneous lipomata may need a biopsy to exclude neurofibromatosis.

Removal of Lipomata in secondary care is restricted. The CCG will fund this treatment if the patient meets the minimum eligibility criteria below.

**Rationale**

This is because all removal of Lipomata that does not meet the criteria below is deemed to be cosmetic and does not meet the principles laid out in this policy.

**Minimum Eligibility Criteria**

The CCG will fund this treatment if the patient meets the following criteria:

- suspected malignancy OR
- significant functional impairment caused by the lipoma OR
- to provide histological evidence in conditions where there are multiple subcutaneous lesions

This excludes lipomas unless they are on the face (including pinna) or the neck and they become infected or be symptomatic. Lipomas on other areas of the body should be referred back to primary care as agreed locally.

This means (for patients who DO NOT meet the above criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.
Procedures of Lower Clinical Value

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Weblink:</td>
<td><a href="http://northwestcsu.nhs.uk/BrickwallResource/GetResource/159f6308-">http://northwestcsu.nhs.uk/BrickwallResource/GetResource/159f6308-</a> bee1-413a-8da1-8098b0495cf6</td>
</tr>
</tbody>
</table>

Applicable OPCS Codes: S06.3/.4/.5; S08.1/.2; S09.1/.2; S10.1/.2/.8/.9; S11.1/.2/.8/.9; S60.4; Y06.4

<table>
<thead>
<tr>
<th>Intervention:</th>
<th>20. Medical and Surgical treatment of Scars and Keloids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Statement</td>
<td>The different types of scars include:</td>
</tr>
<tr>
<td></td>
<td>• Flat, pale scars – these are the most common type of scar and are due to the body's natural healing process. Initially, they may be red or dark and raised after the wound has healed, but will become paler and flatter naturally over time. This can take up to two years.</td>
</tr>
<tr>
<td></td>
<td>• Hypertrophic scars – red, raised scars that form along a wound and can remain this way for a number of years.</td>
</tr>
<tr>
<td></td>
<td>• Keloid scars – these are caused by an excess of scar tissue produced at the site of the wound, where the scar grows beyond the boundaries of the original wound, even after it has healed.</td>
</tr>
<tr>
<td></td>
<td>• Pitted (atrophic or &quot;ice-pick&quot;) scars – these have a sunken appearance.</td>
</tr>
<tr>
<td></td>
<td>• Contracture scars – these are caused by the skin shrinking and tightening, usually after a burn, which can restrict movement.</td>
</tr>
</tbody>
</table>

Treating scars - Depending on the type and age of a scar, a variety of different treatments may help make them less visible and improve their appearance. Scars are unlikely to disappear completely, although most will gradually fade over time. If scarring is unsightly, uncomfortable or restrictive, treatment options may include:

- silicone gel sheets
- pressure dressings
- corticosteroid injections
- cosmetic camouflage (make-up)
- surgery

It is often the case that a combination of treatments can be used.

Refashioning or removal of scars/treatment and keloids are restricted. The CCG will fund this treatment if the patient meets the minimum eligibility criteria below. This is because Medical and Surgical treatment of Scars and Keloids that does not meet the criteria below is deemed to be cosmetic and does not meet the principles laid out in this policy.
Procedures of Lower Clinical Value

Minimum Eligibility Criteria

- For severe post burn cases or severe traumatic scarring or severe post-surgical scarring OR
- Revision surgery for scars following complications of surgery, keloid formation or other hypertrophic scar formation will only be commissioned where there is significant functional deformity or to restore normal function

This means (for patients who DO NOT meet the above criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Applicable OPCS Codes: X37.5; X85.1; Z60.1

<table>
<thead>
<tr>
<th>Intervention</th>
<th>21. Botulinum Toxin Injection for the Ageing Face</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Statement</td>
<td>Botulinum toxin A is a powerful neurotoxin which is used medically to relax muscles and for certain conditions there are recognised clinical benefits to patients. However, due to its mechanism of action botulinum toxin A can be used for medical conditions for which the clinical benefits have not been proven or are unclear and inconsistencies have arisen before this policy existed. Botulinum toxin injections, such as Botox, are used to help relax facial muscles and make lines and wrinkles less obvious. During the procedure, your skin is cleaned and small amounts of botulinum toxin are injected into the area to be treated. Several injections are usually needed at different sites. The injections usually take effect about three to five days after treatment and it can take up to two weeks for the full effect to be realised. The effects generally last for about three to four months. Botulinum Toxin Injection for the ageing face will not be routinely commissioned. This is because Botulinum Toxin Injection for the ageing face is deemed to be cosmetic and does not meet the principles laid out in this policy. This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>

Guidance:

NHS Choices – Guide to Non-surgical cosmetic procedures
Procedures of Lower Clinical Value

Applicable OPCS Codes: S11.1/2

<table>
<thead>
<tr>
<th>Intervention</th>
<th>22. Treatment for Viral Warts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Statement</td>
<td>Warts are small lumps that often develop on the skin of the hands and feet. Warts vary in appearance and may develop singly or in clusters. Some are more likely to affect particular areas of the body. For example, verrucas are warts that usually develop on the soles of the feet. Warts are non-cancerous, but can resemble certain cancers. Treatment for Viral Warts is restricted to the minimum eligibility criteria below. The CCG will fund this treatment if the patient meets the following criteria below. This is because most plantar warts can be managed with over-the-counter topical treatments or by treatments prescribed by your general practitioner. Treatment for Viral Warts that does not meet the criteria below is deemed to be cosmetic and does not meet the principles laid out in this policy.</td>
</tr>
<tr>
<td>Minimum Eligibility Criteria</td>
<td>The CCG will fund this treatment if the patient meets the following criteria. • ano-genital warts that have failed treatment within primary care setting or Genito-Urinary Medicine (GUM) clinic. This means (for patients who DO NOT meet the above criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>

Guidance:

British Association of Dermatologists - Plantar Warts patient information leaflet

### Intervention 23. Thread/ Telangiectasis/ Reticular veins (Spider Angiomas)

**Policy Statement**

A spider angioma is an enlarged little artery (resembling the body of a spider), from which smaller blood vessels are filled (resembling the spider’s legs). It has also been called several other names, for example ‘naevus araneus’, ‘vascular spider’, ‘arterial spider’, ‘spider telangiectasia’ and ‘spider naevus/nevus’.

The cause of spider angiomas is not known. The vast majority affect healthy people, and most only have one spider angioma or a just a few. Spider angiomas may appear in certain conditions with increased levels of oestrogen hormones such as in pregnancy or when taking the oral contraceptive pill. They may occasionally be linked to liver or thyroid disease. Spider angiomas can develop at any age, but are more common in children.

Treatment for Thread Veins/Telangiectasia will not be routinely commissioned.

This is because:

- In children and some adults, spider angiomas may go away on their own, which can take several years. Treatment is usually not necessary.
- If spider angiomas are related to increased oestrogen hormones and the levels then go back to normal (after a pregnancy or on stopping an oral contraceptive pill), the spider angiomas may go away within about nine months.
- A spider angioma can also completely disappear after treatment, but sometimes repeated treatments may be required. The problem may come back a few months later after treatment.

Treatment for removal of Spider Angioma involves the central artery being treated with an electric current (‘electrodissication’), causing it to dry up.

A vascular laser such as the pulsed dye laser or KTP laser can target the blood in the central small artery, causing it to shrink. This treatment is deemed to be cosmetic and does not meet the principles laid out in this policy.

This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

**Guidance:**

British Association of Dermatologists - Spider Angioma patient information leaflet
Procedures of Lower Clinical Value

<table>
<thead>
<tr>
<th>Intervention</th>
<th>24. Rhinophyma (bulbous, red nose)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Statement</td>
<td>Rhinophyma is a swelling of the nose. If the condition progresses, the nose becomes redder, swollen at the end and gains a bumpy surface which changes its shape. This swelling is because there is formation of scar-like tissue and the sebaceous glands (which produce oil on the skin) get bigger. Much more rarely, swellings can arise on other parts of their face such as the ears and chin. The condition is mainly seen in those who have rosacea, a rash that can affect the cheeks, forehead and nose (see rosacea leaflet for further information). Rhinophyma usually only develops in rosacea which has been active for many years. However, although rosacea affects woman more than men, rhinophyma is seen mainly in fair-skinned men aged 50 to 70 years. Surgical treatment of Rhinophyma is not routinely commissioned. This is because there is no cure for rhinophyma, although some treatments may control it. These treatments are deemed to be cosmetic and does not meet the principles laid out in this policy. This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>

Guidance:
British Association of Dermatologists - Rhinophyma patient information leaflet


<table>
<thead>
<tr>
<th>Intervention</th>
<th>25. Resurfacing Procedures: Dermabrasion, Chemical Peels and Laser</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Statement</td>
<td>Resurfacing procedures including dermabrasion, chemical peels and laser treatment are not routinely commissioned. This is because purely removal of surplus skin or fat irrespective of site on body is deemed to be cosmetic and does not meet the principles laid out in this policy. This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>

Guidance:
British Association of Dermatologists - Rhinophyma patient information leaflet
Procedures of Lower Clinical Value
Applicable OPCS Codes (not covered above): S01.1/.2/.4/.5/.6; C13.1/.2/.3/.4; D03.8/.9; V19.2; S05.1/.2/.3/.4/.8/.9

<table>
<thead>
<tr>
<th>Intervention</th>
<th>26. Other Cosmetic Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Statement</td>
<td>Cosmetic Procedures are not routinely commissioned. The Royal College of Surgeons ‘Categorisation of Cosmetic Surgery’ includes the following procedures:</td>
</tr>
<tr>
<td></td>
<td><strong>Cosmetic breast surgery</strong></td>
</tr>
<tr>
<td></td>
<td>- Cosmetic surgery of the nipple areolar complex</td>
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<tr>
<td></td>
<td>- Augmentation mammoplasty</td>
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<tr>
<td></td>
<td>- Autologous fat transfer to breast for symmetrisation / augmentation</td>
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<tr>
<td></td>
<td>- Breast symmetrisation</td>
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<td></td>
<td>- Correction of gynaecomastia</td>
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<td></td>
<td>- Mastopexy</td>
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<td></td>
<td>- Reduction mammoplasty</td>
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<td></td>
<td><strong>Cosmetic nasal surgery</strong></td>
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<td></td>
<td>- Rhinoplasty</td>
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<tr>
<td></td>
<td><strong>Cosmetic surgery of the periorbital region</strong></td>
</tr>
<tr>
<td></td>
<td>- Brow lift</td>
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<tr>
<td></td>
<td>- Midface lift</td>
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<tr>
<td></td>
<td>- Upper lid blepharoplasty</td>
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<tr>
<td></td>
<td>- Lower lid blepharoplasty</td>
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<tr>
<td></td>
<td><strong>Cosmetic surgery of the ear</strong></td>
</tr>
<tr>
<td></td>
<td>- Otoplasty</td>
</tr>
<tr>
<td></td>
<td><strong>Cosmetic facial contouring surgery</strong></td>
</tr>
<tr>
<td></td>
<td>- Alloplastic augmentation of the facial skeleton</td>
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<tr>
<td></td>
<td>- Bone grafting of the facial skeleton</td>
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<tr>
<td></td>
<td>- Free fat grafting to the face</td>
</tr>
<tr>
<td></td>
<td>- Genioplasty: sliding, reduction, lengthening and symmetrising</td>
</tr>
<tr>
<td></td>
<td><strong>Cosmetic surgery of the face</strong></td>
</tr>
<tr>
<td></td>
<td>- Cosmetic facial contouring</td>
</tr>
<tr>
<td></td>
<td>- Brow lift</td>
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<tr>
<td></td>
<td>- Rhytidectomy</td>
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<td></td>
<td>- Platysmaplasty</td>
</tr>
<tr>
<td></td>
<td><strong>Cosmetic surgery of the face/nose/periorbital region/ears</strong></td>
</tr>
<tr>
<td></td>
<td>- Alloplastic augmentation of the facial skeleton</td>
</tr>
<tr>
<td></td>
<td>- Alloplastic facial augmentation</td>
</tr>
<tr>
<td></td>
<td>- Autologous fat transfer</td>
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<td>- Blepharoplasty</td>
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<td></td>
<td>- Bone grafting of the facial skeleton</td>
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<td>- Brow Lift</td>
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<tr>
<td></td>
<td>- Rhytidectomy</td>
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<tr>
<td></td>
<td>- Facial contouring surgery</td>
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</tbody>
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## Procedures of Lower Clinical Value

<table>
<thead>
<tr>
<th>Category</th>
<th>Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cosmetic body contouring surgery</td>
<td>Free fat grafting to the face, Genioplasty, Midface lift, Otoplasty, Platysmaplasty, Reconstructive facial recontouring or remodelling, Rhinoplasty</td>
</tr>
<tr>
<td>Cosmetic body contouring surgery</td>
<td>Abdominoplasty, Cosmetic surgery of the hand, Autologous fat transfer, Body lift, Brachioplasty, Gluteal augmentation, Calf augmentation, Liposuction, Thigh lift</td>
</tr>
<tr>
<td>Massive weight loss surgery (MWL) - Supplementary certificate in body contouring following massive weight loss</td>
<td>Post bariatric surgery/MWL abdominoplasty, Post bariatric surgery/MWL brachioplasty, Post bariatric surgery/MWL autologous fat transfer, Post bariatric surgery/MWL body lift, Post bariatric surgery/MWL liposuction, Post bariatric surgery/MWL thigh lift</td>
</tr>
</tbody>
</table>

This is because Other Cosmetic Procedures not specified in the Cosmetic Surgery policy but detailed in the Royal College of Surgeons ‘Categorisation of Cosmetic Surgery’ is deemed to be cosmetic and does not meet the principles laid out in this policy.

