



NORTH EAST ESSEX CLINICAL COMMISSIONING GROUP

Clinical Priorities Policy

NEE/CCG/2016/042

Brief Description (max 50 words)	This policy sets out the funding arrangements for treatments/ interventions/ procedures not currently included in commissioned established care pathways or identified for funding through the commissioning process and are not routinely funded. This policy should also be read in conjunction with the CCG Fertility Services commissioning Policy.
Target Audience	GPs, Optometrists, Dentists, Secondary Care consultants, Referral Service Triagers, Public and Patients
Action Required	The IFR Co-ordinator will maintain an up to date policy and will ensure that this is appropriately reflected on the CCG website

Document Information

Title /Version Number/(Date)	Clinical Priorities Policy/Version 2.4/Sept 2016
Document Status (for information/ action etc.)and timescale	For circulation to all staff, and immediate implementation
Accountable Executive	Director of Transformation & Strategy
Responsible Post holder/Policy Owner	Kathy West IFR Coordinator – Exceptional Clinical Cases & Individual Funding Requests
Date Approved	September 2016
Approved By	Transformation & Delivery Committee
Review Date	August 2017 or sooner if national or local policy changes
Author	Kathy West
Stakeholders engaged in development/review	IFR Coordinator / Director of Transformation & Strategy Contract Manager / GP lead/ Public Health Consultant/Transformation & Delivery Committee
Equality Impact Assessment	EQUALITY IMPACT ASSESSMENT This document has been assessed for equality impact on the protected groups, as set out in the Equality Act 2010. This Policy is applicable to the Board, every member of staff within the CCG irrespective of their age, disability, sex, gender reassignment, pregnancy, maternity, race (which includes colour, nationality and ethnic or national origins), sexual orientation, religion or belief, marriage or civil partnership, and those who work on behalf of the CCG
Contact details for further information	Please contact the IFR Coordinator for any queries.

Amendment History

Version	Date	Reviewer Name(s)	Comments
1.0	March 2014	Special Registrar in Public Health	Search and review of the current published clinical evidence to inform threshold criteria for approval of funding requests
1.1	5 th June 2014	Kathy West, Pam Green	Approval by TDC to amend policy wording
1.2	20 th October 2014	Kathy West	Minor amendments to policy wording
1.3	21 st January 2015	Kathy West, Victoria Sawtell	Inclusion of revised fertility policy and updated NHS England policy wording.
2.0	June and July 2015	Victoria, Sawtell, Pam Green, Dr Nirmalan De Silva, TDC members	Policy updated to align with Mid Essex CCG policy areas where clinically indicated, plus addition of local criteria, as agreed by CCG Board and TDC in June and July 2015.
2.1	Oct 2015	Kathy West	Policy index updated and inclusion of revised fertility policy and criteria
2.2	18 th November 2015	Kathy West	Typo corrected within Tonsillectomy policy.
2.3	3 rd March 2016	Kathy West	Bariatric Surgery Policy funding arrangements updated – NHS England no longer funding. NEE CCG approval for funding required.
2.4	31 st August 2016	Kathy West	Inclusion of Hernia Policy and inclusion of Fentons Procedure Policy

This policy progresses the following Authorisation Domains and Equality Delivery System (tick all relevant boxes).

Clear and Credible Plan		Collaborative Arrangements	
Clinical Focus and Added Value	x	Engagement with Patients/Communities	
Commissioning processes	x	Leadership Capacity and Capability	
Equality Delivery System	x	NHS Constitution ref	

Associated Policy Documents

Reference	Title
NEE-CCG-2014-057	Fertility Services Commissioning Policy
NEE-CCG-2014-037	Prior Approval, Individual Funding and Exceptional Cases Requests Policy

Document Summary

This policy covers the following types of treatments/ interventions/ procedures:

1. **Threshold Approvals** – Those procedures which may be offered on a routine basis but only for patients who meet defined criteria agreed in a clinical protocol, e.g. cataract surgery.

The responsibility for adherence to these policies lies with the referring and accepting clinicians and prior approval should be sought from the CCG (see below) where this is part of the contracting arrangements.

2. **Individual Prior Approvals** - Those procedures which are not routinely provided by the CCG and where provision is only possible on an individual patient basis, e.g. abdominoplasty.

For these procedures, the criteria listed form guidance to referring clinicians and the CCG commissioner. In instances in which eligibility is unclear the final decision is made through the application of the Exceptional Cases process.

3. **Exceptional Clinical Circumstances** – These are procedures which are only funded in exceptional circumstances, e.g. breast augmentation.

Applications for these procedures should be made to the Exceptional Case Team and should only be made where the patient demonstrates exceptionality.

Core Principles

Please read before making any referral.

Please note that it is the policy of North East Essex CCG that it will be a requirement for any patient who is a smoker will be required to first be referred to a smoking cessation before an initial *routine* referral to elective surgery as set out in this policy. Referral and attendance at a smoking cessation service will need to be evidenced as part of any referral. Any routine referral for a smoker where smoking cessation attempts have not been made may be rejected.

Patients requiring a *ROUTINE* referral to *General Surgery, Spinal surgery or surgery on their Hips or Knees* will be required to have a BMI of 35 or less before they are referred and at point of surgery for their routine elective surgery. Patients with a BMI of over 35 will be required to reduce BMI via independent weight loss or via attendance and support from an NHS commissioned weight management programme before referral to demonstrate weight loss.

Where patients that do manage to lose and maintain weight loss but are still above the BMI threshold of 35 and still require surgery, the referring clinician will be required to make an exceptional case application to the IFR team. The Secondary Care Specialist to whom the referral is subsequently passed should evidence that the benefits of surgery outweigh the risks of not proceeding. This information will be used to support an exceptional cases request for the patient, which should be made via the CCG IFR team.

Index

Abdominoplasty or Apronectomy	6
Acne Vulgaris	7
Aesthetic Facial Surgery	8
Assisted Conception Using IVF/ICS/IUI for infertility	9
Autologous Cartilage Transplantation (ACT)	11
Bariatric Surgery	12
Benign Skin Lesions	14
Blepharoplasty	16
Bobath Therapy	17
Bone Anchored Hearing Aid (BAHA)	18
Bone healing ultrasound system-Exogen	19
Breast Asymmetry / Breast Augmentation / Mastopexy (including revision and replacement)	20
Breast Reconstruction	21
Breast Reduction	22
Bunions (Hallux valgus) surgery	23
Caesarean Section	24
Carpal Tunnel	25
Cataracts	26
Chalazia	28
Chronic Fatigue Syndrome	29
Circumcision	30
Cochlear Implants	31
Complementary and Alternative Therapies	32
Cosmetic Surgery General Principles	33
Cosmetic Surgery on mental health grounds	34
Dental Procedures (Implants, Orthodontics, Wisdom Teeth)	35
Dilation and Curettage/Hysteroscopy	36
Drugs	37
Dupuytren's Contracture	38
Dysthyroid eye disease	40
Endoscopy:- Capsule Endoscopy & Double Balloon Endoscopy	41
Face Lifts and Brow Lifts (Rhytidectomy)	44
Facet joint injections	45
Fenton's Procedure (Gynaecology)	46
Fibroid Embolisation / Uterine Artery Embolisation	47
Functional Electrical Stimulation	48
Ganglion	49
Gastroelectrical Stimulation	50
Gender Dysphoria	51
General Surgery	52
Grommets/Adenoidectomy	53
Gynaecomastia	54
Hernia - Elective Surgical Repair	55
Hip Arthroscopy	57
Hip Injections	58
Hip Replacement	59
Hip Resurfacing	62
Hirsutism / hair depilation	63
Hysterectomy for heavy menstrual bleeding	64
Knee Arthroscopy	65
Knee Replacement	66

Laser treatment for Rosacea	68
Laser treatment for soft palate	69
Liposuction	70
Lymphodema Services	71
Microsuction/ Ear wax removal	72
Nasal Surgery (including Rhinoplasty and Septorhinoplasty)	73
Nipple Inversion	74
Open/Wide Bore MRIs	75
Orthoses	76
Penile Implants	77
Pinnaplasty/Otoplasty	78
Repair of Ear Lobes	79
Reversal of Sterilisation	80
Rhinophyma	81
Scar Revision	82
Shoulder Arthroscopy	83
Skin Contouring	84
Snoring and sleep apnoea	85
Sperm & Egg storage	86
Spinal Cord Stimulation	88
Spinal Injections (Therapeutic) for Pain Related to the Lumbar Spine	89
Spinal Surgery for Non-Acute Lumbar Conditions	91
Sterilisation (female)	93
Surrogacy	94
Tattoo Removal	95
Temporomandibular Joint Replacement	96
Temporalmadibular Joint Retainers and Appliances	97
Tier 3 Weight Management	98
Tinnitus	100
Tonsillectomy	101
Trigger Finger	103
Vaginal Labia Reduction/Refashioning	104
Varicose Veins	105
Vasectomies	107
Wigs, Hairpieces and Hair Transplant/Replacement Systems	108

Policy statement:	Abdominoplasty or Apronectomy
Status:	Individual Prior Approval

North East Essex CCG commissions abdominoplasty and apronectomy on a restricted basis in patients who meet the following criteria:

A Where it is required as part of abdominal hernia correction or other abdominal wall Surgery

OR

B Those patients from the following groups who have significant abdominal aprons as a result of weight loss **and** the flap (panniculus) hangs at or below the level of the symphysis pubis **and** have severe functional problems*:

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

OR

- Patient with excessive abdominal folds who have an initial BMI > 50 and have achieved a minimum drop of 20 BMI points and have maintained this BMI (reduction of a minimum of 20 points) for at least 2 years.