This means the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

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**Guidance:**
Royal College of Surgeons - Cosmetic Surgery Categorisation

NHS Choices – Ear Reshaping
Weblink: [http://www.nhs.uk/conditions/ear-reshaping/Pages/Introduction.aspx](http://www.nhs.uk/conditions/ear-reshaping/Pages/Introduction.aspx)
Procedures of Lower Clinical Value

<table>
<thead>
<tr>
<th>Intervention</th>
<th>27. Revision of Previous Cosmetic Surgery Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Statement</td>
<td>Revision surgery following previous NHS cosmetic surgery is not routinely commissioned. This is because the financial risk of revision surgery lies with the provider. It is also important to note that revision of plastic surgery procedures originally performed in the private sector will not be funded. Referring clinicians should re-refer to the practitioner who carried out the original treatment. This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>

Guidance:

Royal College of Surgeons - Cosmetic Surgery Categorisation
Policy for Back Pain

(See also ‘Spinal fusion surgery for chronic low back pain’ and ‘Lumbar spinal epidural injections’ policies on pages 86 & 87)

Category: Restricted

Applicable OPCS Codes: Non-specific low back pain: A52.1, A52.2, (A52.8, A52.9 with Z06.3); (X30.6, X30.8, or X30.9 with Z06.3).

Back Pain

Back pain is a common problem that affects most people at some point in their life. The pain can be triggered by bad posture while sitting or standing, bending awkwardly, or lifting incorrectly. Back pain is not generally caused by a serious condition and, in most cases, it gets better within 12 weeks. It can usually be successfully treated by taking painkillers and keeping mobile.

In most cases, the pain disappears within six weeks but may come back (recur) from time to time. Chronic (persistent) pain develops in some cases and further treatment may then be needed.

This policy is split into 3 parts, these are described in summary here and the funding criteria as follows:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Status</th>
<th>Funding Criteria</th>
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</thead>
<tbody>
<tr>
<td>Non-specific back pain</td>
<td>Restricted</td>
<td>This means (for patients who DO NOT meet the specified criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
<tr>
<td>Specific back pain</td>
<td>Restricted</td>
<td>This means (for patients who DO NOT meet the specified criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
<tr>
<td>Chronic back pain</td>
<td>Restricted</td>
<td>This means (for patients who DO NOT meet the specified criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
<tr>
<td>Spinal cord stimulation</td>
<td>Restricted</td>
<td>This means (for patients who DO NOT meet the specified criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.</td>
</tr>
</tbody>
</table>
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Non Specific Back Pain

This is the type of back pain that most people will have at some point in their life. It is called nonspecific because it is usually not clear what is actually causing the pain. In other words, there is no specific problem or disease that can be identified as the cause of the pain. It may be triggered by bad posture while sitting or standing, bending awkwardly, or lifting incorrectly. It is not generally caused by a serious condition. More information about back pain can be found at the NHS Choices weblink below.

In most cases, back pain will improve in a few weeks or months, although some people experience long-term pain or pain that keeps coming back.

Policy Statement
In accordance with NICE NG59 guidance, the following are not routinely commissioned for managing low back pain with or without sciatica.

Electrotherapies
Do not offer
- Ultrasound
- Percutaneous Electrical Nerve Simulation (PENS)
- Transcutaneous Electrical Nerve Simulation (TENS)
- Interferential therapy

Orthotics
Do not offer
- belts or corsets
- foot orthotics
- rocker sole shoes

Manual therapies
- Do not offer traction for managing low back pain with or without sciatica.

Acupuncture
Do not offer acupuncture for managing low back pain with or without sciatica.

Injections for nonspecific low back pain without sciatica (NHSE EBI guidance 2018)
Spinal injections of local anaesthetic and steroid in people with non-specific low back pain without sciatica. NICE recommends that spinal injections should not be offered for non-specific low back pain. Alternative options like pain management and physiotherapy have been shown to work.

Criteria
Spinal injections of local anaesthetic and steroid should not be offered for patients with non-specific low back pain.

For people with non-specific low back pain the following injections should not be offered:
- facet joint injections
- therapeutic medial branch blocks
- intradiscal therapy
- prolotherapy
- Trigger point injections with any agent, including botulinum toxin
- Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients

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with central spinal canal stenosis

• Any other spinal injections not specifically covered above

Radiofrequency denervation can be offered according to NICE guideline (NG59) if all non-surgical and alternative treatments have been tried and there is moderate to severe chronic pain that has improved in response to diagnostic medical branch block.

Epidurals (local anaesthetic and steroid) should be considered in patients who have acute and severe lumbar radiculopathy at time of referral.

Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic. Alternative options are suggested in line with the National Back Pain Pathway. For further information, please see: https://www.nice.org.uk/guidance/ng59

NICE guidelines recommend that spinal injections should not be offered for non-specific low back pain.

Radiofrequency denervation (to destroy the nerves that supply the painful facet joint in the spine) can be considered in some cases as per NICE guidance.

Exclusion criteria for the NICE (NG59) include:

• Conditions of a non-mechanical nature, including:
  o Inflammatory causes of back pain (for example, ankylosing spondylitis or diseases of the viscera)
  o Serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse)
• Neurological disorders (including cauda equina syndrome or mononeuritis)
• Adolescent scoliosis

Not covered were conditions with a select and uniform pathology of a mechanical nature (e.g. spondylolisthesis, scoliosis, vertebral fracture or congenital disease). Other agreed exclusions by the GDG are: Pregnancy-related back pain, Sacroiliac joint dysfunction, Adjacent-segment disease, Failed back surgery syndrome, Spondylolisthesis and Osteoarthritis.

NICE recommends the following approach for non-surgical invasive treatments for low back pain and sciatica in over 16s

• Spinal injections
  o 1.3.1 Do not offer spinal injections for managing nonspecific low back pain.

• Radiofrequency denervation
  o 1.3.2 Consider referral for assessment for radiofrequency denervation for people with non-specific low back pain when: non-surgical treatment has not worked for them and the main source of pain is thought to come from structures supplied by the medial branch nerve and they have 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.
  o 1.3.3 Only perform radiofrequency denervation in people with non-specific low back pain after a positive response to a diagnostic medial branch block.
  o 1.3.4 Do not offer imaging for people with non-specific low back pain with specific facet joint pain as a prerequisite for radiofrequency denervation.
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References

1. NICE guidance: https://www.nice.org.uk/guidance/ng59
2. United Kingdom Spine Societies Board: https://www.ukssb.com/improving-spinal-care-project

NICE guidance suggests considering the following therapies;

Manual therapies
Consider manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy.

Psychological therapy
Consider psychological therapies using a cognitive behavioural approach for managing low back pain with or without sciatica but only as part of a treatment package including exercise, with or without manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage).

Combined physical and psychological programmes
Consider a combined physical and psychological programme, incorporating a cognitive behavioural approach (preferably in a group context that takes into account a person’s specific needs and capabilities), for people with persistent low back pain or sciatica:

- when they have significant psychosocial obstacles to recovery (for example, avoiding normal activities based on inappropriate beliefs about their condition) or
- when previous treatments have not been effective.

Guidance:
NICE guidance: https://www.nice.org.uk/guidance/ng59

Specific Back Pain

Applicable OPCS Codes
Specific low back pain – Facet Joint Injection/medial branch block
V54.4

Eligibility Criteria:

The CCG will fund this treatment if the patient meets the following criteria.

- Interventional pain therapies should be part of comprehensive treatment by a multidisciplinary team (MDT) where there should be arrangements for on-going assessment following a trial of treatment to show evidence of response.
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Facet Joint Injections and Medial Branch Block or Spinal/Epidural injections should be part of comprehensive treatment by an MDT.

- Diagnostic Facet Joint injections are only commissioned for the assessment of patients being considered for surgical management of chronic back pain performed by a clinician trained in back pain assessment, diagnosis and management as part of an MDT process.
- This should be used as a screening tool to improve specificity if radiofrequency lesioning is being considered.

OR

One injection will be funded if a patient meets ALL of the following criteria:

- Pain lasting more than or equal to 12 months AND
- Failed conservative treatment including maximum oral and topical analgesia AND
- A Clinician trained in back pain assessment, diagnosis and management has assessed the patient and considers it would enable mobilisation and participation in rehabilitation as part of an MDT approach AND
- Documented use of a standardised Pain and Quality Of Life (QOL) tool before and after procedure.

Further injections will only be funded as part of a pain management pathway if significant improvement is seen on PAIN score & QOL score.

In such case no more than TWO injection sessions will be funded per year.

This is because few patients will need referral to secondary care, this is a high value part of the pathway hence the detail above (see Royal College of Surgeons Commissioning Guidance weblink below).

This means (for patients who DO NOT meet the specified criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Guidance:
Royal College of Surgeons - Commissioning guide: Low Back Pain: Broad Principles of the patient pathway (2013)
Weblink: https://www.rcseng.ac.uk/healthcare-bodies/docs/commissioning-guides-boa/lower-back-pain-commissioning-guide

Chronic Back Pain

Applicable OPCS Codes

Chronic back pain – Radiofrequency denervation lumbar facet joint V48.5/.6/.7/.8/.9

Chronic pain tends to be very difficult to manage because of its complex natural history, unclear aetiology (cause) and poor response to therapy. Chronic pain is characterised by pain which persists despite adequate time for healing. There is no clear definition but it is often defined as pain that has been present for more than 12 weeks.

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Chronic pain is not simply a physical problem. It is often associated with severe and extensive psychological, social and economic factors. Apart from poor general physical health and disability there may also be depression, unemployment, and family stress. Many of these factors interact and the whole picture needs to be considered when managing individual patients.

The impact of chronic pain on patients' lives varies from minor restrictions to complete loss of independence.

Eligibility Criteria

The CCG will fund this treatment if the patient meets the following criteria.

**Radiofrequency and Endothermal Ablation for Chronic Back Pain - Denervation of Lumbar Spine:**
Radiofrequency denervation should be part of comprehensive treatment by a multidisciplinary team. There should be ongoing assessment following a trial of treatment to show evidence of response. ONE diagnostic Medial Branch Block will be funded prior to denervation techniques.

Radiofrequency denervation should only be undertaken after a successful - >80% improvement on a validated scoring tool - following one set of diagnostic local anaesthetic blocks and as part of a MDT managed programme of care.

Repeat radiofrequency procedure may only be offered to those patients with a previous successful response (as above) if the benefits of the procedure lasted for at least 6 months.

Repeat radiofrequency denervation is only permitted at a minimum interval of 12 months. Therefore those patients who consistently experience less than 12 months relief following two radiofrequency procedures will not be offered further radiofrequency treatment.

This is because few patients will need referral to secondary care, this is a high value part of the pathway hence the detail above (see Royal College of Surgeons Commissioning Guidance weblink below).

This means (for patients who DO NOT meet the specified criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

**Guidance:**

**Spinal Cord Stimulation for Chronic Back Pain**

**Applicable OPCS Code:** V48.3/.4

The CCG will fund this treatment if the patient meets the following criteria:

**Eligibility Criteria**
Spinal Cord Stimulation for Chronic pain of Neuropathic or Ischaemic origin is ONLY commissioned in accordance with criteria NICE TA159 which states Spinal cord stimulation is recommended as a possible...
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treatment for adults with chronic pain of neuropathic origin if they:

- continue to experience chronic pain (measuring at least 50 mm on a 0–100 mm visual analogue scale) for at least 6 months despite standard treatments, and
- have had a successful trial of spinal cord stimulation as part of an assessment by a specialist team.
- Treatment with spinal cord stimulation should only be given after the person has been assessed by a specialist team experienced in assessing and managing people receiving treatment with spinal cord stimulation.

Neurostimulators may be either implantable pulse generators (IPGs), which use either a non-rechargeable or a rechargeable internal battery, or radio frequency devices, which receive energy in the form of radio frequency pulses from an external device powered by a rechargeable battery. Devices are not specific to pain conditions.

This means (for patients who DO NOT meet the specified criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Guidance

Botulinum Toxin for Hyperhidrosis

Category: Not routinely commissioned

Applicable OPCS Codes: S53.2 with X85.1 (to identify Botulinum Toxin) and Z49.2

Normal sweating helps to keep the body temperature steady in hot weather, during a high temperature (fever) or when exercising. Excessive sweating (hyperhidrosis) means sweating more than normal. Hyperhidrosis can be challenging to treat and it may take a while to find the best treatment for you. Less invasive treatments will usually be recommended first, including:

- Lifestyle changes
- Stronger antiperspirants
- Prescribing Anticholinergics
- Referral to a dermatologist (see British Association of Dermatologists patient information weblink below).

Botulinum toxin A is a powerful neurotoxin which is used medically to relax muscles and for certain conditions there are recognised clinical benefits to patients. However, due to its mechanism of action botulinum toxin A can be used for medical conditions for which the clinical benefits have not been proven or are unclear and inconsistencies have arisen before this policy existed. Therefore this document summarises the commissioning status of botulinum toxin A for specified medical conditions.

Botulinum toxin (type A) for hyperhidrosis is not routinely commissioned.

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This is because Botulinum toxin is only licensed for underarm sweating and not for large areas. The skin can be numbed with an anaesthetic cream or injection, but this is often not needed as underarm skin is not very sensitive. Botulinum toxin is not commonly used in the palms and soles because it can cause temporary weakness of hand and foot muscles and is painful.

This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Guidance:
British Association of Dermatologists - Hyperhidrosis patient information leaflet

NHS Choices – Guide to Hyperhidrosis Weblink:
http://www.nhs.uk/conditions/hyperhidrosis/Pages/Introduction.aspx; and
http://www.nhs.uk/Conditions/Hyperhidrosis/Pages/Treatment.aspx

Cataracts
Category: Restricted
Applicable OPCS Codes: C71.1, C71.2, C71.3, C71.8, C71.9, C72.1, C72.2, C72.3, C72.8, C72.9, C74.1, C74.2, C74.3, C74.8, C74.0, C75.1, C75.2, C75.3, C75.8, C75.9

A cataract exists when the lens of an eye becomes cloudy and may affect vision. Cataracts most commonly occur in older people and develop gradually. Cataracts can usually be treated with a routine day case operation where the cloudy lens is removed and is replaced with an artificial plastic lens (an Intraocular Implant).

The Royal College of Ophthalmologists’ National Ophthalmology Database indicates that in 2006-2010 (before restrictions on access to cataract surgery based on visual acuity were commonplace), for eyes undergoing cataract surgery preoperative following percentages of cataract patients had visual acuities of better than or equal to:

- 6/6 Snellen (3% of cataract surgery patients)
- 6/9 Snellen (5% of cataract surgery patients)
- 6/12 Snellen (36% of cataract surgery patients)

So eyes with visual acuities of 6/9 or better, accounted for less than 10% of cataract surgery.