Patients who have predictable abdominal changes due to pregnancy are excluded

**Severe functional problems include:*

- Chronic and persistent skin condition (for example, intertriginous dermatitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics
- Abdominal wall prolapse with proven urinary symptoms
- Problems associated with poorly fitting stoma bag

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

All patients who are smokers should be referred to smoking cessation services before referral for an initial assessment appointment.

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

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request

OPCS S02.1, S02.2

Policy statement:	Acne Vulgaris
Status:	Exceptional Clinical Circumstances

Patients with severe facial post acne scarring should only be referred for resurfacing and other surgical interventions once the active disease is controlled (this will need to be evaluated as inactive by the referrer), and primary care interventions have failed to be successful.

All patients who are smokers should be referred to smoking cessation services before referral for an initial assessment appointment.

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

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request

ACNE S09.1, S09.2, S10.3, S11.3, S60.1, S60.2

Policy statement:	Aesthetic Facial Surgery
Status:	Exceptional Clinical Circumstances

North East Essex CCG does not routinely fund Aesthetic Facial Surgery.

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

All patients who are smokers should be referred to smoking cessation services before referral for an initial assessment appointment.

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request.

Facial Surgery S01.1 – S01.9

Policy statement:	Assisted Conception Using IVF/ICS/UI for infertility
Status:	Prior Approval

This policy statement should be read in conjunction with the North East Essex Fertility Service Policy which outlines full policy criteria:-

See full policy document available at:

http://www.neessexccg.nhs.uk/library_uploads/files/nhs_nee_fertility_services_commissioning_policy_-_version_1_3_-_1_october_15.pdf

Eligibility criteria for accessing fertility services:

Minimum and maximum age

Any treatment cycle will not be commenced before the female is 23 years of age but must be commenced before the female reaches her 43rd birthday.

Any treatment cycle must be commenced before the male is 55 years of age.

North East Essex Resident

Couples must be resident within North East Essex for 12 months prior to treatment. Active forces personnel are exempt from the 12 month North East Essex residency requirement.

Body Mass Index

The woman must have a body mass index of between at least 19 and up to and including 30 prior to referral for fertility treatment and at any time throughout treatment.

Maximum FSH Level

A maximum FSH level of 9U/L on day 2 of any menstrual cycle. Where couples are eligible for IUI treatment with donor eggs, the female must not have menstruated for 9 months.

Duration of sub-fertility

The criterion in this policy apply to couples where there is a need to prevent the transmission of chronic viral infections, during conception, such as HIV, Hep C etc. and requires the use of ICSI technology AND for couples undergoing cancer treatments or who have a disease or a condition requiring medical or surgical treatment that has a significant likelihood of making them infertile.

This may not be a fertility treatment, but should be considered as a risk reduction measure for a couple who wish to have a child, but do not want to risk the transmission of a serious pre-existing viral condition to the woman and therefore potentially her unborn baby. Earlier access to IVF treatment may be considered if the woman is aged 36 or over.

Previous IVF treatment

Previous privately funded treatment will not preclude patients from being eligible to NHS funded cycles up to a maximum of two embryo transfers or two fresh cycles. However previous cycles, whether NHS or privately funded, will be taken into account by the responsible clinician in determining the clinical appropriateness of commencing further cycles. In line with current clinical evidence, couples should undergo no more than 5 fresh cycles in total.

Smoking status

Where couples smoke, only those who agree to take part in a supportive programme of smoking cessation will be accepted on the IVF treatment waiting list, and should be non-smoking at the time of treatment.

Parental status

There should be no living child from the couples current or any previous relationships, regardless of whether the child resides with them. This includes any adopted child within their current or previous relationships; this will apply to adoptions either in or out of the current or previous relationships.

Previous sterilisation

Couples are ineligible if previous sterilisation has taken place (either partner), even if it has been reversed.

Child welfare

Couples must conform to the statutory 'Welfare of the Child' requirements.

Medical conditions

Treatment may be denied on other medical grounds not explicitly covered in this document.

All patients who are smokers should be referred to smoking cessation services before referral for an initial assessment appointment. However please see the Fertility Commissioning Services Policy for specific guidance in regards to application of this policy statement.

OPCS Q13.1 – Q13.9, Y96.1 – Y96.9. Q48.1 – Q48.9 (oocyte recovery)

[Back to index](#)

Policy statement:	Autologous Cartilage Transplantation (ACT)
Status:	Exceptional Clinical Circumstances

Routine primary treatment of cartilage defects of the knee joint are not funded.

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

All patients who are smokers should be referred to smoking cessation services before referral for an initial assessment appointment.

Policy statement:	Bariatric Surgery
Status:	Individual Prior Approval

The commissioning responsibility for the provision of Adult Morbid Obesity Services is being transferred from NHE England to CCGs from 1st April 2016.

Funded patients are those who fulfil criteria for treatment as per the NHS England pathway. Prior Approval for funding is required from NEE CCG. Please see criteria below and pathway



Complex and Spec
Obesity Surgery Polic

as detailed in the NHS England document attached:

NEE CCG will commission complex and specialised surgery as a treatment for selected patients with severe and complex obesity that has not responded to all other non-invasive therapies, in accordance with the criteria outlined in their policy document.

Eligibility for bariatric surgery

Surgery will only be considered as a treatment option for people with morbid obesity providing all of the following criteria are fulfilled:

- The individual is considered morbidly obese. For the purpose of this policy bariatric surgery will be offered to adults with a BMI of 40kg/m² or more, or between 35 kg/m² and 40kg/m² or greater in the presence of other significant diseases.
- There must be formalised MDT led processes for the screening of co-morbidities and the detection of other significant diseases. These should include
- identification, diagnosis, severity/complexity assessment, risk stratification/scoring and appropriate specialist referral for medical management. Such medical evaluation is mandatory prior to entering a surgical pathway.
- Morbid/severe obesity has been present for at least five years.
- The individual has recently received and complied with a local Tier 2 weight loss programme for at least 6 months, followed by, a specialist obesity service weight loss programme (non surgical Tier 3 / 4), described as follows: This will have been for duration of 12-24 months. For patients with BMI > 50 attending a specialist bariatric service, this period may include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is six months. The specialist obesity weight loss programme and MDT should be decided locally. This will be led by a professional with a specialist interest in obesity and include a physician, specialist dietician, nurse, psychologist and physical exercise therapist, all of whom must also have a specialist interest in obesity. There are different models of local MDT structure. Important features are the multidisciplinary, structured and organised approach, lead professional, assessment of evidence that all suitable non invasive options have been explored and trialled and individualised patient focus and targets. In addition to offering a programme of care the service will select and refer appropriate patients for consideration for bariatric surgery.

Patients will be referred to a provider of bariatric services by their GPs/ referring clinician.

All patients who are smokers should be referred to smoking cessation services before the initial assessment appointment.

Please note: NEE CCG does not commission bariatric surgery for children. This is carried out on an exceptional treatment case basis by the local CCG

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

OPCS

G28.1 – G28.9 with ICD10 code E66

G30.1 – G30.9.

G31.1, G31.2, G31.8, G31.9 with ICD10 code E66

G48.1, G48.5

Policy statement:	Benign Skin Lesions
Status:	Threshold and Individual Prior Approval

NEECCG does not commission surgical removal, laser treatment or cryotherapy of clinically benign skin lesions/conditions for purely cosmetic reasons. The fact that a patient wants to have a lesion removed does not constitute a sound reason for doing so at NHS expense.

N.B. A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be referred to an appropriate setting for assessment – this may be a 2 week wait clinic (for suspected melanoma/SCC) or Tier 2 clinic in dermatology or minor surgery.

Surgery or treatments to improve appearance alone is not provided for normal changes such as those due to ageing.

Lesions included in this policy:

- Benign pigmented naevi (moles)
- Corn/callous
- Dermatofibromas (skin growths)
- Lipomas
- Milia
- Molluscum contagiosum
- Sebacious cysts (epidermoid and pilar cysts)
- Seborrhoeic keratoses (benign skin growths basal cell papillomas)
- Comedones
- Skin tags including anal tags
- Spider naevus (telangiectasia)
- Thread veins
- Warts and plantar warts
- Xanthelasma (cholesterol deposits underneath the skin),
- Neurofibromata

NEECCG commissions the removal of benign skin lesions on a restricted basis only. This applies to GPs providing Directed Enhanced Services for Minor Surgery under GMS/PMS contracts as well as secondary care consultants. Practices should not submit, and the CCG reserves the right not to fund, claims for procedures that would be classified as exclusions under this service restriction.

Individual prior approval must be obtained before referral to secondary care except where a patient meets criteria A below.

A. Threshold Approval

If a benign skin lesion of the eye obscures vision or is causing a separate ocular problem then the patient can be referred to an ophthalmologist for removal

B. Individual Prior Approval

Requests for the removal of benign skin lesions will be considered for:

- Sebaceous cysts where there has been more than one episode of infection
- OR
- Lesions which cause functional impairment which prevents the individual from fulfilling work/study/carer or domestic responsibilities
- OR
- Lesions on the face where the extent, location and size of the lesion can be regarded as considerable disfigurement, and which sets them apart from the cohort of people with lesions.

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

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

All patients who are smokers should be referred to smoking cessation services before the initial assessment appointment.

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

ICD10 codes D22.0 – D22.9, L70.0, (D23.0 –D23.9 dermatofibroma and papillomas but may be used for other conditions). D17.0 – D17.9, (L57.8, milia but may be used for other conditions). B08.1, L72.0, L72.1 (sebaceous cyst eyelid, breast, genital organs – H02.8, N60.8, N94.8, N50.8 – may be used for other conditions). L82, (L91.8 Skin tag, may be used for other conditions). I84.6 I78.1, B07, H02.6, D33.3, D36.1.

Policy statement:	Blepharoplasty
Status:	Individual Prior Approval

Upper Lid

This procedure will be funded to correct functional impairment (not purely for cosmetic reasons).

Indications:

- Impairment of visual fields in the relaxed, non-compensated state. Evidence will be required that eyelids impinge on visual fields reducing field to 120° laterally and 40° vertically (to be confirmed by visual fields test with eyelid un-retracted).
- Clinical observation of poor eyelid function, discomfort, e.g. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow.

Lower Lid

This will be funded for correction of ectropion or entropion or for the removal of lesions of the eyelid skin or lid margin.

Also see related policy Disthyroid eye disease.

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

All patients who are smokers should be referred to smoking cessation services before the referral for the initial assessment appointment.

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request.

OPCS C13.1 – C13.9

Policy statement:	Bobath Therapy
Status:	Exceptional Clinical Circumstances

NEECCG commissions a number of Bobath trained therapists as part of its routine therapy services. Referral for assessment and/or treatment at specific Bobath centres will not be routinely funded.

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

Policy statement:	Bone Anchored Hearing Aid (BAHA)
Status:	NHS England commissioned service

NHS North East Essex CCG does not commission Bone Anchored Hearing Aids as this is a commissioning responsibility of NHS England.

NHS England routinely commissions unilateral BAHAs for patient's meeting the commissioning policy but will not normally commission bilateral Bone Anchored Hearing Aid (BAHA) implantation. Such requests for funding will only be considered through an exceptions route.

See full NHS England Policy at: <http://www.england.nhs.uk/wp-content/uploads/2013/04/d09-p-a.pdf>

BAHA D13.1 – D13.9

Policy statement:	Bone healing ultrasound system-Exogen
Status:	Individual Prior Approval

NEECCG commissions Exogen ultrasound bone healing system for non-union in long bone fracture on a restricted basis,

Ref: NICE guidance Medical Technology Guidance 12 found at guidance.nice.org.uk/mtg12
The case for adopting the EXOGEN ultrasound bone healing system to treat long bone fractures with non-union i.e.failure to heal after 9 months is supported by the clinical evidence, which shows high rates of fracture healing.

On this basis NECCG only funds Exogen in the following circumstances:

- EXOGEN for use in patients with non-union fractures in long bones which have failed to heal after 9 months.

NEECCG **does not commission** the use of EXOGEN in patients with delayed healing fractures that have no radiological evidence of healing after 3 months.

Patients not meeting this criteria will only be funded in exceptional clinical circumstances.

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

Policy statement:	Breast Asymmetry / Breast Augmentation / Mastopexy (including revision and replacement)
Status:	Exceptional Clinical Circumstances

NEECCG does not routinely fund all forms of breast augmentation

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

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

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request.

Policy statement:	Breast Reconstruction
Status:	Threshold Approval

Breast reconstruction surgery, including the insertion of implants, is commissioned for reconstructive surgery following mastectomy;

Where patients are assessed by clinicians to meet the criteria, prior approval to treat is not required from the CCG.

Removal and replacement of breast implants:

There are instances for clinical indications where breast implants will need to be removed and replaced.

These include when both of the following indications are met:

- Original procedure was provided by the NHS (e.g. as part of treatment for breast cancer), and
- Implant is proven to be ruptured.

The removal and replacement of breast implants is not otherwise commissioned.

Patient must be aged at least 18 years. Surgery for patients aged 16 or 17 years will only be funded if breast size has been stable for at least one year, and the referring clinician can satisfy the clinical review group that it is unreasonable to wait until the patient is 18.

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

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

Policy statement:	Breast Reduction
Status:	Exceptional Clinical Circumstances

NEECCG does not routinely fund breast reduction treatments

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

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

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request

Policy statement:	Bunions (Hallux valgus) surgery
Status:	Individual Prior Approval

NEECCG commissions surgery for bunions on a restricted basis.

Bunion surgery is justified and appropriate when:

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

AND

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

AND

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

OR

- there is a higher risk of ulceration or other complications, for example, neuropathy, for patients with diabetes. Such patients should be referred for an early assessment. A patient should **not** be referred for surgery for prophylactic or cosmetic reasons for asymptomatic bunions.

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

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

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

Policy statement:	Caesarean Section
Status:	Threshold

This policy relates to **Elective c-sections only**. This procedure is only funded where there is a clear clinical or psychological indication, not for patient choice.

Clinical indications for CS – where CS is the best option - in the current pregnancy include:

- 2+ previous CS with no vaginal birth
- Proven Cephalo-pelvic Disproportion (CPD)
- Classical or T shaped incision
- Previous uterine rupture
- Chronic medical/obstetric condition
- Known malposition/malpresentation
- Placenta praevia/accrete (grade 3 or 4)
- Previous 3rd/4th degree tear with associated morbidity and proven anal sphincter damage on ano-anal ultrasound
- Previous difficult 2nd stage CS following failed instrumental with extension of the uterine artery, supported by documentation by surgeon at time of operation that future vaginal delivery is not indicated
- Proven IUGR/Macrosomia
- Women with HIV who are not receiving ARV therapy OR have a viral load of 400copies per ml or more regardless of ARV therapy.
- Women who are co-infected with HIV and Hepatitis C.

Psychological indications should be discussed on a case by case basis:

- Previous traumatic delivery and fear of childbirth unresolved, following debrief and support by an experienced midwife, which has not resolved the issues, with a view to providing a dedicated counselling service to help improve outcomes.

All women who have had a previous CS for non-recurrent reasons will automatically default at booking to the normal care pathway for vaginal birth. Non-recurrent reasons for CS include:

- Breech
- Fetal distress
- Failure to progress with malposition
- Multiple birth
- Maternal request
- IUGR/Macrosomia
- Placental site insertion

Managing the Breech

- All women with a breech presentation will be offered ECV if suitable
- Multiparous women with breech presentation will be offered choice of vaginal birth if they have had a previous vaginal delivery
- Nulliparous women with breech presentation will be offered Elective Caesarean Section if ECV fails

All other indications require individual prior approval

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

Policy statement:	Carpal Tunnel
Status:	Threshold Approval

Patients typically present with nocturnal dysaesthesia in the hands wearing off with activity; pins & needles, numbness and/or pain in the media distribution of the hands; clumsiness and frequent dropping of things. The presence of a positive Phalen's (wrist flexion test) or Tinel's sign confirms. Nerve conduction studies are NOT generally needed to confirm the diagnosis. In elderly patients the condition may develop insidiously.

Conservative treatment may include adjustment of activities or posture, with night splintage in neutral wrist position. Non-steroidal anti-inflammatory drugs and diuretics are occasionally of benefit. Steroid injections may be of value in uncomplicated cases (requires clinical experience). Treatment provided in line with NICE guidelines

Refer to the community service if any of the following:

- Acute severe symptoms (fewer than 5% of patients) uncontrolled by conservative measures, particularly in pregnancy, significantly interfere with daily activities.
- Mild to moderate symptoms with failure of conservative management, (3 months)
- Neurological deficit i.e. sensory blunting or weakness of the thenar abduction (wasting or weakness of abductor pollicis brevis).
- Unclear diagnosis
- Corticosteroid injections are not available from the patient's GP practice. Limited to 1 injection per hand, extended to 2 injections if surgery is not an option

For triage:

Complex cases are referred by the Community service only, to secondary care in line with DH patient choice framework :

- Rheumatoid
- Flexor tenosynovitis
- Significant cervical spondylosis
- Previous trauma
- Previous surgery
- Diabetic neuropathy
- Cubital tunnel syndrome
- Dual pathology

Referrals are made by the community service only, to secondary care for EMGs

Where applicable, referral letter must detail conservative methods tried.

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

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

Policy statement:	Cataracts
Status:	Threshold Approval

NEECCG commissions surgery for cataracts/lens extraction on a restricted basis.

Referrals should not be based simply on the presence of a cataract. Cataract surgery should, therefore, not normally be offered to patients with a visual acuity better than 6/12 in the worst eye. This applies to both first and second eye surgery.

Patients with the following symptoms or clinical conditions may benefit from cataract surgery when their visual acuity in the worse eye is 6/12 or worse. This list is not exhaustive:

1. Patients experiencing significant glare and dazzle in daylight or difficulties with night vision when these symptoms are due to lens opacities. This indication applies particularly, but not exclusively to driving.
2. Patients requiring particularly good vision for employment purposes.
3. Difficulty with reading due to lens opacities.
4. Significant optical imbalance (anisometropia or anisekonia) following cataract surgery on the first eye.
5. Management of co-existing other eye conditions.
6. Refractive error primarily due to cataract.