Eligibility criteria
Cataract eye surgery is restricted. The CCG will fund this treatment if the patient meets the following eligibility criteria for each eye:

- The patient should have sufficient cataract to account for the visual symptoms (6/9 or worse)

AND
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- The patient's lifestyle is affected:
  - Difficulty carrying out everyday tasks such as recognising faces, watching TV, cooking, playing sport/cards etc.
  - Reduced mobility, unable to drive or experiencing difficulty with steps or uneven ground.
  - Ability to work, give care or live independently is affected.

This information, together with a report from a recent sight test, should form the minimum data on the referral form.

AND/OR

Other indications for cataract surgery include facilitating treatment for one or more of the following:

- Monitoring posterior segment disease e.g. diabetic retinopathy
- Correcting anisometropia
- Patient with Glaucoma who require cataracts surgery to contract intraocular pressure.

Patients with single sight (monocular vision)

The indications for cataract surgery in patients with monocular vision and those with severe reduction in one eye e.g. dense amblyopia, are the same as for patients with binocular vision, but the ophthalmologist should explain the possibility of total blindness if severe complications occur.

Guidance


Royal College of Ophthalmologists – Cataract Surgery Guidelines (2010)

Health Information and Quality Authority (2013) Health Technology Assessment of Scheduled Surgical Procedures: Cataract Surgery

DVLA Driving Standards
Available at: https://www.gov.uk/driving-eyesight-rules
These describe the minimum standards of vision for driving.

Cholecystectomy for Asymptomatic Gallstones

Category: Not routinely commissioned


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

Note: Patients with suspected gallbladder carcinoma or severe complications should be
referred/treated immediately, without delay.

Cholecystectomy for Asymptomatic Gallstones is not routinely commissioned.

This is because the majority of people with gallbladder stones remain asymptomatic (without symptom) and require no treatment. If you do not have any symptoms, a policy of 'active monitoring' is often recommended. This means you won’t receive immediate treatment, but you should let your GP know if you notice any symptoms. As a general rule, the longer you go without symptoms, the less likely it is that your condition will get worse.

This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

For patients with symptoms follow the Royal College of Surgeons guidance detailed below.

RCS Commissioning Guide: Gallstone Disease

High value care pathway for gallstone disease

Management

- Patients with an incidental finding of stones in an otherwise normal gallbladder require no further investigation or referral.
- Most patients with symptomatic gallstones present with a self-limiting attack of pain that lasts for hours only. This can often be controlled successfully in primary care with appropriate analgesia, avoiding the requirement for emergency admission. When pain cannot be managed or if the patient is otherwise unwell (e.g. sepsis), he or she should be referred to hospital as an emergency.
- Further episodes of biliary pain can be prevented in around 30% of patients by adopting a low fat diet. Fat in the stomach releases cholecystokinin, which precipitates (brings about) gallbladder contraction and might result in biliary pain.
- Patients with suspected acute cholecystitis, cholangitis or acute pancreatitis should be referred to hospital as an emergency.
- There is no evidence to support the use of hyoscine or proton pump inhibitors in the management of gallbladder symptoms. Antibiotics should be reserved for patients with signs of sepsis.
- There is no evidence of benefit from the use of non-surgical treatments in the definitive management of gallbladder stones (e.g. gallstone dissolution therapies, ursodeoxycholic acid or extracorporeal lithotripsy).

Best practice referral guidelines

- Epigastric or right upper quadrant pain, frequently radiating to the back, lasting for several
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minutes to hours (often occurring at night) suggests symptomatic gallstones. These patients should have liver function tests checked and be referred for ultrasonography.

- Confirmation of symptomatic gallstones should result in a discussion of the merits of a referral to a surgical service regularly performing cholecystectomies.
- Following treatment for CBD stones with endoscopic retrograde cholangiopancreatography (ERCP) and sphincterotomy, removal of the gallbladder should be considered in all patients. However, in patients with significant co-morbidities (other risk factors alongside the primary problem), the risks of surgery may outweigh the benefits.

Treatment is available for patients that are at high risk of the following:

- Patients with diabetes mellitus/transplant recipient patients/patients with cirrhosis who have been managed conservatively and subsequently develop symptoms
- Where there is clear evidence of patients being at risk of gallbladder carcinoma
- Confirmed episode of Gallstone induced pancreatitis
- Confirmed episode of Cholecystitis
- Episode of obstructive jaundice caused by biliary calculi.

Guidance
Weblink: https://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/gallstones/view

Male Circumcision

Category: Restricted

Applicable OPCS Codes: N30.3

Male circumcision is an operation to remove the foreskin (the skin covering the top of the penis). It is mostly done in babies and young children but can be done at any age. It is an effective procedure and confers benefit for a range of medical indications. Sometimes it is requested on cultural, social and religious reasons and is a common practice in the Jewish and Islamic faiths, and is also practised by many African communities as a tribal or ethnic tradition.

This policy refers only to male circumcision for medical reasons which is restricted. The CCG will fund this treatment if the patient meets the eligibility criteria below.

For religious circumcision please contact the CCG.

Note: Female circumcision has no medical benefits and is illegal under the Female Genital Mutilation Act.

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Eligibility Criteria

The CCG will fund this treatment if the patient meets the following criteria.

Circumcision will be funded in the following medical circumstances:

- Pathological phimosis - a condition where the foreskin gets trapped under the tip of the penis
- 3 documented episodes of balanoposthitis - an uncommon condition causing hardening and inflammation of the tip of the penis
- Relative indications for circumcision or other foreskin surgery include the following:
  - Prevention of urinary tract infection in patients with an abnormal urinary tract
  - Recurrent paraphimosis
  - Trauma (e.g. zipper injury)
  - Tight foreskin causing pain on arousal/ interfering with sexual function
  - Congenital abnormalities

This is because if the patient does not meet the medical indications above non-medical circumcisions do not confer any health gain but do carry health risk.

This means (for patients who DO NOT meet the specified criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Guidance

The Royal College of Surgeons of England and British Associations of Urological Surgeons/ British Associations of Paediatric Surgeons/British Associations of Paediatric Urologists – Draft Commissioning guide: Foreskin conditions (2016).


Dilation and Curettage (D&C) for heavy menstrual bleeding (NHSE EBI 2018)

Applicable OPCS Codes: Q10.3/.8/.9

Updated description of the intervention

NICE guidelines recommend that D&C is not offered as a diagnostic or treatment option for heavy menstrual bleeding, as there is very little evidence to suggest that it works to investigate or treat heavy periods.

Ultrasound scans and camera tests, with sampling of the lining of the womb (hysteroscopy and biopsy), can be used to investigate heavy periods. Medication and intrauterine systems (IUS), as well as weight...
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loss (if appropriate) can treat heavy periods.

Summary of the Intervention

Dilation and curettage (D&C) is a minor surgical procedure where the opening of the womb (cervix) is widened (dilatation) and the lining of the womb is scraped out (curettage).

Criteria

D&C should not be used for diagnosis or treatment for heavy menstrual bleeding in women because it is clinically ineffective.

Ultrasound scans and camera tests with sampling of the lining of the womb

(Hysteroscopy and biopsy) can be used to investigate heavy periods. Medication and intrauterine systems (IUS) can be used to treat heavy periods.

For further information, please see:

- [https://www.nice.org.uk/guidance/ng88](https://www.nice.org.uk/guidance/ng88)
- [https://www.nhs.uk/conditions/hysteroscopy/#alternatives-to-hysteroscopy](https://www.nhs.uk/conditions/hysteroscopy/#alternatives-to-hysteroscopy)

Rationale

NICE guidelines recommend that D&C is not offered as a treatment option for heavy menstrual bleeding. There is very little evidence to suggest that D&C works to treat heavy periods and the one study identified by NICE showed the effects were only temporary. D&C should not be used to investigate heavy menstrual bleeding as hysteroscopy and biopsy work better. Complications following D&C are rare but include uterine perforation, infection, adhesions (scar tissue) inside the uterus and damage to the cervix.

References

1. NICE guidance: [https://www.nice.org.uk/guidance/ng88](https://www.nice.org.uk/guidance/ng88)

2. NHS advice: [https://www.nhs.uk/conditions/hysteroscopy/#alternatives-to-hysteroscopy](https://www.nhs.uk/conditions/hysteroscopy/#alternatives-to-hysteroscopy)


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Eyelid Surgery (Upper and Lower)
Including Chalazia removal (NHSE EBI 2018)

Category: Restricted


Blepharoplasty is a surgical procedure performed to correct puffy bags below the eyes and droopy upper eyelids. It can improve appearance and widen the field of peripheral vision. This procedure will be commissioned by the NHS to correct functional impairment. As detailed in the Cosmetic Surgery policy eyelid surgery will not be routinely commissioned for purely for cosmetic reasons. This policy refers to upper and lower eyelid surgery which is restricted. The CCG will fund this treatment if the patient meets the eligibility criteria below.

Note: The following eyelid surgery procedures will not be funded:

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

This is because all removal of Benign (non-cancerous) or Congenital Skin Lesions that does not meet the criteria below is deemed to be cosmetic and does not meet the principles laid out in the Cosmetic Surgery policy unless there are clear clinical symptoms significantly affecting the patient’s vision/visual field (see upper and lower eyelid surgery categories below).

This means (for patients who either DO NOT meet the eligibility criteria below or require treatment for cosmetic reasons) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Surgery on the upper eyelid (upper lid blepharoplasty)

Many people acquire excess skin in the upper eyelids as part of the process of ageing and this may be considered normal. However if this starts to interfere with vision or function of the eyelid then this can warrant treatment.

Eligibility criteria

This procedure is restricted. The CCG will fund this treatment if the patient meets the following eligibility criteria:

Demonstrated by:

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- Impairment of vision in the relaxed, non-compensated state as determined by the Visual field test reducing visual field to 120° laterally and/or more than 40° reduction vertically OR
- Severe congenital (from birth) ptosis

This criterion applies to ptosis as well as brow lift cases.

This is because all eyelid surgery procedures other than for the eligibility criteria are deemed to be cosmetic and do not meet the principles laid out in the Cosmetic Surgery.

This means (for patients who DO NOT meet the specified criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Surgery on the Lower eyelid (Lower lid blepharoplasty)

Eligibility criteria

The CCG will fund this treatment if the patient meets the following eligibility criteria:

- ectropion (eyelid turned outwards from the eyeball), and/or
- entropion (eyelid folds into the eyeball) or for the removal of lesions of the eyelid skin or lid margin.

Note: Excessive skin in the lower lid may cause ‘eyebags’ but does not affect function of the eyelid or vision and therefore does not need correction.

Blepharoplasty type procedures may form part of the treatment of pathological conditions of the lid or overlying skin and not for cosmetic reasons.

This is because all eyelid surgery procedures are deemed to be cosmetic and do not meet the principles laid out in the Cosmetic Surgery.

This means (for patients who DO NOT meet the specified criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Guidance
Royal College of Surgeons – Blepharoplasty Guide Weblink:
http://www.rcseng.ac.uk/members/resources/pre-op-leaflets/Ophthalmology/Blepharoplasty.pdf/at_download/file
http://northwestcsu.nhs.uk/BrickwallResource/GetResource/159f6308-bee1-413a-8da1-8098b0495cf6
NHS Choices – Cosmetic Surgery Procedures Weblink:
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx#eyelid
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Chalazia removal (NHSE EBI 2018)

Description of the intervention
The evidence shows that alternative treatment options (warm compresses, drops or ointment, steroid injection) or a “watch and wait” approach will lead to resolution of many chalazia without the risks of surgery.

Summary of intervention
This procedure involves incision and curettage (scraping away) of the contents of the chalazion. Chalazia (meibomian cysts) are benign lesions on the eyelids due to blockage and swelling of an oil gland that normally change size over a few weeks. Many but not all resolve within six months with regular application of warm compresses and massage.

Criteria
Incision and curettage (or triamcinolone injection for suitable candidates) of chalazia should only be undertaken if at least one of the following criteria have been met:

- Has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks
- Interferes significantly with vision
- Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy
- Is a source of infection that has required medical attention twice or more within a six month time frame
- Is a source of infection causing an abscess which requires drainage
- If malignancy (cancer) is suspected eg. Madarosis/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions.

Rationale
NICE recommend that warm compresses and lid massage alone are sufficient first line treatment for chalazia. If infection is suspected a drop or ointment containing an antibiotic (e.g. Chloramphenicol) should be added in addition to warm compresses. Only if there is spreading lid and facial cellulitis should a short course of oral antibiotics (e.g. co-amoxiclav) be used.

Where there is significant inflammation of the chalazion a drop or ointment containing an antibiotic and steroid can be used along with other measures such as warm compresses. However, all use of topical steroids around the eye does carry the risk of raised intraocular pressure or cataract although this is very low with courses of less than 2 weeks.

Many chalazia, especially those that present acutely, resolve within six months and will not cause any harm however there are a small number which are persistent, very large, or can cause other problems such as distortion of vision.

In these cases surgery can remove the contents from a chalazion. However all surgery carries risks. Most people will experience some discomfort, swelling and often bruising of the eyelids and the cyst can take a few weeks to disappear even after successful surgery. Surgery also carries a small risk of infection, bleeding and scarring, and there is a remote but serious risk to the eye and vision from any procedure on the eyelids. Lastly in a proportion of successful procedures the chalazion can come back. The alternative option of an injection of a steroid (triamcinolone) also carries a small risk of serious complications such as raised eye pressure, eye perforation or bleeding.
Procedures of Lower Clinical Value

Some trials comparing the two treatments suggest that using a single triamcinolone acetonide injection followed by lid massage is almost as effective as incision and curettage in the treatment of chalazia and with similar patient satisfaction but less pain and patient inconvenience. However, this is controversial and other studies show that steroid injection is less effective than surgery. Therefore both options can be considered for suitable patients.

References
1. NICE clinical knowledge summaries, [https://cks.nice.org.uk/meibomian-cyst-chalazion](https://cks.nice.org.uk/meibomian-cyst-chalazion)
Procedures of Lower Clinical Value

Ganglion Excision  (NHSE EBI 2018)

Category: Restricted

Description of the intervention
Most people live comfortably with ganglia and they often resolve spontaneously over time. Ganglion excision can be unnecessary, can cause complications, and recurrence is common following surgery. The complications may be similar to or worse than the original problem. Ganglion excision should only be offered under the criteria outlined below.