Cataract surgery/lens extraction should not normally be performed solely for the purpose of correcting longstanding pre-existing myopia (short sighted or near sighted) or hypermetropia (long sightedness).

The reasons why the patient's vision and lifestyle are adversely affected by cataract and the likely benefit from surgery must be documented in the clinical records.

All patients referred to be considered for cataract should, whenever possible, have completed the Patient Decision Aid on <http://sdm.rightcare.nhs.uk/pda/>. This is available on website, on paper and phone app.

The referring optometrist or GP should discuss the risks and benefits using an approved information leaflet (national or locally agreed) and ensure that the patient understands and is willing to undergo surgery before referring.

Second eye: As the benefits of second eye surgery have been demonstrated patients will be offered second eye surgery provided they fulfil the referral criteria. Second eye surgery should be deemed urgent when there is resultant anisometropia (a large refractive difference between the two eyes of 2 ½ dioptas) which would result in poor binocular vision or diplopia (this should be clearly recorded in the patient's notes).

The reasons why the patient's vision and lifestyle are adversely affected by cataract and the likely benefit from surgery must be documented in the clinical records.

Providers will be audited on the indications for cataract surgery.

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

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

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

Policy statement:	Chalazia
Status:	Threshold Approval

The CCG will fund excision of chalazia when the patient presents with two or more of the following:

- Present for more than six months
- Present on the upper eyelid
- Interferes with vision
- Conservative management has been tried & failed and there is no appropriate alternative to surgical intervention.
- The site of the lesion or lashes renders the condition as requiring specialist intervention.

If a community based service is available then the following referrals are excluded from the community and should be referred to secondary care:

- All children should be referred on.
- Any recurrent chalazion should be referred.
- Any atypical features i.e lash loss, bleeding should be referred.
- Any elderly (age cut off to be agreed) should be referred, as it may not be chalazion.
- Any patient with previous history of Basal cell carcinoma (BCC) or Squamous cell carcinoma (SCC) should be referred on.

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

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

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request.

Policy statement:	Chronic Fatigue Syndrome
Status:	Individual Prior Approval

Funding will be approved for outpatient treatment - where all other diagnoses have been investigated. The patient will be referred to Southend for an assessment and outpatient treatment (subject to the service Provider's criteria – see form attached).



Referral Form New
2014.rtf

Funding will not be approved for:

- Inpatient treatment – this is excluded and regarded as an exception.

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

Chronic Fatigue syndrome ICD10 G93.3

Policy statement:	Circumcision
Status:	Threshold Approval

Circumcision should only be performed for medical reasons for one or more of the following indications:

- Phimosis in adults or children- this is defined as the inability to retract the foreskin due to a narrow prepuce ring. In addition for cases in children consideration will also be given for spraying, ballooning and/or recurrent infection, recurrent balanitis, balanitis xerotica obliterans (chronic inflammation leading to a rigid fibrous foreskin)
- Paraphimosis (inability to pull forward a retracted foreskin)
- Suspicion or evidence of malignancy, dermatological disease (such as lichen planus or eczema) which is unresponsive to other treatment, where biopsy is required and occasionally for selected patients with urinary tract infections (normally referred by a paediatrician)
- Balanoposthitis (recurrent bacterial infection of the prepuce)

There are several alternatives to treating retraction difficulties before circumcision is carried out. It is important that all those performing circumcision should follow the General Medical Council (GMC) guidelines

All adult patients who are smokers should be referred to smoking cessation services before the initial assessment appointment

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

Policy statement:	Cochlear Implants
Status:	NHS England commissioned service

NHS England commissions cochlear implantation services. This includes the multidisciplinary assessment, surgical implantation and rehabilitation (including maintenance of the implant).

For full policy see: <http://www.england.nhs.uk/wp-content/uploads/2013/04/d09-ps-a.pdf>

Cochlear implants OPCS D24.1, D24.2

Policy statement:	Complementary and Alternative Therapies
Status:	Exceptional Clinical Circumstances

Complementary and alternative therapies are considered a Low Priority and not routinely funded. This restriction applies equally to primary and secondary care provision, and GPs must not prescribe such products on FP10s.

These include: Acupuncture, Alexander Technique, Applied Kinesiology, Aromatherapy, Autogenic Training, Ayurveda, , Chinese Medicines, Chiropractic Therapy, Osteopathy, Clinical Ecology, Healing, Herbal Remedies, Homeopathy, Hypnotherapy (see exception below), Massage, Meditation, Naturopathy, Nutritional Therapy, Reiki, Shiatsu, Reflexology and other alternative therapies .

The only exclusion to this list is that referrals to Osteopathy and Chiropractic Therapy only, will be accepted as part of the back and neck pain service pathway.

This list is not exhaustive and other procedures not listed here but that are considered 'alternative' therapies will be considered in the same way.

Some procedures may be available through services in hospices and hospitals as part of a palliative care package; these are through charitable services and not commissioned services.

Approval is required on a case by case basis through the CCG's exceptional case process for any requests outside the above criteria. This will require proven evidence of effectiveness of the therapy, failure of conventional treatment and assurance concerning the training and qualifications of the proposed provider practitioners.

Acupuncture is occasionally used as a treatment as part of an integrated multidisciplinary approach to symptom control by a hospital based pain management team and as such will be funded either as part of the PBR tariff or explicitly agreed in the SLA.

Other complementary procedures may have been agreed as part of CCG or GP commissioning – please refer to local circumstances.

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

Policy statement:	Cosmetic Surgery General Principles
Status:	

Referrals for plastic surgery from both primary and tertiary sources will be assessed in line with the Clinical Priorities Policy and the clinical evidence provided.

For an authorised first appointment, the Plastic Surgery Specialist to whom the referral is subsequently passed should decide whether the patient would benefit from plastic surgical intervention, and if so, establish that the patient fully understands the risks and benefits of surgery.

All referrals should be assessed for both first OPD appointments and subsequent procedure appointments, in line with the policy and clinical evidence.

Cosmetic surgery undertaken exclusively to improve appearance should not be funded in adults, in the absence of previous trauma, disease or congenital deformity.

The CCG does not support commissioning cosmetic surgery to treat mental health symptoms. It concluded that this would be considered a low priority mental health intervention and that there was insufficient evidence to support the effectiveness of the intervention in terms of treating mental health conditions.

Assessment of patients being considered for referral who have an underlying genetic or endocrine reason should have had this fully investigated by a relevant specialist prior to the referral to plastic surgery being made.

Surgery should be supported where a patient has been accepted onto an NHS waiting list prior to taking up residence in North East Essex, providing the existing clinical evidence has remained the same.

Referrals within the NHS for the revision of treatments originally performed outside the NHS will not usually be permitted unless the patient meets the local criteria for the original treatment. Referrers should be encouraged to re-refer to the practitioner who carried out the original treatment for resolution first where not endangering the health of the individual.

Where a patient has previously had NHS funded treatment, procedures necessary for dealing with complications or an outcome that, because of complications or technical difficulties, has resulted in cosmetic or physical problems that, from a professional point of view, are severe enough to oblige the NHS to fund corrective treatment, should be supported.

Revision surgery will not be funded for purely aesthetic reasons, including revisions following surgery as the result of pregnancy.

The National Service Framework for Children (National Service Framework for Children, Young People and Maternity Services (DH October 2004)), defines childhood as ending at 19 years. Funding for this age group should only be considered if there is a problem likely to impair normal emotional development. Children under the age of five rarely experience teasing and referrals may reflect concerns expressed by the parents rather than the child, which should be taken into consideration prior to referral. Some patients are only able to seek correction surgery once they are in control of their own healthcare decisions and again this should be taken into consideration prior to referral.

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

Policy statement:	Cosmetic Surgery on mental health grounds
Status:	Exceptional Clinical Circumstances

This is a low priority. Referrals will only be reviewed on an exceptional cases basis.

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

Policy statement:	Dental Procedures (Implants, Orthodontics, Wisdom Teeth)
Status:	Commissioning of all dental treatments and procedures including orthodontic treatment and wisdom tooth removal is now the responsibility of NHS England, and is therefore not commissioned or funded by North East Essex CCG

Policy statement:	Dilation and Curettage/Hysteroscopy
Status:	Threshold Approval

D&C and hysteroscopy will only be used in line with NICE guidance (CG44, 2007)

Patients will undergo hysteroscopy in the investigation and management of heavy menstrual bleeding only when it is carried out:

- as an investigation for structural and histological abnormalities where ultrasound has been used as a first line diagnostic tool and where the outcomes are inconclusive, for example to determine the exact location of a fibroid or the exact nature of the abnormality;
- where dilatation is required for non-hysteroscopic ablative procedures, hysteroscopy should be considered immediately prior to the ablative procedure to ensure correct placement of the device (unless pre-operative ultrasound assessment has already been undertaken).