Summary of intervention
Ganglia are cystic swellings containing jelly-like fluid which form around the wrists or in the hand. In most cases wrist ganglia cause only mild symptoms which do not restrict function, and many resolve without treatment within a year. Wrist ganglion rarely press on a nerve or other structure, causing pain and reduced hand function.
Ganglia in the palm of the hand (seed ganglia) can cause pain when carrying objects.
Ganglia which form just below the nail (mucous cysts) can deform the nail bed and discharge fluid, but occasionally become infected and can result in septic arthritis of the distal finger joint.

Criteria
Wrist ganglia
• No treatment unless causing pain or tingling/numbness or concern (worried it is a cancer);
• Aspiration if causing pain, tingling/numbness or concern
• Surgical excision only considered if aspiration fails to resolve the pain or tingling/numbness and there is restricted hand function.

Seed ganglia that is painful
• Puncture/aspirate the ganglion using a hypodermic needle
• Surgical excision only considered if ganglion persists or recurs after puncture/aspiration.

Mucous cysts
• No surgery considered unless recurrent spontaneous discharge of fluid or significant nail deformity.

Rationale
Most wrist ganglia get better on their own. Surgery causes restricted wrist and hand function for 4-6 weeks, may leave an unsightly scar and be complicated by recurrent ganglion formation. Aspiration of wrist ganglia may relieve pain and restore hand function, and “cure” a minority (30%). Most ganglia reform after aspiration but they may then be painless. Aspiration also reassures the patient that the swelling is not a cancer but a benign cyst full of jelly. Complication and recurrence are rare after aspiration and surgery for seed ganglia

References
Procedures of Lower Clinical Value

Groin Hernia Repair

Category: Restricted


A hernia occurs when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall. In many cases, hernias cause no or very few symptoms, although you may notice a swelling or lump in your tummy (abdomen) or groin. The lump can often be pushed back in, or will disappear when you lie down. Coughing or straining may make the lump appear.

Patients may experience pain or discomfort that can limit their daily activities. Hernias can also present as a surgical emergency should the bowel strangulate or become obstructed due to the hernia.

There are many different types of hernia; this policy relates to groin (inguinal) hernias only.

Groin hernias occur when fatty tissue or a part of your bowel pokes through into your groin at the top of your inner thigh. This is the most common type of hernia and it mainly affects men. It is often associated with ageing and repeated strain on the abdomen.

Eligibility Criteria

Groin hernia repair is restricted. The CCG will fund this treatment if the patient meets one or more of the following criteria:

- irreducible and partially reducible inguinal hernias
- patients who experience pain or discomfort that limits daily activities
- patients with suspected strangulated or obstructed inguinal hernia should be referred as an emergency
- all children <18 years with inguinal hernia (should be referred to a paediatric surgical provider)
- all hernias in women (should be referred urgently)

This is in line with 2013 RCS Guidance. Other patients with minimally symptomatic / asymptomatic/ occult reducible inguinal hernia who have significant comorbidity (ASA 3 or 4) AND do not want to have surgical repair after appropriate information has been provided. For these patient conservative management at GP level with no routine follow up.

This means (for patients who DO NOT meet the specified criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Note:
The ASA physical status classification system is a system for assessing the fitness of patients before surgery. In 1963 the American Society of Anesthesiologists (ASA) adopted the five-category physical status classification system; a sixth category was later added. These are:
1. Healthy person
2. Mild systemic disease
3. Severe systemic disease

DW 03/05/19 v 1.0
Procedures of Lower Clinical Value
4. Severe systemic disease that is a constant threat to life
5. A moribund person who is not expected to survive without the operation
6. A declared brain-dead person whose organs are being removed for donor purposes

Guidance

Royal College of Surgeons - Commissioning guide: Groin Hernia (2013) Weblink:
http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/hernia
http://www.britishherniasociety.org/patients/

NHS Choices – Inguinal hernia repair Weblink:
http://www.nhs.uk/conditions/inguinalherniarepair/pages/whatisitpage.aspx

Grommets (NHSE EBI 2018)
Category: Restricted

Applicable OPCS Codes: D15.1/.8/.9; D20.2/.3

Updated description of the intervention
Evidence suggests that grommets only offer a short-term hearing improvement in children with glue ear who have no other serious medical problems or disabilities. They should be offered in cases that have a history of persistent (at least 3 months) bilateral, hearing loss as defined by the NICE guidance. Hearing aids can also be offered as an alternative to surgery.

Summary of intervention
This is a surgical procedure to insert tiny tubes (grommets) into the eardrum as a treatment for fluid build up (glue ear) when it is affecting hearing in children.
Glue ear is a very common childhood problem (4 out of 5 children will have had an episode by age 10), and in most cases it clears up without treatment within a few weeks. Common symptoms can include earache and a reduction in hearing.

Often, when the hearing loss is affecting both ears it can cause language, educational and behavioural problems.

Please note this guidance only relates to children with Glue Ear (Otitis Media with Effusion) and SHOULD NOT be applied to other clinical conditions where grommet insertion should continue to be normally funded, these include:

- Recurrent acute otitis media
- Atrophic tympanic membranes
- Access to middle ear for trans tympanic instillation of medication
- Investigation of unilateral glue ear in adults

Criteria
The NHS should only commission this surgery for the treatment of glue ear in children when the criteria set out by the NICE guidelines are met:

- All children must have had specialist audiology and ENT assessment.
- Persistent bilateral otitis media with effusion over a period of 3 months.
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- Hearing level in the better ear of 25-30dbHL or worse averaged at 0.5, 1, 2, & 4kHz
- Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25-30dbHL where the impact of the hearing loss on a child’s developmental, social or educational status is judged to be significant.
- Healthcare professionals should also consider surgical intervention in children who cannot undergo standard assessment of hearing thresholds where there is clinical and tympanographic evidence of persistent glue ear and where the impact of the hearing loss on a child’s developmental, social or educational status is judged to be significant.
- The guidance is different for children with Down’s Syndrome and Cleft Palate, these children may be offered grommets after a specialist MDT assessment in line with NICE guidance.
- It is also good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum.

For further information, please see: https://www.nice.org.uk/Guidance/CG60.

The risks to surgery are generally low, but the most common is persistent ear discharge (10-20%) and this can require treatment with antibiotic eardrops and water precautions. In rare cases (1-2%) a persistent hole in the eardrum may remain, and if this causes problems with recurrent infection, surgical repair may be required (however this is not normally done until around 8-10 years of age).

Rationale

In most cases glue ear will improve by itself without surgery. During a period of monitoring of the condition a balloon device (e.g. Otovent) can be used by the child if tolerated, this is designed to improve the function of the ventilation tube that connects the ear to the nose. In children with persistent glue ear, a hearing aid is another suitable alternative to surgery. Evidence suggests that grommets only offer a short-term hearing improvement in children with no other serious medical problems or disabilities.

The NHS should only commission this surgery when the NICE criteria are met, as performing the surgery outside of these criteria is unlikely to derive any clinical benefit.

This means (for patients who DO NOT meet the specified criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

References

1. NICE guidance: https://www.nice.org.uk/Guidance/CG60
2. Browning, G; Rovers, M; Williamson, I; Lous, J; Burton, MJ. Grommets (ventilation tubes) for hearing loss associated with otitis media with effusion in children. Cochrane Database of Systematic Reviews 2010, Issue 10. Art. No.: CD001801. DOI: 10.1002/14651858.CD001801.pub3
Haemorrhoidectomy
(NHS EBI 2018)

Category: Restricted
Applicable OPCS Codes: H55.1/.2/.8/.9

Description of the intervention
Numerous interventions exist for the management of haemorrhoids (piles). The evidence recommends that surgical treatment should only be considered for haemorrhoids that keep coming back after treatment or for haemorrhoids that are significantly affecting daily life. Changes to the diet like eating more fibre and drinking more water can often help with haemorrhoids. Treatments that can be done in clinic like rubber band ligation, may be effective especially for less severe haemorrhoids.

Summary of intervention
This procedure involves surgery for haemorrhoids (piles).

Criteria
Often haemorrhoids (especially early stage haemorrhoids) can be treated by simple measures such as eating more fibre or drinking more water. If these treatments are unsuccessful many patients will respond to outpatient treatment in the form of banding or perhaps injection.

Surgical treatment should only be considered for those that do not respond to these non-operative measures or if the haemorrhoids are more severe, specifically:

- Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding; or
- Irreducible and large external haemorrhoids

In cases where there is significant rectal bleeding the patient should be examined internally by a specialist.

Rationale
Surgery should be performed, according to patient choice and only in cases of persistent grade 1 (rare) or 2 haemorrhoids that have not improved with dietary changes, banding or perhaps in certain cases injection, and recurrent grade 3 and 4 haemorrhoids and those with a symptomatic external component.

Haemorrhoid surgery can lead to complications. Pain and bleeding are common and pain may persist for several weeks. Urinary retention can occasionally occur and may require catheter insertion. Infection, iatrogenic fissuring (tear or cut in the anus), stenosis and incontinence (lack of control over bowel motions) occur more infrequently.
Procedures of Lower Clinical Value

References


4. NHS website: https://www.nhs.uk/conditions/piles-haemorrhoids/


Guidance:

NHS Choices - Piles (haemorrhoids)
http://www.nhs.uk/conditions/Haemorrhoids/Pages/What-is-it-page.aspx
A hip replacement is a common type of surgery where a damaged hip joint is replaced with an artificial one (known as a prosthesis). The hip joint is one of the largest joints in the human body and is what is known as a "ball and socket joint". In a healthy hip joint, the bones are connected to each other with bands of tissue known as ligaments. These ligaments are lubricated with fluid to reduce friction. Joints are also surrounded by a type of tissue called cartilage that is designed to help support the joints and prevent bones from rubbing against each other.

The main purpose of the hip joints is to support the upper body when a person is standing, walking and running, and to help with certain movements, such as bending and stretching.

Some common reasons why a hip joint can become damaged include:

- osteoarthritis – so-called "wear and tear arthritis", where the cartilage inside a hip joint becomes worn away, leading to the bones rubbing against each other
- rheumatoid arthritis – this is caused by the immune system (the body’s defence against infection) mistakenly attacking the lining of the joint, resulting in pain and stiffness
- hip fracture – if a hip joint becomes severely damaged during a fall or similar accident it may be necessary to replace it

Many of the conditions treated with a hip replacement are age-related so hip replacements are usually carried out in older adults aged between 60 and 80. However, a hip replacement may occasionally be performed in younger people.

The purpose of a new hip joint is to:

- relieve pain
- improve the function of your hip
- improve your ability to move around
- improve your quality of life

Referral for elective hip surgery should be considered for people with osteoarthritis who experience the following joint symptoms:

- Pain
- Stiffness
- reduced function
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Patients should be informed that the decision to have surgery can be a dynamic process and a decision to not undergo surgery now, does not exclude them from having surgery at a future point in time.

Eligibility Criteria

The CCG will fund this treatment if the patient meets one or more of the following criteria: The patient has a BMI less than or equal to 35 supported by a primary care referral.

AND

Conservative means (e.g. Analgesics, NSAIDS, physiotherapy, advice on walking aids, home adaptations, curtailment of inappropriate activities and general counselling as regards to the potential benefits of joint replacement) have failed to alleviate the patients pain and disability

AND

Pain and disability should be sufficiently significant to interfere with the patients’ daily life and or ability to sleep/patients whose pain is so severe

AND

Patient must accept and want surgery as the rehabilitation process after surgery can be a demanding time and requires commitment.

OR

The patient has a BMI less than or equal 35 and the destruction of their joint is of such severity that delaying surgical correction would increase technical difficulty of the procedure.

Patients with a BMI of 35 or more will be actively supported to engage with local weight management programmes to reduce their BMI. Level 1 and 2 weight management services are typically commissioned by Local Authority Public Heath; level 3 specialist weight management services are typically commissioned by CCGs who from 1 April 2016 are also responsible for level 4 Bariatric Surgery.

Total Hip Replacement-

After appropriate diagnosis, consider total hip replacement when a patient meets all of the following:

• pain is inadequately controlled by medication
• there is restriction of function
• the quality of life is significantly compromised
• there is narrowing of the joint space on radiograph

Hip Resurfacing Techniques (primary resurfacing arthroscopy of joint)

Except in the following, metal on metal hip resurfacing techniques are not normally funded:

• Those who qualify for primary total hip replacements, AND
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• are likely to outlive conventional primary hip replacements

This is because of the effects of higher BMI on post-surgical success per Journal of Arthroplasty, 2013, 28(5), p714-721 (A workgroup of the American Association of Hip and, Obesity and total joint arthroplasty: a literature based review) which concluded:

‘The morbidly obese (BMI >40) and the super obese (BMI >50) have complication profiles that may outweigh the functional benefits of total joint arthroplasty. These patients should be counselled regarding these risks prior to any surgical intervention. It is our consensus opinion that consideration should be given to delaying total joint arthroplasty in a patient with a BMI >40, especially when associated with other comorbid conditions, such as poorly controlled diabetes or malnutrition.’

This means (for patients who DO NOT meet the specified criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Guidance

Royal College of Surgeons Commissioning Guide for Painful Osteoarthritis of the Hip (2013)

http://www.rcseng.ac.uk/healthcare-bodies/docs/Painarisingfromthehipinadults.pdf


https://www.nice.org.uk/guidance/cg177

NHS Choices – Hip replacement

Weblink: http://www.nhs.uk/conditions/Hip-replacement/Pages/Introduction.aspx

Resurfacing verses total hip replacement

Royal College of Surgeons Commissioning guide (2013, updated June 2014). Weblink:

http://www.rcseng.ac.uk/healthcare-bodies/docs/commissioning-guides-boa/painful-hip-commissioning-guide

There are important choices to be made on technique, implant and bearing surface, and these should be made on a case-by-case basis by the surgeon taking into account the most recent evidence from the NJR (2). Hip resurfacing may be appropriate in young active patients with suitable anatomy. (23)


1.1 Prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options 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.