Patients will not receive D&C:

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

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

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

NICE Heavy Menstrual Bleeding (CG44) – Full Guideline Consultation January 2007

<https://www.nice.org.uk/guidance/cg44>

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

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

Policy statement:	Drugs
Status:	As per each drug policy

Drugs will only be funded in line with the locally agreed policy, formulary and guidelines. Updates to drug policy will be communicated to clinicians directly and posted on the CCG website at

<http://www.neessexccg.nhs.uk/Library/Prescribing%20Information.html>

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

Policy statement:	Dupuytren's Contracture
Status:	Threshold Approval

Treatment for Dupuytren's contracture in secondary care is commissioned by NEECCG on a restricted basis.

Cases will only be funded for treatments stated if they meet the criteria below:

Moderate

Notable functional problems.

AND one of the following:

- Moderate metacarpo-phalangeal joint contracture (30° – 60°).

OR

- Moderate proximal inter-phalangeal joint contracture (<30°).

OR

- First web contracture.

Treatment at this stage is collagenase in line with SMC (Scottish Medicines Consortium) recommendation* **OR** needle fasciotomy, if appropriately trained. For metacarpo-phalangeal joint contracture, or in rapidly progressing cases, referral for limited fasciectomy.

Severe

- Severe contracture of both metacarpo-phalangeal (>60°) joint and proximal interphalangeal joint (>30°)

Treatment at this stage is referral for surgery for limited fasciectomy or dermofasciectomy, as appropriate.

The use of collagenase is as per the SMC advice. i.e. as an alternative to limited fasciectomy in adult patients with Dupuytren's contracture of moderate severity (as defined by the British Society for Surgery of the Hand), with a palpable cord and up to two affected joints per hand, who are suitable for limited fasciectomy, but for whom percutaneous needle fasciotomy is not considered a suitable treatment option, and will be funded additionally to tariff only when patient is treated as an outpatient. **NICE is due to publish TAG in January 2015 and this recommendation is subject to change depending upon NICE determination.**

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

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

Radiation therapy for early Dupuytren's contracture is not funded.

Ref: www.nice.org.uk/guidance/IPG43
www.nice.org.uk/guidance/IPG368

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

Policy statement:	Dysthyroid eye disease
Status:	Individual Prior Approval

NEECCG commissions surgery for proptosis on a restricted basis for which individual prior approval is required.

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

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

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

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

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

Policy statement:	Endoscopy:- Capsule Endoscopy & Double Balloon Endoscopy
Status:	Threshold Approval

Criteria for upper GI endoscopy for the investigation of dyspepsia should be based on NICE guidance:

Urgent specialist referral for endoscopic investigation is indicated for patients of any age with dyspepsia when presenting with any of the following:

- chronic gastrointestinal bleeding
- progressive unintentional weight loss
- progressive difficulty swallowing
- persistent vomiting
- iron deficiency anaemia
- epigastric mass or suspicious barium meal.

Routine endoscopic investigation of patients of any age, presenting with dyspepsia and without alarm signs, is not necessary. However, in patients aged 55 years and older with unexplained and persistent recent onset dyspepsia alone despite treatment, an urgent referral for endoscopy should be made.

Relevant OPCS code(s): G16, G19, G45

Audit note: These OPCS coded procedures will also be used for other indications, so audit of implementation of guidance should be specific to dyspepsia.

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

NEECCG commissions wireless capsule endoscopy and double balloon endoscopy on a restricted basis in the following circumstance

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

Criteria

MECCG will fund wireless capsule endoscopy or double balloon enteroscopy for obscure gastrointestinal bleeding when:

Patients with gastrointestinal bleeding have undergone a gastroscopy and/or endoscopy and results are negative then

- Capsule endoscopy for investigation

A) If wireless capsule endoscopy identifies source of bleeding in small bowel then

- Where indicated, double balloon enteroscopy for treatment

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

- Consider second look wireless capsule endoscopy
- OR
- Double balloon enteroscopy for investigation and treatment where appropriate

Rationale

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

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

Criteria

CCGs will fund wireless capsule endoscopy or double balloon enteroscopy for Crohn's disease when:

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

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

Rationale

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

Evidence

NICE produced interventional procedure guidance on WCE in 2004

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

References:

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

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

Policy statement:	Face Lifts and Brow Lifts (Rhytidectomy)
Status:	Exceptional Clinical Circumstances

NEECCG does not routinely fund Face Lifts and Brow Lifts.

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

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

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request.

Policy statement:	Facet joint injections
Status:	Threshold Approval

CCG will fund the specific facet joint injections as specified below:

- Intraarticular injections for the management somatic or nonradicular pain of lumbar origin.
- Medial branch blocks for the management of somatic or nonradicular pain of cervical, thoracic and lumbar back origin.

Absolute Criteria

CCG will fund facet joint injections when all the following criteria are met:

- Facet joint pain is confirmed by controlled diagnostic local anaesthetic block;
- The pain has lasted for more than 12 months and average pain levels of ≥ 6 on a scale of 0 to 10. Levels of pain must be assessed using a validated tool e.g. McGill Pain Questionnaire, Pain Visual Analogue Score (VAS) **AND**
- The pain has resulted in significant impact on daily functioning using a validated tool eg Oswestry Disability Index, BPI, HAD; **AND**
- All conservative management options (bed rest, exercise, pharmacotherapy including analgesia and muscle relaxants) have been tried and failed.

Therapeutic facet joint injections beyond the first three injections are only provided as part of a comprehensive pain management programme.

In the diagnostic phase the patient may receive 2 injections 1-2 weeks apart, in the therapeutic phase, up to 3 injections 2-3 months apart provided there has been >50% reduction in symptoms for eight weeks

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

Policy statement:	Fenton's Procedure (Gynaecology)
Status:	Prior Approval

Fenton's Procedure or Fenton's Repair is an operation to remove scar tissue and widen the vaginal opening when a woman experiences persistently painful sexual intercourse.

Conservative Treatment should be given, before considering invasive procedures. Conservative treatment may include, but not be limited to:

- **After childbirth** - Perineal massage directed by a professional, the use of trainers and review by a Gynaecologist, to ensure that the anatomy has been appropriately restored.
- **For Lichen sclerosus** – Potent topical steroid ointments, moisturisers, vaginal trainers, directed perineal massage and reassurance.

The vast majority of women will respond to conservative treatment and generally, only a small number of women will require the Fenton's Procedure.

NB. GPs would not be expected to give conservative treatment in cases of Female Genital Mutilation (FGM),

Where conservative treatments fail, patients can be considered for this procedure, where the symptom is caused by one of the following:

- Complications of childbirth including childbirth tears and cuts
- Lichen Sclerosus (most common in postmenopausal patients)
- Lichen Planus
- Previous vaginal surgery complications
- Episiotomy tears
- Radiotherapy (genital area)
- Congenital
- Female genital mutilation (FGM), where for example the impact might be medical complications relating to conception, childbirth, urology and gynaecology.

NB. This procedure will not be available to correct previous cosmetic vaginal surgery.

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request

The referral letter should detail conservative methods tried, with the exception of FGM cases

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

Policy statement:	Fibroid Embolisation / Uterine Artery Embolisation
Status:	Exceptional Clinical Circumstances

Patients wishing to request funding for treatment will need to show that they have exceptional circumstances to justify approving their request.

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

Fibroid embolization OPCS L71.3 + Y53.- +Z96.6

Policy statement:	Functional Electrical Stimulation
Status:	Exceptional Clinical Circumstances

NEECCG does not routinely fund Functional electrical stimulation (FES) for the treatment of dropped foot in patients with neurological conditions as this is considered a low priority Procedure.

For patients already being treated and funded by the NHS, who require ongoing funding for maintenance and support, prior approval will be required and the following criteria apply:

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

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

Policy statement:	Ganglion
Status:	Threshold Approval

Referral for surgical removal of ganglion in secondary care is commissioned on a restricted basis. Cases will only be funded if they meet the criteria below:

- Painful seed ganglia OR
- Mucoïd cysts that are disturbing nail growth or have a tendency to discharge (risk of septic arthritis in distal inter-phalangeal joint) OR
- Symptoms associated with the ganglion such as pain, increase in size, loss of sensation in parts of the hand, neurological loss or weakness of the wrist OR
- The ganglion has resulted in functional impairment which prevents the individual from fulfilling work/study/carer or domestic responsibilities OR
- Where there is doubt about the diagnosis

Consider conservative treatments first eg aspirations.

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

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

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

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

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

[Back to index](#)

Policy statement:	Gastroelectrical Stimulation
Status:	Exceptional Clinical Circumstances

NEECCG does not routinely commission Gastric nerve/Gastro electrical stimulation for use in intractable nausea and vomiting from idiopathic or diabetic gastroparesis

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

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

Policy statement:	Gender Dysphoria
Status:	Individual Prior Approval

NECCG does not commission gender identity disorder services. This is the commissioning responsibility of NHS England.

NHS England commissions gender identity disorder services from Specialist Gender Identity Disorder Clinic Centres. This includes specialist assessment, non-surgical care packages, transgender surgery and associated aftercare. In this context, commissioning includes deciding which treatments should be commissioned by the NHSE – in the light of clinical and cost effectiveness information – and which should not. Clinical Commissioning Groups (CCGs) do not commission any elements of this service, regardless of whether or the NHS England funds them. CCGs should not accept requests to fund these treatments.

North East Essex CCG is responsible for the initiation and on-going prescribing of hormone therapy and for organising blood and other diagnostic tests as recommended by the Specialist Gender Identity Disorder Clinic Centres.

GPs should ensure that a patient has been accepted on an NHS treatment pathway at an NHS England commissioned Specialist Gender Identity Disorder Clinic before accepting any prescribing responsibility for hormone therapy.

Non core treatments such as cosmetic procedures will be subject to the same thresholds and restrictions as set out in the NHS North East Essex Clinical Priorities Policy.

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

Gender dysphoria ICD10 code F64.0 F64.2

Policy statement:	General Surgery
Status:	Threshold

Referrals for routine General Surgery from both primary and tertiary sources will be assessed in line with the Clinical Priorities Policy and the clinical evidence provided.

Referrals should only be accepted where the patient has a BMI < 35

Where patients have a BMI greater than 35 and require a routine referral to General Surgery will be required to reduce BMI via independent weight loss or via attendance a weight management programme (tier 2 e.g. Health Trainers) before referral to demonstrate weight loss.

Where patients that do manage to lose and maintain weight loss but are still above the BMI threshold of 35 and still require surgery, the referring clinician will be required to make an exceptional case application to the IFR team. The Secondary Care Specialist to whom the referral is subsequently passed should evidence that the benefits of surgery outweigh the risks of not proceeding. This information will be used to support an exceptional cases request for the patient, which should be made via the CCG IFR team.

Surgery should be supported where a patient has been accepted onto an NHS waiting list prior to taking up residence in North East Essex, providing the existing clinical evidence has remained the same

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

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

Policy statement:	Grommets/Adenoidectomy
Status:	Threshold Approval

Threshold Approval

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

- Children with persistent bilateral OME documented over a period of 3 months with a hearing level in the better ear of 25–30 dBHL or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available) **OR**
- Children who have had at least 5 occurrences of acute otitis media in the last year with additional complications such as perforations, persistent discharge, febrile convulsions, sensorineural deafness or cochlear implantation.

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

Individual prior approval

- Children with persistent bilateral OME with a hearing loss less than 25–30 dBHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant.
- Adjuvant adenoidectomy will not be considered in the absence of persistent and/or frequent upper respiratory tract symptoms in the child.
- Children with Down's Syndrome or cleft palate, as an alternative to hearing aids for treating persistent bilateral OME with hearing loss (and/or significant impact on child's developmental, social or educational status)

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

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

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

Policy statement:	Gynaecomastia
Status:	Exceptional Clinical Circumstance

NEECCG does not routinely fund surgery for gynaecomastia.

All patients who are smokers should be referred to smoking cessation services before the referral for the initial assessment appointment.

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

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request.

Gynaecomastia ICD10 N62 OPCS B27.5

Policy statement:	Hernia - Elective Surgical Repair
Status:	Exceptional Clinical Circumstances

Emergency treatment – when this is required eg suspected strangulation, the patient should be referred for emergency treatment.

Femoral hernias – should be referred to secondary care due to the increased risk of incarceration / strangulation.

Symptoms - Patients typically present with a weakness or hole in the muscles of the abdomen that allows part of the contents of the abdomen to bulge through, forming a swelling or lump under the skin. Normally these muscles are strong enough to hold the contents of the abdomen in place – including fat, intestines and organs. There are several different types of hernias.

Conservative treatment approach includes living with the hernia, making lifestyle changes and watching for changes to the hernia and possibly the fitting of a truss. Lifestyle changes may include giving up smoking and avoiding heavy lifting.

Restrictions - Surgical treatment of the following hernias is commissioned on a restricted basis for patients meeting the defined criteria below:

- Inguinal (groin) hernias in adults
- Incisional hernias in adults
- Umbilical hernias in adults

Inguinal Hernias – criteria for referral

For asymptomatic hernias, a watchful waiting approach is advocated with informed consent. Surgical treatment should only be offered when one of the following criteria is met:

- Pain or discomfort significantly interfering with work or activities of daily living.
- History of incarceration, or difficulty in reducing the hernia
- Inguino-scrotal hernia
- Progressive increase in size month on month
- The patient is currently asymptomatic but works in a heavy manual occupation and there is an increased risk of strangulation and future complications

Umbilical Hernias – criteria for referral

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

- Pain / discomfort significantly interfering with activities of daily living
- Progressive increase in size month on month
- To avoid incarceration or strangulation of bowel
- The patient is currently asymptomatic but works in a heavy manual occupation and there is an increased risk of strangulation and future complications

Incisional hernias - criteria for referral

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

- Pain / discomfort interfering with activities of daily living and appropriate conservative management has been tried first eg weight reduction where appropriate

Or

- The patient is currently asymptomatic but works in a heavy manual occupation and there is an increased risk of strangulation and future complications

Where applicable, referral letter must detail conservative methods tried.

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment.

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

Patient information

NHS Choices - <http://www.nhs.uk/conditions/hernias/pages/introduction.aspx>

Rightcare shared decision making tool

<http://sdm.rightcare.nhs.uk/pda/inguinal-hernia/compare-options/>

References

1. Simons MP, Aufenacker T. European Hernia Society guidelines on treatment on inguinal hernia in adult patients *Hernia* 2009; 13:343-403
2. Fitzgibbons RJ, Giobbe-Hurder A. Watchful waiting vs Repair of inguinal hernia in minimally symptomatic men. *JAMA* 2006; 295:285292
3. O'Dwyer PJ, Norrie j. Observation or operation for patients with asymptomatic inguinal hernia. *Ann Surg* 2006; 244:167-173>

Policy statement:	Hip Arthroscopy
Status:	Individual Prior Approval

Current evidence on safety and efficacy does not appear adequate to recommend hip arthroscopy other than as listed below. On this basis the CCG would not routinely support Hip Arthroscopy.

NICE Interventional Procedure Guidance IPG408 suggests that Arthroscopic femoro-acetabular surgery for hip impingement syndrome be allowed.

Arthroscopic femoro–acetabular surgery for hip impingement syndrome should only be carried out by surgeons with specialist expertise in arthroscopic hip surgery.

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

Policy statement:	Hip Injections
Status:	Individual Prior Approval

Current evidence on safety and efficacy does not appear adequate to recommend hip injections. On this basis we would not routinely support hip injections. Funding is approved for the following:

- Diagnostic aid
- To introduce contrast medium to the joint as part of hip arthrogram
- Babies for hip arthrography
- Children and adults with inflammatory arthropathy
- Investigation of infection in biological and replaced hips.

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

Policy statement:	Hip Replacement
Status:	Threshold Approval

Referral should be when other pre-existing medical conditions have been optimised **AND** conservative measures have been exhausted and failed.

Evidence suggests that the following patients would benefit from hip joint replacement surgery:

- The patient complains of severe joint pain **AND** has radiological features of moderate to severe disease **AND** has severe functional limitation irrespective of whether conservative management has been trialed, **OR**
- The patient complains of severe joint pain **AND** has radiological features of moderate to severe disease **AND** has minor to moderate functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.
- The patient complains of mild to moderate joint pain **AND** has radiological features of moderate to severe disease **AND** has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies **AND** is assessed to be at low surgical risk.

Please refer to the classification of pain levels and functional limitations in the table on the next page.

Referrals will not be accepted if the patient is morbidly obese (BMI >35). Exceptions may be considered for patients who have undertaken an approved CCG supervised weight reduction programme, have lost at least 5% weight and have maintained that 5% weight loss for at least 6 months. Referring GP should apply through the prior approvals process.

Referrals will not be accepted if the patient has an Oxford Hip Score greater than or equal to 20. This scoring should be completed in Primary Care prior to referral. The tool can be found at http://www.orthopaedicscore.com/scorepages/oxford_hip_score.html

All patients referred to be considered for hip replacement should have completed the Patient Decision Aid on <http://sdm.rightcare.nhs.uk/pda/>. This is available on website, on paper and phone app.

Patients who do not fulfil the above criteria may be considered where there are exceptional clinical circumstances

Evidence suggests that the following patients would be INAPPROPRIATE candidates for hip joint replacement surgery:

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

Patients whom are assessed by the above criteria to be inappropriate for hip replacement surgery should not be listed for surgery.

Patients who partially fulfil the criteria for appropriate hip joint replacement surgery *may* benefit from the operation and a decision will need to be taken on an individual basis; prior approval must be sought.

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

Hip replacement: Classification of Pain Levels and Functional Limitations

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

Policy statement:	Hip Resurfacing
Status:	Individual Prior Approval

NEECCG commissions hip resurfacing on a restricted basis.

NEECCG will only fund those patients who otherwise qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements as restricted by NICE Guidance Hip disease - metal on metal hip resurfacing (TA44). Hip resurfacing is not generally considered the best option for women over the age of 65. Clinicians applying for funding approval should provide full clinical rationale for choice.

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

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

Issued: February 2014

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

Policy statement:	Hirsutism / hair depilation
Status:	Exceptional Clinical Circumstances

NEECCG does not routinely fund hair depilation procedures or medication e.g. Vaniqa

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

Hair depilation OPCS S60.6, S60.7 ICD10 L68.0

Policy statement:	Hysterectomy for heavy menstrual bleeding
Status:	Threshold Approval

Hysterectomy for heavy menstrual bleeding will only be funded within NICE guidance and when

A There has been a prior trial, after appropriate clinical assessment, with a LNG-IUS intra-uterine device (the Mirena®, unless contraindicated¹), and this has not successfully relieved symptoms or has produced unacceptable side effects.