Resurfacing arthroplasty compared with total hip replacement

4.1.4 of the 3 RCTs comparing the effectiveness of resurfacing arthroplasty with THR, 1 RCT compared metal-on-metal (MoM) resurfacing arthroplasty with large-head MoM THR, 1 RCT compared MoM resurfacing arthroplasty with MoM THR, and 1 RCT compared MoM resurfacing arthroplasty with an unspecified bearing surface of THR. The 3 RCTs randomised a total of 422 patients (ranging from 104 to 192 per study) and the length of follow-up in the trials ranged from 1 to 6 years.

4.1.5 The reported outcomes in the 3 RCTs comparing resurfacing arthroplasty with THR were function (assessed in 3 RCTs), risk of revision (assessed in 1 RCT), infection (assessed in 2 RCTs), aseptic loosening (assessed in 1 RCT), dislocation (assessed in 2 RCTs), deep vein thrombosis (assessed in 2 RCTs) and health-related quality of life (assessed in 2 RCTs; 1 used the EQ-5D and 1 used the SF-36 questionnaire). Five functional measures were used across the 3 RCTs. There was no difference between resurfacing arthroplasty and THR for the Oxford Hip Score, Western Ontario McMaster Osteoarthritis Index score, or the Merle D’Abigine and Postel score. The evidence was inconclusive for the Harris Hip Score and the University of California, Los Angeles activity score. The Assessment Group reported that infection rates differed between patients who had resurfacing arthroplasty and those who had THR. The Assessment Group’s meta-analysis of the 2 RCTs that assessed this outcome indicated that, 12–56 months after surgery, patients who had had THR developed more infections than patients who had had resurfacing arthroplasty (pooled odds ratio 7.94, 95% confidence interval [CI] 1.78 to 35.40). All data for the other outcomes (quality of life, revision dislocation, deep vein thrombosis, wound complication, aseptic loosening and mortality) reported in the 3 RCTs were inconclusive.

4.1.6 Of the 3 systematic reviews comparing the effectiveness of resurfacing arthroplasty with THR, 2 synthesised data on function, 2 on risk of revision, 1 on infection, 2 on aseptic loosening, 2 on dislocation and 2 on mortality. The systematic reviews included data from both RCTs and observational studies, including single-arm studies of resurfacing arthroplasty or THR. Two of the systematic reviews assessed resurfacing arthroplasty compared with all types of THR and 1 systematic review compared resurfacing arthroplasty with cementless THR. Two of the systematic reviews included RCTs that the Assessment Group had critiqued separately. The Assessment Group considered the reported data on function to be inconclusive. The 2 systematic reviews that compared revision rates between resurfacing arthroplasty and THR showed that revision rates were higher after resurfacing arthroplasty (1 estimated a relative risk [RR] of 2.60 [95% CI 1.31 to 5.15] over a 10-year follow-up, 1 estimated an RR of 1.72 [95% CI 1.20 to 2.45] but did
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not report length of follow-up). Two systematic reviews found that resurfacing arthroplasty was associated with more component loosening than THR (RR 3.00, 95% CI 1.11 to 8.50 and RR 4.96, 95% CI 1.82 to 13.50 respectively). Both of these systematic reviews assessed dislocation rates and 1 found statistically significantly lower dislocation rates associated with resurfacing arthroplasty compared with THR (RR 0.20, 95% CI 0.10 to 0.5). The Assessment Group considered the reported data on all of the other outcomes (mortality, prosthesis failure and infection) to be inconclusive.
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**Hysterectomy for Heavy Menstrual Bleeding**
(NHSE EBI 2018)

Category: Restricted

Applicable OPCS Codes: Q07.2/.4/.5/.8/.9, Q08.2, Q08.8, Q08.9 with or without subsidiary OPCS code Y50.3

**Description of the intervention**

NICE recommends that hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding (HMB). Heavy periods can be reduced by using medicines or intrauterine systems (IUS) or losing weight (if necessary).

**Summary of intervention**

Hysterectomy is the surgical removal of the uterus.

**Criteria**

Based on NICE guidelines [Heavy menstrual bleeding: assessment and management [NG88] Published date: March 2018], hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding.

It is important that healthcare professionals understand what matters most to each woman and support her personal priorities and choices.

Hysterectomy should be considered only when: other treatment options have failed, are contradicted; there is a wish for amenorrhoea (no periods); the woman (who has been fully informed) requests it; the woman no longer wishes to retain her uterus and fertility.

**NICE guideline NG88 1.5 Management of HMB**

1.5.1 When agreeing treatment options for HMB with women, take into account: the woman's preferences, any comorbidities, the presence or absence of fibroids (including size, number and location), polyps, endometrial pathology or adenomyosis, other symptoms such as pressure and pain.

**Treatments for women with no identified pathology, fibroids less than 3 cm in diameter, or suspected or diagnosed adenomyosis**

1.5.2 Consider an LNG-IUS (levonorgestrel-releasing intrauterine system) as the first treatment for HMB in women with: no identified pathology or fibroids less than 3 cm in diameter, which are not causing distortion of the uterine cavity or suspected or diagnosed adenomyosis.

1.5.3 If a woman with HMB declines an LNG-IUS or it is not suitable, consider the following pharmacological treatments: non-hormonal: tranexamic acid, NSAIDs (non-steroidal anti-inflammatory drugs), hormonal: combined hormonal contraception, cyclical oral progestogens.
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1.5.4 Be aware that progestogen-only contraception may suppress menstruation, which could be beneficial to women with HMB.

1.5.5 If treatment is unsuccessful, the woman declines pharmacological treatment, or symptoms are severe, consider referral to specialist care for: investigations to diagnose the cause of HMB, if needed, taking into account any investigations the woman has already had and alternative treatment choices, including: pharmacological options not already tried (see recommendations 1.5.2 and 1.5.3); surgical options: second-generation endometrial ablation, hysterectomy.

1.5.6 For women with submucosal fibroids, consider hysteroscopic removal.

Treatments for women with fibroids of 3 cm or more in diameter

1.5.7 Consider referring women to specialist care to undertake additional investigations and discuss treatment options for fibroids of 3 cm or more in diameter.

1.5.8 If pharmacological treatment is needed while investigations and definitive treatment are being organised, offer tranexamic acid and/or NSAIDs.

1.5.9 Advise women to continue using NSAIDs and/or tranexamic acid for as long as they are found to be beneficial.

1.5.10 For women with fibroids of 3 cm or more in diameter, take into account the size, location and number of fibroids, and the severity of the symptoms and consider the following treatments: pharmacological: non-hormonal: tranexamic acid, NSAIDs, hormonal: LNG-IUS, combined hormonal contraception, cyclical oral progestogens, uterine artery embolization, surgical: myomectomy, hysterectomy.

1.5.13 Be aware that the effectiveness of pharmacological treatments for HMB may be limited in women with fibroids that are substantially greater than 3 cm in diameter.

1.5.14 Prior to scheduling of uterine artery embolisation or myomectomy, the woman's uterus and fibroid(s) should be assessed by ultrasound. If further information about fibroid position, size, number and vascularity is needed, MRI should be considered. [2007]

1.5.15 Consider second-generation endometrial ablation as a treatment option for women with HMB and fibroids of 3 cm or more in diameter who meet the criteria specified in the manufacturers' instructions.

1.5.16 If treatment is unsuccessful: consider further investigations to reassess the cause of HMB, taking into account the results of previous investigations and offer alternative treatment with a choice of the options described in recommendation

1.5.17 Pretreatment with a gonadotrophin-releasing hormone analogue before hysterectomy and myomectomy should be considered if uterine fibroids are causing an enlarged or distorted uterus.
Procedures of Lower Clinical Value
For further information, please see:

- [https://www.nice.org.uk/guidance/ng88.](https://www.nice.org.uk/guidance/ng88)
- [https://www.nhs.uk/conditions/heavy-periods/#Causes](https://www.nhs.uk/conditions/heavy-periods/#Causes)

**Rationale**
NICE’s Guideline Development Group considered the evidence (including 2 reviews, four randomised control trials and one cohort study comparing hysterectomy with other treatments) as well as the views of patients and the public and concluded that hysterectomy should not routinely be offered as first line treatment for heavy menstrual bleeding. The Group placed a high value on the need for education and information provision for women with heavy menstrual bleeding.

Complications following hysterectomy are usually rare but infection occurs commonly. Less common complications include: intra-operative haemorrhage; damage to other abdominal organs, such as the urinary tract or bowel; urinary dysfunction – frequent passing of urine and incontinence. Rare complications include thrombosis (DVT and clot on the lung) and very rare complications include death. Complications are more likely when hysterectomy is performed in the presence of fibroids (non-cancerous growths in the uterus). There is a risk of possible loss of ovarian function and its consequences, even if their ovaries are retained during hysterectomy. If oophorectomy (removal of the ovaries) is performed at the time of hysterectomy, menopausal-like symptoms occur.

**References**

1. NICE guidance: [https://www.nice.org.uk/guidance/ng88.](https://www.nice.org.uk/guidance/ng88)
2. NHS website: [https://www.nhs.uk/conditions/heavy-periods/#Causes](https://www.nhs.uk/conditions/heavy-periods/#Causes)
Procedures of Lower Clinical Value

**Diagnostic Hysteroscopy for Menorrhagia**

Category: Not routinely commissioned

Applicable OPCS Codes: Q18.1/.8/.9; Y41.2 or Y76.3 with Z45.1/.8/.9

Heavy periods, also called menorrhagia, is when a woman loses an excessive amount of blood during consecutive periods. Menorrhagia can occur by itself or in combination with other symptoms, such as menstrual pain (dysmenorrhoea). Heavy bleeding does not necessarily mean there is anything seriously wrong, but it can affect a woman physically, emotionally and socially, and can cause disruption to everyday life.

Eligibility Criteria

Diagnostic Hysteroscopy for Menorrhagia is not routinely commissioned.

This is because NICE Clinical Guideline 44 recommends that:

- Ultrasound is the first-line diagnostic tool for identifying structural abnormalities.
- Hysteroscopy should be used as a diagnostic tool only when ultrasound results are inconclusive, for example, to determine the exact location of a fibroid or the exact nature of the abnormality.
- If imaging shows the presence of uterine fibroids then appropriate treatment should be planned based on size, number and location of the fibroids.
- Saline infusion sonography should not be used as a first-line diagnostic tool.
- Magnetic resonance imaging (MRI) should not be used as a first-line diagnostic tool.

This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

**Guidance**


NHS Choices - Heavy periods (menorrhagia) Weblink: [http://www.nhs.uk/conditions/Periods-heavy/Pages/Introduction.aspx](http://www.nhs.uk/conditions/Periods-heavy/Pages/Introduction.aspx)
Knee Replacement Surgery

Category: Restricted


Knee replacement surgery (arthroplasty) involves replacing a damaged, worn or diseased knee with an artificial joint. It's a routine operation for knee pain most commonly caused by arthritis. More than 70,000 knee replacements are carried out in England and Wales each year, and the number is rising. Most people who have a total knee replacement are over 65 years old.

For most people, a replacement knee lasts over 20 years, especially if the new knee is cared for properly and not put under too much strain.

There are two main types of surgery, depending on the condition of the knee:

- total knee replacement (TKR) – both sides of your knee joint are replaced
- partial (half) knee replacement (PKR) – only one side of your joint is replaced in a smaller operation with a shorter hospital stay and recovery period

The most common reason for knee replacement surgery is osteoarthritis. Other conditions that cause knee damage include:

- rheumatoid arthritis
- haemophilia
- gout
- knee injury

A knee replacement is major surgery, so is normally only recommended if other treatments, such as physiotherapy or steroid injections, haven’t helped reduce pain or improve mobility.

You may be offered knee replacement surgery if:

- you have severe pain, swelling and stiffness in your knee joint and your mobility is reduced
- your knee pain is so severe that it interferes with your quality of life and sleep
- everyday tasks, such as shopping or getting out of the bath, are difficult or impossible
- you cannot work or have a normal social life

Referral for joint replacement surgery should be considered for people with osteoarthritis who experience all of the following joint symptoms:

- Pain
- Stiffness
- Reduced function
Procedures of Lower Clinical Value

Eligibility criteria

The CCG will fund this treatment if the patient meets ALL the following criteria.

The patient has a BMI less than or equal 35 supported by a primary care referral.

AND

Conservative means (e.g. Analgesics, NSAIDS, physiotherapy, advice on walking aids, home adaptations, curtailment of inappropriate activities and general counselling as regards to the potential benefits of joint replacement) have failed to alleviate the patients pain and disability

AND

Pain and disability should be sufficiently significant to interfere with the patients’ daily life and or ability to sleep/patients whose pain is so severe

AND

Patient must accept and want surgery (most total knee replacements are carried out on people between the ages of 60 and 80. The patient will need to be well enough to cope with both a major operation and the rehabilitation afterwards)

OR

The patient has a BMI less than or equal 35 and the destruction of their joint is of such severity that delaying surgical correction would increase technical difficulty of the procedure.

Patients with a BMI of 35 or more will be actively supported to engage with local weight management programmes to reduce their BMI.

This is because of the effects of higher BMI on post-surgical success per Journal of Arthroplasty, 2013, 28(5), p714-721 (A workgroup of the American Association of Hip and, Obesity and total joint arthroplasty: a literature based review) which concluded:

“The morbidly obese (BMI >40) and the super obese (BMI >50) have complication profiles that may outweigh the functional benefits of total joint arthroplasty. These patients should be counselled regarding these risks prior to any surgical intervention. It is our consensus opinion that consideration should be given to delaying total joint arthroplasty in a patient with a BMI >40, especially when associated with other comorbid conditions, such as poorly controlled diabetes or malnutrition.”