AND

B At least **one** of another treatment has failed, is not appropriate or is contra-indicated in line with NICE guidelines²:

- Alternative hormonal treatment in keeping with NICE guidance
- NSAIDs and Tranexamic Acid

AND

C either of the following:

- Endometrial ablation if normal uterus or if mirena contraindicated or if ablation is contraindicated eg previous multiple caesarean section
- Endometrial resection

Women who require hysterectomy as a first line treatment with no evidence of pelvic pathology should receive a second opinion; exceptional cases approval should be sought.

¹ Contraindications to the levonorgestrel intrauterine system are:

- Distorted or small uterine cavity (with proven ultrasound measurements; Uterocervical canal length < 5cm)
- Genital malignancy
- Active trophoblastic disease
- Active pelvic inflammatory disease

² For those who for ethical reasons cannot accept the use of Mirena®, they should have tried at least **two** of the alternative treatments.

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

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

Policy statement:	Knee Arthroscopy
Status:	Threshold Approval

Knee arthroscopy in secondary care is commissioned on a restricted basis. Cases will only be funded if they meet the criteria below:

Arthroscopy of the knee can be undertaken where a competent clinical examination (or MRI scan if there is diagnostic uncertainty or red flag¹ symptoms/signs/conditions) has demonstrated clear evidence of an internal joint derangement (meniscal tear, ligament rupture or loose body) and where conservative treatment has failed or where it is clear that conservative treatment will not be effective.

Knee arthroscopy can therefore be carried out for:

- Removal of loose body
- Meniscal repair or resection / repair of chondral defects
- Ligament reconstruction/repair (including lateral release)
- Synovectomy / symptomatic plica
- To assist selection of appropriate patients for uni-compartmental knee replacement

Knee arthroscopy should **NOT** be carried out for any of the following indications:

- Investigation of knee pain (MRI is a less invasive alternative for the investigation of knee pain)
- Treatment of osteoarthritis including arthroscopic lavage and debridement.
In line with NICE guidance CG177; this should not be offered as part of treatment for osteoarthritis unless the individual has knee osteoarthritis with a clear history of mechanical locking (not gelling, 'giving way')

In rare circumstances, intractable knee pain may benefit from arthroscopic treatment (subject to agreement by exceptional cases panel).

HRG HB25B and HB25C (knee washout) will only be funded only subject to agreement by the exceptional cases panel.

¹ Red flag symptoms or signs include recent trauma, constant progressive non-mechanical pain (particularly at night), previous history of cancer, long term oral steroid use, history of drug abuse or HIV, fever, being systematically unwell, recent unexplained weight loss, persistent severe restriction of joint movement, widespread neurological changes, and structural deformity. Red flag conditions include infection, carcinoma, nerve root impingement, bony fracture and avascular necrosis

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

Policy statement:	Knee Replacement
Status:	Threshold Approval

Referral should be when other pre-existing medical conditions have been optimised **AND** conservative measures have been exhausted and failed. This will include weight reduction, NSAIDs and analgesics, changing activity, and introducing a walking aid.

Please refer to the classification of pain levels and functional limitations in the table on the next page.

Referrals should be made if any one of the three following applies:

- The patient complains of intense or severe symptomatology **AND** has radiological features of severe disease **AND** has demonstrated disease within all three compartments of the knee (tri-compartmental) or localised to one compartment plus patello-femoral disease (bi-compartmental). **OR**
- The patient complains of intense or severe symptomatology **AND** has radiologic features of moderate disease **AND** is troubled by limited mobility or stability of the knee joint. **OR**
- The patient has severe symptomatology **AND** has radiological features of slight disease **AND** is troubled by limited mobility or stability of the knee joint.

Referrals will not be accepted if the patient is morbidly obese (BMI > 35). Exceptions may be considered for patients who have undertaken a supervised weight reduction programme (local Tier 2 service), have lost at least 5% weight and have maintained that 5% weight loss for at least 6 months. Referring GP should apply through the prior approvals process.

Referrals will not be accepted if the patient has an Oxford Knee Score greater than or equal to 20. This scoring should be completed in Primary Care prior to referral. The tool can be found at http://www.orthopaedicscore.com/scorepages/oxford_hip_score.html

All patients referred to be considered for knee replacement should have completed the Patient Decision Aid on <http://sdm.rightcare.nhs.uk/pda/>. This is available on website, on paper and phone app.

Patients who partially fulfil the criteria for knee joint replacement surgery *may* benefit from the operation and a decision will need to be taken on an individual basis; prior approval must be sought.

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

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

For Knee Replacement: Classification of Mobility, Stability, Symptomatology, Radiology and Localisation

Variable	Definition
Mobility and Stability	
Preserved mobility and stable joint	Preserved mobility is equivalent to minimum range of movement from 0° to 90°. Stable or not lax is equivalent to an absence of slackness of more than 5mm in the extended joint.
Limited mobility and/or stable joint	Limited mobility is equivalent to a range of movement less than 0° to 90° unstable or lax is equivalent to the presence of slackness of more than 5mm in the extended joint.
Symptomatology	
Slight	Sporadic pain. Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects.
Moderate	Occasional pain. Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities. Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.
Intense	Pain of almost continuous nature. Pain when walking short distances on level surfaces or standing for less than half an hour. Daily activities significantly limited. Continuous use of NSAIDs for treatment to take effect. Requires the sporadic use of support systems walking stick, crutches).
Severe	Continuous pain. Pain when resting. Daily activities significantly limited constantly. Continuous use of analgesics - narcotics/NSAIDs with adverse effects or no response. Requires more constant use of support systems (walking stick, crutches).
Radiology	
Slight	Ahlback grade I.
Moderate	Ahlback grade II and III.
Severe	Ahlback grade IV and V.
Localisation	
Unicompartmental	Excluded patello-femoral isolated.
Bicompartmental	Unicompartmental plus patello-femoral.
Tricompartmental	Disease affecting all three compartments of the knee.

Policy statement:	Laser treatment for Rosacea
Status	Exceptional Clinical Circumstances

NEECCG does not routinely fund laser treatment for Rosacea

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request.

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

Policy statement:	Laser treatment for soft palate
Status	Exceptional Clinical Circumstances

NEECCG does not routinely fund laser treatment for soft palate.

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

Policy statement:	Liposuction
Status	Exceptional Clinical Circumstances

NEE CCG does not routinely fund liposuction procedures.

Liposuction procedures have been assessed as a **Low Clinical Priority** by NEE CCG and will not be funded unless there are **exceptional clinical circumstances**. Applications for funding for these procedures can be made to the Exceptional Case Team but should only be made where the patient demonstrates true clinical exceptionality.

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request.

Liposuction OPCS S62.1, S62.2

Policy statement:	Lymphodema Services
Status:	Individual Prior Approval

As lymphoedema is only one cause of oedema, the GP should ensure

- the correct diagnosis (remembering that most causes of peripheral oedema are cardiac, renal, hepatic or venous in origin, rather than lymphoedema)
- The oedema is persistent or greater than 3 months duration; or
- Patient is at known risk of lymphoedema.
- Patient must have tried and failed all available conservative management options

GPs must include evidence of the patient meeting the above criteria and confirm that conservative management has been maximised before making a referral to a community based lymphoedema service.

Patients who are restricted from having treatment for an unrelated condition that is usually available on the NHS and has the effect of increasing life-expectancy or quality life years as a direct result of the lymphoedema will be offered treatment.

Treatment of lymphoedema by specialist units in the private sector will only be funded in exceptional circumstances following involvement of appropriate local services.

Intensive inpatient therapy will not be provided.

Patients not meeting these criteria or without evidence to support this will be expected to make an individual request for approval.

ICD10 I89.0

Policy statement:	Microsuction/ Ear wax removal
Status:	Exceptional Clinical Circumstances

NEE CCG does not routinely fund removal of ear wax in secondary care unless there are exceptional clinical circumstances to indicate that the wax cannot be removed by a primary care based service.

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

Policy statement:	Nasal Surgery (including Rhinoplasty and Septorhinoplasty)
Status:	Individual Prior Approval

Nasal Surgery to correct deformity and the cosmetic appearance of the nose, including Rhinoplasty and Septorhinoplasty is not routinely funded by NEE CCG.

Primary care must obtain prior approval before referring patients to secondary care providers and secondary care providers must satisfy themselves that the patient has funding secured prior to seeing the patient. This is to ensure inappropriate out-patient appointments are avoided and patient expectations are properly managed.

NB: This policy does not apply to immediate post trauma nasal manipulation which normally occurs two to three weeks after the trauma and does not require prior approval from the Commissioner.

Requests for corrective nasal surgery will be considered where the patient has:

- Post-traumatic nasal injury causing continuous and chronic nasal airway obstruction associated with septal/bony deviation of the nose which is causing significant functional impairment.

OR

- Nasal deformity secondary to a cleft lip/palate or other congenital craniofacial deformity causing significant functional impairment.

OR

- Part of reconstructive head and neck surgery.

NEE CCG will not approve funding for patients who are unhappy with the outcome of previous surgeries including immediate post-trauma corrections (whether provided by the NHS or private providers) or for snoring unless they meet the criteria above.