This means (for patients who DO NOT meet the specified criteria) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.
Procedures of Lower Clinical Value

Guidance

Royal College of Surgeons - Commissioning Guide for Painful Osteoarthritis of the Knee (2013) Weblink:

http://www.rcseng.ac.uk/healthcare-bodies/docs/Painfulosteoarthritisontheknee.pdf


https://www.nice.org.uk/guidance/cg177


Weblink:

(http://www.biomedcentral.com/2052-1847/5/25)

NHS Choices – Knee replacement

Weblink:

http://www.nhs.uk/conditions/Knee-replacement/Pages/Kneereplacementexplained.aspx

Arthroscopic shoulder decompression for sub acromial shoulder pain (NHSE EBI 2018)

Category: Restricted

Applicable OPCS Codes: O29.1

Description of the intervention

Recent research has indicated that in patients with pure subacromial impingement (with no other associated diagnoses such as rotator cuff tears, calcific tendinopathy and acromio-clavicular joint pain), non-operative management with a combination of exercise and physiotherapy is effective in the majority of cases.

Patients suffering with persistent symptoms, despite appropriate non-operative management, should be given the option to choose decompression surgery.

Treating clinicians and surgeons should refer to the 2015 BESS/BOA/NICE commissioning guidelines (guideline update due in 2018/19) for details of appropriate treatment of these patients.


In order to facilitate non-operative treatment in primary and intermediate care, BESS and Getting It Right First Time programme have produced patient exercise rehab videos and booklets for GPs and

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Summary of procedure
Arthroscopic sub-acromial decompression is a surgical procedure that involves decompressing the sub-acromial space by removing bone spurs and soft tissue arthroscopically.

Criteria
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 calcific tendinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases.

For patients who have persistent or progressive symptoms, in spite of adequate non-operative treatment, surgery should be considered. The latest evidence for the potential benefits and risks of subacromial shoulder decompression surgery should be discussed with the patient and a shared decision reached between surgeon and patient as to whether to proceed with surgical intervention.

Rationale
Recruiting patients with pure subacromial impingement and no other associated diagnosis, a recent randomised, pragmatic, parallel group, placebo-controlled trial investigated whether subacromial decompression compared with placebo (arthroscopy only) surgery improved pain and function. While statistically better scores were reached by patients who had both types of surgery compared to no surgery, the differences were not clinically significant, which questions the value of this type of surgery.

On the other hand, a more recent prospective randomised trial comparing the long term outcome (10 year follow up) of surgical or non-surgical treatment of subacromial impingement showed surgery to be superior to non-surgical treatment.

Other studies of limited quality identify certain patients with impingement syndrome that improve with surgical subacromial decompression if non-operative management fails. There is also some evidence to show the benefit of surgery when used selectively and applying national clinical guidelines.

A review of the literature identified one further systematic review that looked at the effectiveness of surgery. The review was limited by the quality of evidence but their findings showed no difference between patients treated with surgery and those treated with non-surgical options.

Healthcare professionals treating patients with subacromial pain should be familiar with the NICE approved commissioning and treatment guidelines for the management of subacromial pain.

Risks associated with arthroscopic sub-acromial decompression are low but include infection, frozen shoulder, ongoing pain, potential damage to blood vessels or nerves and those associated with having a general anaesthetic.

References
Procedures of Lower Clinical Value


Tonsillectomy for Recurrent Tonsillitis
(NHSE EBI 2018)
Category: Restricted

Description of the intervention
Recurrent sore throats are a very common condition that present a considerable health burden. In most cases they can be treated with conservative measures. In some cases, where there are recurrent, documented episodes of acute tonsillitis that are disabling to normal function, then tonsillectomy is beneficial, but it should only be offered when the frequency of episodes set out by the Scottish Intercollegiate Guidelines Network criteria are met.

Summary of Intervention
This guidance relates to surgical procedures to remove the tonsils as a treatment for recurrent sore throats in adults and children.

Recurring sore throats are a very common condition that presents a large burden on healthcare; they can also impact on a person’s ability to work or attend school. It must be recognised however, that not all sore throats are due to tonsillitis and they can be caused by other infections of the throat. In these cases, removing the tonsils will not improve symptoms.

Criteria
The NHS should only commission this surgery for treatment of recurrent severe episodes of sore throat when the following criteria are met, as set out by the SIGN guidance and supported by ENT UK commissioning guidance:

- Sore throats are due to acute tonsillitis AND
- The episodes are disabling and prevent normal functioning AND
- Seven or more, documented, clinically significant, adequately treated sore throats in the preceding year OR
- Five or more such episodes in each of the preceding two years OR
Procedures of Lower Clinical Value

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

There are a number of medical conditions where episodes of tonsillitis can be damaging to health or tonsillectomy is required as part of the on-going management. In these instances tonsillectomy may be considered beneficial at a lower threshold than this guidance after specialist assessment:

- Acute and chronic renal disease resulting from acute bacterial tonsillitis.
- As part of the treatment of severe guttate psoriasis.
- Metabolic disorders where periods of reduced oral intake could be dangerous to health.
- PFAPA (Periodic fever, Aphthous stomatitis, Pharyngitis, Cervical adenitis)
- Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous

Further information on the Scottish Intercollegiate Guidelines Network guidance can be found here: http://www.sign.ac.uk/assets/sign117.pdf

Please note this guidance only relates to patients with recurrent tonsillitis. This guidance should not be applied to other conditions where tonsillectomy should continue to be funded, these include:

- Obstructive Sleep Apnoea / Sleep disordered breathing in Children
- Suspected Cancer (e.g. asymmetry of tonsils)
- Recurrent Quinsy (abscess next to tonsil)
- Emergency Presentations (e.g. treatment of parapharyngeal abscess)

It is important to note that national randomised control trial is underway comparing surgery versus conservative management for recurrent tonsillitis in adults in underway which may warrant review of this guidance in the near future.

Rationale

Recurrent sore throats are a very common condition that presents a considerable health burden. In most cases they can be treated with conservative measures. In some cases, where there are recurrent, documented episodes of acute tonsillitis that are disabling to normal function, then tonsillectomy is beneficial, but it should only be offered when the frequency of episodes set out by the Scottish Intercollegiate Guidelines Network criteria are met.

The surgery carries a small risk of bleeding requiring readmission to hospital (3.5%). A previous national audit quoted a 0.9% risk of requiring emergency surgery to treat bleeding after surgery but in a more recent study of 267, 159 tonsillectomies, 1.88% of patients required a return to theatre. Pain after surgery can be severe (especially in adults) for up to two weeks after surgery; this requires regular painkillers and can cause temporary difficulty swallowing. In addition to bleeding; pain or infection after surgery can require readmission to hospital for treatment. The Getting it Right First Time ENT report is due late 2018 and will present updated figures on readmission rates in relation to tonsillectomy.

References

Trigger Finger Release in Adults (NHSE EBI 2018)
Category: Restricted
Applicable OPCS Codes: T69.1/.2/.8/.9; T70.1/.2/.8/.9; T72.3/.8/.9 with any one of Z89.4/.5/.6/.7.

Description of the intervention
Trigger finger often resolves over time and is often a nuisance rather than a serious problem. If treatment is necessary steroid injection can be considered. Surgery should only be offered in specific cases according to NICE accredited guidelines by the British Society for Surgery to the Hand, where alternative measures have not been successful and persistent or recurrent triggering, or a locked finger occurs.

Summary of intervention
Trigger digit occurs when the tendons which bend the thumb/finger into the palm intermittently jam in the tight tunnel (flexor sheath) through which they run. It may occur in one or several fingers and causes the finger to “lock” in the palm of the hand. Mild triggering is a nuisance and causes infrequent locking episodes. Other cases cause pain and loss and unreliability of hand function. Mild cases require no treatment and may resolve spontaneously.

Criteria
Mild cases which cause no loss of function require no treatment or avoidance of activities which precipitate triggering and may resolve spontaneously.

Cases interfering with activities or causing pain should first be treated with:
  a) one or two steroid injections which are typically successful (strong evidence), but the problem may recur, especially in diabetics;
  or
  b) Splinting of the affected finger for 3-12 weeks (weak evidence).

Surgery should be considered if:
  a) the triggering persists or recurs after one of the above measures (particularly steroid injections);
  or
  b) the finger is permanently locked in the palm;
  or
  c) the patient has previously had 2 other trigger digits unsuccessfully treated with appropriate non-operative methods;
  or
  d) Diabetics.

Surgery is usually effective and requires a small skin incision in the palm, but can be done with a needle.
Procedures of Lower Clinical Value
through a puncture wound (percutaneous release).

Rationale
Treatment with steroid injections usually resolve troublesome trigger fingers within 1 week (strong evidence) but sometimes the triggering keeps recurring. Surgery is normally successful (strong evidence), provides better outcomes than a single steroid injection at 1 year and usually provides a permanent cure. Recovery after surgery takes 2-4 weeks. Problems sometimes occur after surgery, but these are rare (<3%).

References
1. https://www.nhs.uk/conditions/trigger-finger/treatment/
Procedures of Lower Clinical Value

Varicose Veins (NHSE EBI 2018)

Category: Restricted

Applicable OPCS Codes: L83.-; L84.-; L85.-; L86.-; L87.-; L88.-

Description of the intervention
NICE has published detailed guidance on what treatment should be considered for varicose veins and when interventions for varicose veins (endothermal ablation, sclerotherapy or surgery) should be offered. Surgery is a traditional treatment that involves removal of the vein; patients can get recurrence of symptoms which may need further treatment. Treatments like endothermal ablation or ultrasound-guided foam sclerotherapy are less invasive than surgery and have replaced surgery in the management of most patients. However surgery is the most appropriate in some cases. Patients with symptomatic varicose veins should be offered treatment of their varicose veins. Compression hosiery is not recommended if an interventional treatment is possible.

Summary of intervention
There are various interventional procedures for treating varicose veins. These include endothermal ablation, ultrasound guided foam sclerotherapy and traditional surgery (this is a surgical procedure that involves ligation and stripping of varicose veins) all of which have been shown to be clinically and cost effective compared to no treatment or treatment with compression hosiery. Varicose veins are common and can markedly affect patients quality of life, can be associated with complications such as eczema, skin changes, thrombophlebitis, bleeding, leg ulceration, deep vein thrombosis and pulmonary embolism that can be life threatening.

Criteria
1.1 Intervention in terms of, endovenous thermal (laser ablation, and radiofrequency ablation), ultrasound guided foam sclerotherapy, open surgery (ligation and stripping) are all cost effective treatments for managing symptomatic varicose veins compared to no treatment or the use of compression hosiery. For truncal ablation there is a treatment hierarchy based on the cost effectiveness and suitability, which is endothermal ablation then ultrasound guided foam, then conventional surgery.

1.2 Refer people to a vascular service if they have any of the following:
1. Symptomatic * primary or recurrent varicose veins.
2. Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency.
3. Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence.
4. A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks).
5. A healed venous leg ulcer.

*Symptomatic: “Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching).”

For patients whose veins are purely cosmetic and are not associated with any symptoms do not refer for NHS treatment

1.3 Refer people with bleeding varicose veins to a vascular service immediately.

1.4 Do not offer compression hosiery to treat varicose veins unless interventional treatment is
Procedures of Lower Clinical Value
unsuitable.

For further information, please see:
- [https://www.nice.org.uk/guidance/qs67](https://www.nice.org.uk/guidance/qs67)
- [https://www.guidelinesinpractice.co.uk/nice-referral-advice-11-varicose-veins/300594.article](https://www.guidelinesinpractice.co.uk/nice-referral-advice-11-varicose-veins/300594.article)
- [https://www.nice.org.uk/guidance/cg168](https://www.nice.org.uk/guidance/cg168)

**Rationale**

International guidelines, NICE guidance and NICE Quality standards provide clear evidence of the clinical and cost-effectiveness that patients with symptomatic varicose veins should be referred to a vascular service for assessment including duplex ultrasound.

Open surgery is a traditional treatment that involves surgical removal by 'stripping' out the vein or ligation (tying off the vein), this is still a valuable technique, it is still a clinically and cost-effective treatment technique for some patients but has been mainly superseded by endothermal ablation and ultrasound guided foam sclerotherapy.

Recurrence of symptoms can occur due to the development of further venous disease, that will benefit from further intervention (see above). NICE guidance states that a review of the data from the trials of interventional procedures indicates that the rate of clinical recurrence of varicose veins at 3 years after treatment is likely to be between 10–30%.

For people with confirmed varicose veins and truncal reflux NICE recommends:
- Offer endothermal ablation of the truncal vein.
- If endothermal ablation is unsuitable, offer ultrasound-guided foam sclerotherapy.
- If ultrasound-guided foam sclerotherapy is unsuitable, offer surgery.
- Consider treatment of tributaries at the same time
- Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable.

Complications of intervention include recurrence of varicose veins, infection, pain, bleeding, and more rarely blood clot in the leg. Complications of non-intervention include decreasing quality of life for patients, increased symptomatology, disease progression potentially to skin changes and eventual leg ulceration, deep vein thrombosis and pulmonary embolism.

**References**

1. [https://www.guidelinesinpractice.co.uk/nice-referral-advice-11-varicose-veins/300594.article](https://www.guidelinesinpractice.co.uk/nice-referral-advice-11-varicose-veins/300594.article)
2. [https://www.nice.org.uk/guidance/cg168](https://www.nice.org.uk/guidance/cg168)
3. [https://www.nice.org.uk/guidance/qs67](https://www.nice.org.uk/guidance/qs67)
Dupuytren’s contracture release in adults  
(NHSE EBI 2018)

Category: Restricted  
Applicable OPCS Codes: T521

Description of the intervention  
NICE recommends no treatment is necessary for people with Dupuytren’s disease who do not have contracture. Referral to hand surgery should be made for people with Dupuytren’s contractures according to the criteria listed below.

Summary of intervention  
Dupuytren’s contracture is caused by fibrous bands in the palm of the hand which draw the finger(s) (and sometimes the thumb) into the palm and prevent them from straightening fully. If not treated the finger(s) may bend so far into the palm that they cannot be straightened. All treatments aim to straighten the finger(s) to restore and retain hand function for the rest of the patient’s life. However none cure the condition which can recur after any intervention so that further interventions are required.

Splinting and radiotherapy have not been shown be effective treatments of established Dupuytren’s contractures.

Several treatments are available: collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy. None is entirely satisfactory with some having slower recovery periods, higher complication rates or higher reoperation rates (for recurrence) than others. The need for, and choice of, intervention should be made on an individual basis and should be a shared decision between the patient and a practitioner with expertise in the various treatments of Dupuytren’s contractures.

No-one knows which interventions are best for restoring and maintaining hand function throughout the rest of the patient’s life, and which are the cheapest and most cost-effective in the long term. Ongoing and planned National Institute for Health Research studies aim to address these questions.

- Treatment is not indicated in cases where there is no contracture, and in patients with a mild (less than 20°) contractures, or one which is not progressing and does not impair function.
- An intervention (collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy) should be considered for:
  - finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint.
  - severe thumb contractures which interfere with function.
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- NICE concluded that collagenase should only be used for:
  a) Participants in the ongoing clinical trial (HTA-15/102/04)
  or
  b) Adult patients with a palpable cord if:
     i. 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 two affected joints;
     and
     ii. needle fasciotomy is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon

Rationale

Contractures left untreated usually progress and often fail to straighten fully with any treatment if allowed to progress too far. Complications causing loss, rather than improvement, in hand function occur more commonly after larger interventions, but larger interventions carry a lower risk of need for further surgery.

Common complications after collagenase injection are normally transient and include skin breaks and localised pain. Tendon injury is possible but very rare. Significant complications with lasting impact after needle fasciotomy are very unusual (about 1%) and include nerve injury. Such complications after fasciectomy are more common (about 4%) and include infection, numbness and stiffness.

References

6. NICE, 2017. Collagenase clostridium histolyticum for treating Dupuytren’s contracture. : https://www.nice.org.uk/guidance/ta459,
12. van Rijssen AL, ter Linden H, Werker PM. Five-year results of a randomized clinical trial on treatment in Dupuytren’s disease: Percutaneous needle fasciotomy versus limited fasciectomy.
Carpal Tunnel Syndrome Release (NHSE EBI 2018)

Category: Restricted

Applicable OPCS Codes: A651

Description of the intervention
Carpal tunnel syndrome is common, and mild acute symptoms usually get better with time. Splinting at night, pain relief and corticosteroid injection should be considered. Surgery should be considered for persistent severe symptoms. Surgical treatment of carpal tunnel should only be offered under the criteria included below.

Summary of intervention
Open or endoscopic surgical procedure to release median nerve from carpal tunnel.

- Mild cases with intermittent symptoms causing little or no interference with sleep or activities require no treatment.
- Cases with intermittent symptoms which interfere with activities or sleep should first be treated with:
  a) corticosteroid injection(s) (medication injected into the wrist: good evidence for short (8-12 weeks) term effectiveness)
  or
  b) night splints (a support which prevents the wrist from moving during the night: not as effective as steroid injections)
- Surgical treatment of carpal tunnel should be considered if one of the following criteria are met:
  a) The symptoms significantly interfere with daily activities and sleep symptoms and have not settled to a manageable level with either one local corticosteroid injection and/or nocturnal splinting for a minimum of 8 weeks;
  or
  b) There is either:
     i) a permanent (ever-present) reduction in sensation in the median nerve distribution;
     or
     ii) muscle wasting or weakness of thenar abduction (moving the thumb away from the hand).

Nerve Conduction Studies if available are suggested for consideration before surgery to predict positive surgical outcome or where the diagnosis is uncertain.

Rationale
Carpal tunnel syndrome is very common, and mild cases may never require any treatment. Cases which interfere with activities or sleep may resolve or settle to a manageable level with non-operative treatments such as a steroid injection (good evidence of short-term benefit (8-12 weeks) but many progress to surgery within 1 year). Wrist splints worn at night (weak evidence of benefit) may also be used but are less effective than steroid injections and reported as less cost-effective than surgery.

In refractory (keeps coming back) or severe case surgery (good evidence of excellent clinical
Procedures of Lower Clinical Value

Effectiveness and long term benefit should be considered. The surgery has a high success rate (75 to 90%) in patients with intermittent symptoms who have had a good short-term benefit from a previous steroid injection. Surgery will also prevent patients with constant wooliness of their fingers from becoming worse and can restore normal sensation to patients with total loss of sensation over a period of months.

The hand is weak and sore for 3-6 weeks after carpal tunnel surgery but recovery of normal hand function is expected, significant complications are rare (∼4%) and the lifetime risk of the carpal tunnel syndrome recurring and requiring revision surgery has been estimated at between 4 and 15%.

References

4. Korthals-de Bos IB, Gerritsen AA, van Tulder MW et al. Surgery is more cost-effective than splinting for carpal tunnel syndrome in the Netherlands: Results of an economic evaluation alongside a randomized controlled trial. BMC Musculoskeletal Disorders. 2006, 7: 86.
10. Royal College of Surgeons: https://publishing.rcseng.ac.uk/doi/10.1308/rcsbull.2017.28

Spinal fusion surgery for chronic low back pain

Category: Restricted

Applicable OPCS Codes: V37, V38

Rationale:

There is no evidence demonstrating that spinal fusion is more clinically effective or cost-effective than a multi-disciplinary rehabilitation programme (physiotherapy, exercise and psychological input) for chronic (>1 year) degenerative back pain.

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Eligibility Criteria:

A patient will only be eligible for spinal fusion surgery for chronic low back pain provided they fulfil the following criteria:

- A sTarT Back score has been completed and recorded at initial assessment
- The patient has undergone an agreed structured physiotherapy programme with a written report from the physiotherapy service
- The patient has attended the pain management service
- The low back pain has lasted more than one year and is documented as a significant interference with daily life (eg loss of function > 50% on EuroQoL22 or BPI tool)

Lumbar spinal epidural injections

Category: Restricted

Applicable OPCS Codes: A521, AB04Z, A522

Rationale:

Intervertebral disc prolapse causing spinal nerve root irritation is a common occurrence and is usually self-limiting with suitable modification of activity (although not ceasing activity), analgesia and time.

Epidurals are the instillation of local anaesthetic and/or corticosteroids into the potential space between the membranes which surround the spinal cord.

As per NICE guidance (NG59, 2017), the CCG will not fund

- Spinal injections for non-specific low back pain
- Epidural injections for neurogenic claudication in people who have central spinal canal stenosis.

Eligibility Criteria:

For acute radicular pain, the CCG will fund lumbar epidural injections (local anaesthetic and long acting corticosteroids, a maximum of 2) for patients over the age of 16 years if they meet the following criteria:

The patient has radicular 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

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Procedures of Lower Clinical Value
Symptoms persist despite some non-operative treatment for at least 3 weeks (e.g. analgesia, physical therapy, bed rest etc.) but less than 12 weeks.

For chronic radicular pain, the CCG will fund lumbar epidural injections (local anaesthetic and long acting corticosteroids, a maximum of 2) for patients over the age of 16 years if they meet the following criteria:

Where all conservative management options, (physiotherapy, exercise, pharmacotherapy) have been tried and failed and the pain has resulted in moderate to significant impact on daily functioning.

Diagnostic arthroscopy of the knee:

Category: Restricted

Applicable OPCS Codes: W879

Rationale:

Knee arthroscopy should not be considered a primary diagnostic tool. MRI should be used where there is diagnostic uncertainty. In the majority of cases clinical assessment (history and examination) by an experienced clinician will provide a diagnosis and demonstrate if internal joint derangement is present.

Eligibility Criteria:

Diagnostic arthroscopy of the knee will not be routinely funded for patients. A diagnostic arthroscopy for the knee may be carried out only if the patient meets the following criteria-

Chronic knee pain with diagnostic uncertainty following an MRI scan

OR

A red flag for infection, fracture or avascular necrosis
Knee arthroscopy for patients with osteoarthritis (NHSE EBI 2018)

Updated description of the intervention

NICE recommends that arthroscopic knee washout should not be used as a treatment for patients with osteoarthritis, unless the knee locks (in which case it may be considered). More effective treatments include physiotherapy, exercise programmes like ESCAPE pain, losing weight (if necessary) and pain management.

If symptoms do not resolve, knee replacement or osteotomy are effective procedures that should be considered.

Summary of Intervention:

Arthroscopic washout of the knee is an operation where an arthroscope (camera) is inserted in to the knee along with fluid. Occasionally loose debris drains out with the fluid, or debridement, (surgical removal of damaged cartilage) is performed, but the procedure does not improve symptoms or function of the knee joint.

Criteria:

Arthroscopic knee washout (lavage and debridement) should not be used as a treatment for osteoarthritis because it is clinically ineffective.

Referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking.

More effective treatment includes exercise programmes (e.g. ESCAPE pain), losing weight (if necessary) and managing pain. Osteoarthritis is relatively common in older age groups. Where symptoms do not resolve after non-operative treatment, referral for consideration of knee replacement or joint preserving surgery such as osteotomy is appropriate.

For further information, please see:

- [https://www.nice.org.uk/guidance/ipg230/chapter/1-Guidance](https://www.nice.org.uk/guidance/ipg230/chapter/1-Guidance)

Rationale:

NICE has reviewed the evidence for how well knee washout works for people with osteoarthritis.
Procedures of Lower Clinical Value

Seven clinical trials and three case studies have shown that knee wash out for people with osteoarthritis did not reduce pain nor improve how well their knees worked. There was a small increased risk of bleeding inside the knee joint (haemarthrosis) (2%) or blood clot in the leg (deep vein thrombosis) (0.5%).

An arthroscopic knee washout involves flushing the joint with fluid, which is introduced through small incisions in the knee. The procedure is often done with debridement, which is the removal of debris around the joint (NICE, 2007).

References

2. NICE guidance: https://www.nice.org.uk/guidance/ipg230/chapter/1- Guidance
Procedures of Lower Clinical Value

**Joint injections** (excluding facet joint injections)

**Category:** Restricted

**Applicable OPCS Codes:** W903, W904

**Rationale:**

NICE guidance on osteoarthritis (2014) states the following:

- Intra-articular corticosteroid injections should be considered as an adjunct to core treatments for the relief of moderate to severe pain in people with osteoarthritis
- Do not offer intra-articular hyaluronan injections for the management of osteoarthritis

Intra-articular corticosteroids are evidenced to be an effective source of pain relief in patients suffering with osteoarthritis, however, they are not without risks and they do not relieve all of the pain for everyone. Therefore, other treatment options, including conservative approaches e.g. physiotherapy should be considered concurrently.

**Eligibility Criteria:**

More than 3 joint injections will not be supported when a patient is likely to be a candidate for joint replacement, except when being used as a diagnostic tool prior to joint replacement to confirm the joint is the major source of pain/symptoms.

Joint injections may also be considered for those patients who are currently unfit or unsuitable for surgery and patients who do not wish to proceed to joint replacement surgery. Evidence of clinical benefit must be demonstrated for continued use of joint injections in these patients.

Where joint injections are supported, these should normally be undertaken in the out-patient setting.

Note: Joint injections will only be commissioned in a sterile theatre when X-ray screening or general anaesthesia is required or when joint injections are performed in conjunction with other invasive procedures.
Procedures of Lower Clinical Value

**Bunions and hallux valgus corrective surgery**

Category: Restricted

Applicable OPCS Codes: W791, W151

**Rationale:**

NICE CKS makes clear that referral for bunion surgery is indicated for pain and is not routinely performed for cosmetic purposes.

Conservative treatment may be more appropriate than surgery for some older people, or people with severe neuropathy or other comorbidities affecting their ability to undergo surgery.

Referral for orthopaedics or podiatric surgery consultation may be of benefit if the deformity is painful and worsening; the second toe is involved; the person has difficulty obtaining suitable shoes; or there is significant disruption to lifestyle or activities.

Bunion surgery may help relieve pain and improve the alignment of the toe in most people (85%–90%); but there is no guarantee that the foot will be perfectly straight or pain-free after surgery.

Complications after bunion surgery may include infection, joint stiffness, transfer pain (pain under the ball of the foot), hallux varus (overcorrection), bunion recurrence, damage to the nerves, and continued long-term pain.

There is very little good evidence with which to assess the effectiveness of either conservative or operative treatments or the potential benefit of one over the other. Untreated HV in patients with diabetes (and other causes of peripheral neuropathy) may lead to ulceration, deep infection and even amputation.

**Eligibility Criteria:**

The CCG will not routinely fund surgery for asymptomatic hallux valgus (bunion), regardless of cosmetic appearance.

Patients should not be referred to secondary care for cosmetic appearance. All patients should be referred to local podiatry services in the first instance.

The above does not apply to patients on diabetic foot pathway with following conditions:

- Non healing skin ulcer
- Peripheral limb ischaemia
- Patients with diabetes

Requests for the removal of symptomatic bunions will ONLY be considered where: Conservative measures have failed to benefit after 3 months (these include trying accommodative footwear, considering orthoses and using appropriate analgesia.)
Procedures of Lower Clinical Value
AND

The patient suffers from severe pain on walking (not relieved by chronic standard analgesia) that causes significant functional impairment

OR

Severe deformity (with or without lesser toe deformity) that causes significant functional impairment OR prevents them from finding adequate footwear

OR

Recurrent or chronic ulceration or infection

The clinician needs to ensure that the patient fulfils all the criteria before they are referred to secondary care. Before referral patients should be informed that

- They will be in plaster for 6 weeks and unable to drive
- It will take at least a further 2 months to regain full function
- The prognosis for treated and untreated HV is very variable
Procedures of Lower Clinical Value

Ear wax removal:

Category: Restricted

Applicable OPCS Codes: None

Eligibility Criteria:

Ear wax removal in secondary care (for all ages) is not routinely funded by the CCG. Patients should only be referred to secondary care for ear wax removal if the following criteria are met:

1. a) There is a foreign body, including vegetable matter, in the ear canal that could swell during irrigation;

OR

1. b) The patient is suffering from significant symptoms due ear wax build up including hearing loss or pain and the patient’s condition warrants micro suction;

AND

2. The patient has previously undergone ear surgery (other than grommets insertion that has been extruded for at least 18 months);

OR

3. The patient has a recent history of Otalgia and/or middle ear infection (in past 6 weeks);

OR

4. The patient suffers from Acute Otitis Externa; OR

5. The patient has a current perforation or history of ear discharge in the past 12 months;

OR

6. The patient has had previous complications following ear irrigation including perforation of the ear drum, severe pain, deafness, or vertigo;

OR

7. Two attempts at irrigation of the ear canal in primary care has been unsuccessful; OR

8. Ear drops have been used per instructions for a minimum of 14 days with no improvement and irrigation is clinically contraindicated. (If funding approval is successful patients are advised to continue with ear drops until their ENT assessment).

Patients who are suspected of suffering from malignancy should be referred under the two week cancer pathway which does not require prior approval.
Procedures of Lower Clinical Value

Routine Ear Irrigation

Category: Excluded

Criteria
Routine ear irrigation will not be funded in a Secondary Care setting

Rationale
Routine ear syringing is not a procedure normally carried out in a secondary care setting. Treatment should be delivered in primary care prior to referral to secondary care.

References

Adult Snoring Surgery (in the absence of OSA)
(NHSE EBI 2018)

Updated description of the intervention
In two systematic reviews of 72 primary research studies, there was no evidence that surgery to the palate to improve snoring provides any additional benefit compared to non-surgical treatments. The surgery has up to 16% risk of severe complications (bleeding, airway compromise, death). Therefore it is no longer commissioned. A number of alternatives to surgery can improve snoring. These include lifestyle changes (weight loss, smoking cessation and reducing alcohol intake) and medical treatment of nasal congestion.

Summary of Intervention
Snoring is a noise that occurs during sleep that can be caused by vibration of tissues of the throat and palate. It is very common and as many as one in four adults snore, as long as it is not complicated by periods of apnoea (temporarily stopping breathing) it is not usually harmful to health, but can be disruptive, especially to a person’s partner.
This guidance relates to surgical procedures in adults to remove, refashion or stiffen the tissues of the soft palate (Uvulopalatopharyngoplasty, Laser assisted Uvulopalatoplasty & Radiofrequency ablation of the palate) in an attempt to improve the symptom of snoring. Please note this guidance only relates to patients with snoring in the absence of Obstructive Sleep Apnoea (OSA) and should not be applied to the surgical treatment of patients who snore and have proven OSA who may benefit from surgical intervention as part of the treatment of the OSA.

It is important to note that snoring can be associated with multiple other causes such as being overweight, smoking, alcohol or blockage elsewhere in the upper airways (e.g. Nose or tonsils) and often these other causes can contribute to the noise alongside vibration of the tissues of the throat and palate.

DW 03/05/19 v 1.0
Procedures of Lower Clinical Value

Criteria

It is on the basis of limited clinical evidence of effectiveness, and the significant risks that patients could be exposed to, this procedure should no longer be routinely commissioned in the management of simple snoring.

Alternative Treatments

There are a number of alternatives to surgery that can improve the symptom of snoring. These include:

• Weight loss
• Stopping smoking
• Reducing alcohol intake
• Medical treatment of nasal congestion (rhinitis)
• Mouth splints (to move jaw forward when sleeping)

Rationale:

In two systematic reviews of 72 primary research studies there is no evidence that surgery to the palate to improve snoring provides any additional benefit compared to other treatments. While some studies demonstrate improvements in subjective loudness of snoring at 6-8 weeks after surgery; this is not longstanding (> 2 years) and there is no long-term evidence of health benefit. This intervention has limited to no clinical effectiveness and surgery carries a 0-16% risk of severe complications (including bleeding, airway compromise and death). There is also evidence from systematic reviews that up to 58-59% of patients suffer persistent side effects (swallowing problems, voice change, globus, taste disturbance & nasal regurgitation). It is on this basis the interventions should no longer be routinely commissioned.

References


Procedures of Lower Clinical Value

Autologous Cartilage Transplant

Category: Not routinely commissioned

Criteria

Autologous Cartilage Transplant will not normally be funded and only considered as part of a randomised controlled trial or in exceptional circumstances.

Rationale

NICE guidance states that autologous chondrocyte implantation (ACI) is not recommended for the treatment of articular cartilage defects of the knee joint, except in the context of ongoing or new clinical studies that are designed to generate robust and relevant outcome data, including the measurement of health-related quality of life and long-term follow-up. Patients should be fully informed of the uncertainties about the long-term effectiveness and the potential adverse effects of this procedure.

References

NICE Guidance TAG 16 (review) - Cartilage injury - autologous chondrocyte implantation:
http://www.nice.org.uk/page.aspx?o=72659


Reversal of Male Sterilisation

Category: Not routinely commissioned

Criteria

Male sterilisation is provided by the NHS as an irreversible procedure. This should be made clear to patients at referral and prior to treatment. Reversal of male sterilisation will not normally be funded, except in exceptional circumstances.

Rationale

Reversal of male sterilisation is a surgical procedure that involves the reconstruction of the vas deferens. Sterilisation procedures are available on the NHS and couples seeking sterilisation should be fully advised and counselled that the procedure is intended to be permanent.

References

Procedures of Lower Clinical Value

Reversal of Female Sterilisation

Criteria

Reversal of female sterilisation will not normally be funded except in exceptional circumstances.

Rationale

Reversal of sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes. One study of 85 women concluded that reversal of sterilisation is a safe and effective method of restoring fertility.

Sterilisation procedures are available on the NHS and couples seeking sterilisation should be fully advised and counselled (in accordance with RCOG guidelines) that the procedure is intended to be permanent.

References

RCOG - Male and Female Sterilisation, Evidence-based Clinical Guideline Number 4 (Jan 2004)

Laser Surgery for Short Sight (Myopia)

Criteria

Laser surgery for correction of short sight will not normally be funded.

Rationale

Current evidence suggests that photorefractive (laser) surgery for the correction of refractive errors is safe and efficacious in appropriately selected patients. Refractive errors are usually corrected by wearing spectacles or contact lenses, and these treatments are currently not available on the NHS. Both have limitations and contact lens wear is associated with an increased risk of sight-threatening corneal infection. Surgical treatments have been developed to permanently improve refraction by re-shaping the cornea.

References

NICE IPG 164 - Photorefractive (laser) surgery for the correction of refractive errors.
Botulinum Toxin Type A - Spasticity

Criteria

Botulinum Toxin Type A will not be funded for Cosmetic Reasons

Rationale

Spasticity is a significant feature of an upper motor neurone syndrome, which occurs quite commonly in many neurological conditions like stroke, multiple sclerosis, brain injury, cerebral palsy etc. It can lead to disabling complications like contractures and pressures sores, which in turn places a huge burden on the patient, family, social services and the NHS. [£10,551 for one pressure sore]. Prompt and effective management of spasticity by a multi-modal, multi-agency approach co-ordinated by an interdisciplinary team can prevent these complications. It is estimated that approximately one-third of stroke patients (van Kuijk et al 2007; Watkins et al 2002), 60% of patients with severe multiple sclerosis (MS) and 75% of patients with physical disability following severe traumatic brain injury will develop spasticity requiring specific treatment. Of these, approximately one-third may require treatment with Botulinum Toxin injections. (Verplancke et al 2005).

BTA has been used for Management of spasticity since 1989 and its use is further recommended in the UK National Guidelines 2009. Effective management of spasticity using Botulinum Toxin injections can lead to benefits-

1) At impairment level: reduce pain; prevent pressure sores and contractures; improved seating etc.
2) At activity level: improved mobility; increase in an ability to use limbs for function like feeding, dressing, grooming; reduce carer burden and
3) At participation level: improve self-esteem and self-image; facilitate social interaction etc.

This should be supplemented by;

a) Use of other pharmacological agents: oral anti-spasticity agents like baclofen, tizanidine etc, phenol nerve blockade
b) Non-pharmacological interventions including effective management of noxious stimuli like constipation, bladder and skin issues
c) Post injection goal-oriented therapy input and
d) Liaising with and incorporating the support of allied agencies like Orthotics, Wheelchair services, Social Services etc.

The clinical benefit can persist for many months (particularly when accompanied by an appropriate physical management regimen) but wears off gradually. Repeat injections generally follow a similar course. Experience in other neurological conditions has demonstrated that spasticity in adults may become biologically resistant to BTA as a result of antibody formation, especially with frequent, large dose injections (Greene and Fahn 1992, 1993; Hambleton and Moore1995). This has led to the general advice to avoid repeated injection at less than three month intervals.

Although secondary non-response is theoretically an issue for the use of BTA in spasticity, it is rarely reported in practice. This may be because spasticity is often self-limiting in the course of natural recovery, e.g. following stroke or brain injury, so that long-term repeated injections are required for only a minority of patients.
Procedures of Lower Clinical Value

BTA is contraindicated in patients who are hypersensitive to any Botulinum toxin reparation or to any components in the formulation

Infection at the Injection Site(s)

BTA is contraindicated in the presence of infection at the proposed injection site(s)

Spasticity

Botulinum Toxin Type A will be funded when medically necessary for Spasticity when the following criteria are met:

1. Spasticity due to a diagnosed neurological condition:
   a) Stroke
   b) Multiple Sclerosis [MS]
   c) Acquired Brain Injury- Traumatic and Non-Traumatic
   d) Acquired Spinal Injury: Traumatic and Non-traumatic
   e) Motor Neurone Disease [MND]
   f) Parkinson’s disease
   g) Miscellaneous condition

2. Spasticity not responding to physical therapy and oral anti-spasticity agents

3. Focal spasticity and not generalised spasticity [therefore not needing systemic oral agents]

4. To improve function in upper and lower limbs

5. To facilitate therapy/ splinting/orthotics/positioning

6. To facilitate carer input/ reduce carer burden

7. To prevent severe complications which require expensive interventions like pressure sores, contractures etc.

8. Reduce severe pain from spasticity in spite of optimal treatment with different pharmacological agents, positioning etc.

Funding will be approved on an on-going basis however the Provider will avoid repeated injection with intervals less than three months.

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

References

The Cochrane Library
http://onlinelibrary.wiley.com/o/cochrane/clsysrev/articles/CD006499/frame.html
Royal College Physicians / BSRM National Guidelines for Management of Spasticity using Bot Toxin [2009]
Extracorporeal Shockwave Therapy for Refractory Plantar Fasciitis

Criteria

Extracorporeal shockwave therapy for refractory plantar fasciitis will not normally be funded

Rationale

Plantar fasciitis is characterised by chronic degeneration of the plantar fascia, which causes pain on the underside of the heel. It is usually caused by injury or biomechanical abnormalities and may be associated with micro tears, inflammation or fibrosis.

Conservative treatments include rest, application of ice, analgesic medication, non-steroidal anti-inflammatory drugs, orthotic devices, physiotherapy, eccentric training/stretching and corticosteroid injection.

Extracorporeal shockwave therapy (ESWT) is a non-invasive treatment in which a device is used to pass acoustic shockwaves through the skin to the affected area. Ultrasound guidance can be used to assist with positioning of the device. Extracorporeal shockwave therapy may be applied in one or several sessions. Local anaesthesia may be used because high-energy ESWT can be painful. Different energies can be used and there is evidence that local anaesthesia may influence the outcome of ESWT.

The evidence on extracorporeal shockwave therapy (ESWT) for refractory plantar fasciitis raises no major safety concerns; however, current evidence on its efficacy is inconsistent, therefore this procedure will not normally be funded.

References

NICE IPG 311- extracorporeal shockwave therapy for refractory plantar fasciitis

Extracorporeal Shockwave Therapy for Refractory Achilles Tendinopathy

Criteria

Extracorporeal shockwave therapy for refractory Achilles tendinopathy will not normally be funded

Rationale

Achilles tendinopathy is characterised by chronic degeneration of the Achilles tendon, and is usually caused by injury or overuse. Symptoms include pain, swelling, weakness and stiffness over the Achilles tendon and tenderness over the heel (insertional tendinopathy). Conservative treatments include rest, application of ice, non-steroidal anti-inflammatory drugs, orthotic devices, physiotherapy (including eccentric loading exercises) and corticosteroid injection. Surgery may be considered in some patients.
Procedures of Lower Clinical Value
with refractory symptoms.

Extracorporeal shockwave therapy (ESWT) is a non-invasive treatment in which a device is used to pass acoustic shockwaves through the skin to the affected area. Ultrasound guidance can be used to assist with positioning of the device. Extracorporeal shockwave therapy may be applied in one or several sessions. Local anaesthesia may be used because high-energy ESWT can be painful. Different energies can be used and there is evidence that local anaesthesia may influence the outcome of ESWT.

The evidence on extracorporeal shockwave therapy (ESWT) for refractory Achilles tendinopathy raises no major safety concerns; however, current evidence on its efficacy is inconsistent, therefore this procedure will not normally be funded.

Minimum Eligibility Criteria

Extracorporeal shockwave therapy for refractory Achilles tendinopathy will not normally be funded.

References

NICE IPG 312 - Extracorporeal shockwave therapy for refractory Achilles tendinopathy.

Inpatient Cognitive Behavioural Therapy (Residential Placements) for Chronic Fatigue Syndrome (CFS)/Myalgic Encephalomyelitis (ME)

Policy

Cognitive Behavioural Therapy Residential Placements will not normally be funded for Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME). This policy excludes Fibromyalgia.

Rationale

Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME) comprises a range of symptoms including fatigue, headache, sleep disturbance, difficulty in concentration and muscle pain. An individual’s symptoms may vary in severity and there is variation between patients. Although many patients improve over time, others do not.

The cause of CFS/ME is unknown. Many different interventions for CFS/ME have been investigated in clinical trials of varying quality. There is increasing evidence from good quality trials to support CBT and/or GET in the management of CFS/ME. CBT with or without GET is more effective than standard medical care and does not appear to be more expensive. There is evidence for effectiveness in both adults and children.

There is currently insufficient evidence to support any other intervention in terms of clinical or cost effectiveness. This includes immunological treatments, anti-viral therapy, pharmacological treatments, dietary supplements, complementary or alternative medicine, multi-treatment regimes, buddy-mentor schemes, group therapy and ‘low sugar low yeast’ diets.
Procedures of Lower Clinical Value
There is currently no evidence relating to patients with severe CFS/ME (who are house or bed-bound). There is currently no evidence to support the use of in-patient or residential settings to deliver effective interventions for CFS/ME. There is currently no evidence to suggest that any group or sub-group of patients with CFS/ME will benefit particularly from any specific intervention or that patients who have failed to improve on one intervention may do better on another.

Exceptional circumstances may be considered where there is evidence of significant health impairment and there is also evidence of the intervention improving health status.

References
The Treatment and Management of Chronic Fatigue Syndrome/Myalgic inclusion and Encephalomyelitis in Adults and Children. Feb 2007. CRD, University of York.