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

OPCS: E02.1 – E02.9

Policy statement:	Nipple Inversion
Status:	Threshold approval

Nipple inversion may occur as a result of underlying breast malignancy. If the inversion is newly developed, it requires urgent referral and assessment.

Surgical correction of nipple inversion is only funded on a restricted basis for function reasons i.e. ability to feed their child in a post-pubertal woman and where the inversion has not been corrected by the correct use of a non-invasive suction device. GPs who refer must ensure that patients comply with this criteria.

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request.

OPCS B35.6

Policy statement:	Open/Wide Bore MRIs
Status:	Individual Prior Approval

Referral for open/wide bore MRIs in secondary care is commissioned on a restricted basis. Cases will only be funded if they meet the criteria below:

Open MRI scans only available for morbidly obese patients unable to access local MRI services because of their size and who have an abdomen girth of less than 65 inches and a neck girth not exceeding of 22 inches for a spinal scan; a maximum weight not exceeding 29 stone

Patients with claustrophobia are not eligible for open/wide bore MRI scans.

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

Policy statement:	Orthoses
Status:	Threshold Approval

NEE CCG does not routinely fund orthoses (custom and 'Off the Shelf') except for specified conditions as detailed below:

Custom Insoles / Pronation control devices

NEE CCG does not routinely commission the use of custom orthotics with the exception of the following conditions.

1. Neurodisability
2. Talipes equinovarus
3. Adolescent Achilles Tendinitis
4. Post operative patients
5. Painful or structural flat foot
6. Congenital skeletal abnormality
7. Burns

Arch Supports / Pronation control orthoses

NEE CCG does not routinely commission the use of 'Off the Shelf' (OFS) orthoses.

Soft Neck Collars

NEE CCG does not routinely commission soft neck collars.

Lumbar Supports

NEE CCG does not routinely commission 'Off the Shelf' lumbar supports.

Policy statement:	Penile Implants
Status:	Exceptional Clinical Circumstances

This will not be funded other than post cancer reconstruction.

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

Funding outside this criterion will only be provided in clinically exceptional circumstances.

OPCS: N32.6 + Y02.2

Policy statement:	Pinnaplasty/Otoplasty
Status:	Individual Prior Approval

The following criteria should be met for funding to be made available:

- The patient must be between the ages of 5 and 18 years at the time of referral

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

OPCS D03.3

Policy statement:	Repair of Ear Lobes
Status:	Individual Prior Approval

This will be routinely funded for primary suture post trauma e.g. the patient is automatically eligible for emergency treatment when he/she presents for repair at A&E at the time of trauma. Funding to repair tears secondary to ear piercing or other ear adornments will not be routinely funded.

Post emergency applications will only be considered on an exceptional basis.

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

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request.

OPCS D06.2

Policy statement	Reversal of Sterilisation
Status:	Exceptional Clinical Circumstances

NEE CCG does not routinely fund reversal of sterilisation.

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

OPCS:

Q29.1 – Q29.9

Q37.1 – Q37.9

N18.1

Policy statement:	Rhinophyma
--------------------------	-------------------

NEE CCG does not routinely fund Rhinophyma.

This procedure has been assessed as **Low Clinical Priority** by NEE CCG and will not be funded unless there are **exceptional clinical circumstances**. Applications for funding for these procedures can be made to the Exceptional Case Team but should only be made where the patient demonstrates true clinical exceptionality.

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

Rhinophyma ICD10 L71.1

Policy statement:	Scar Revision
Status:	Individual Prior Approval

NEECCG commissions surgery for scar revision on a restricted basis

- Funding for surgery for revision of scars will only be considered where the scar interferes with function.
- Scar revision will only be offered after 2 years to allow the natural healing process to complete.

GPs should not refer unless the above criterion applies and referrals must include objective information to demonstrate this.

Photographs will be required to support any application for funding

Funding will only be made outside this criterion available where there are exceptional clinical circumstances.

All patients who are smokers should be referred to smoking cessation services before referral for the initial assessment appointment - smoking contributes to the efficacy of surgery.

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

OPCS

S06.5, S06.9 + Y06.4, S23.1 – S23.9

ICD10

L91.0, L90.5

Policy statement:	Shoulder Arthroscopy
Status:	Threshold approval

NEE CCG commissions shoulder arthroscopy on a restricted basis.

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

- (a) Activity modification
- (b) Physiotherapy and exercise programme
- (c) Oral analgesics including NSAIDs (unless contraindicated)
- (d) Intra-articular steroid injections
- (e) Manipulation under anaesthetic

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

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

Funding will only be made available outside this criterion where there are exceptional clinical circumstances.

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

OPCS

W88.1 – W88.9 + Z81.1, Z81.2, Z81.4, Z81.8 or Z81.9

Policy statement:	Skin Contouring
Status:	Exceptional Case Funding

Skin contouring including Buttock lifts, thigh lifts and arm lifts (brachioplasty) and labial skin contouring procedures will only be funded in exceptional circumstances.

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request.

Skin contouring OPCS S03.3, S03.8, S03.9

Policy statement:	Snoring and sleep apnoea
Status:	Threshold Approval

NHS North East Essex CCG considers treatment for snoring to be a LOW PRIORITY and will not normally fund treatment where this is the sole problem. Patients with snoring and other symptoms such as nasal obstruction should be assessed by nasendoscopy

If sleep apnoea is suspected, one or more criteria must be present prior to referral to the sleep unit.

1) Daytime sleepiness (rather than tiredness) assessed by Epworth score (>15)

And one or more of the following

2) Witnessed regular or frequent nocturnal apnoeic episodes of stopping breathing

3) Waking with sensations of choking/obstruction

4) Neck circumference 17ins or over

5) Significant retrognathia

6) Small oedematous pharynx on visual inspection

Patients referred for sleep studies should also have a nasendoscopic assessment of their upper airways to exclude any structural cause for obstruction

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

Sleep studies OPCS A84.7

Policy statement:	Sperm & Egg storage
Status:	Individual Prior Approval

Fertility preservation will be offered to patients undergoing cancer treatments or who have a disease or a condition requiring medical or surgical treatment that has a significant likelihood of making them infertile

The following fertility preservation methods will be considered for funding where the applicable criteria is met:

- Sperm cryostorage
- Embryo cryostorage
- Oocyte cryostorage

Patients will have to meet the following criteria

- Commenced puberty and be aged up to 42 years (inclusive up until they reach their 43rd birthday) old for female patients or up to 55 years old for male patients.
- Female patients not only need to be well enough to undergo ovarian stimulation and egg collection but this should not worsen their condition and that sufficient time is available prior to starting treatment.

The procedures recommended by the Royal College of Physicians and the Royal College of Radiologists should be followed before commencing chemotherapy or radiotherapy likely to affect fertility, or management of post- treatment fertility problems.

Men and adolescent boys preparing for medical treatment, that is likely to make them infertile, should be offered semen cryostorage because the effectiveness of this procedure has been established.

Local protocols should exist to ensure that health professionals are aware of the values of semen cryostorage in these circumstances, so that they deal with the situation sensitively and effectively.

Women preparing for medical treatment that is likely to make them infertile should be offered oocyte or embryo cryostorage as appropriate if they are well enough to undergo ovarian stimulation and egg collection, provided that this will not worsen their condition and that sufficient time is available.

The sperm, embryos or oocytes will be stored for an initial period of 10 years, as permitted in current legislation. It is possible to extend the time or storage, if the material has not been used. This will require additional approval from the CCG.

Eligibility for fertility preservation does not entitle patients to assisted conception treatments such as in-vitro fertilisation (IVF). Patients requiring subsequent assisted conception treatments will only be funded if they meet the criteria specified in the NEE CCG Fertility Services Commissioning Policy:

http://www.neessexccg.nhs.uk/library_uploads/files/nhs_nee_fertility_services_commissioning_policy_-_version_1_3_-_1_october_15.pdf

Where couples smoke, only those who agree to take part in a supportive programme of smoking cessation will be accepted on the IVF treatment waiting list, and should be non-smoking at the time of treatment.

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment. However please see the Fertility Services Commissioning Policy for specific guidance in regards to application of this policy statement.

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

Policy statement:	Spinal Cord Stimulation
Status:	Individual Prior Approval

NEE CCG commissions spinal cord stimulation in accordance with NICE TA 159.

Spinal cord stimulation is recommended as a possible 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.

NEE CCG will not routinely fund high frequency stimulators.

Re-chargeable batteries for implantable pulse generators will be funded where this avoids the need for further surgery. It is expected that where there are different systems of equal effectiveness, the least costly system is used.

NEE CCG does not commission Spinal Cord Stimulation as a treatment option for adults with chronic pain of ischaemic origin.

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

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

Policy statement:	Spinal Injections (Therapeutic) for Pain Related to the Lumbar Spine
Status:	Threshold Approval

NB: This policy addresses therapeutic use of spinal injections. It does not address diagnostic indications.

(1) Any Spinal therapeutic injection for patients with chronic pain

Injections of therapeutic substances for pain related to the lumbar spine are not routinely commissioned for patients with **chronic non-specific back pain**.

NEE CCG routinely commissions spinal therapeutic injections for **chronic radicular pain only**:

where recommended as part of a specialist multidisciplinary pain clinic management plan
AND

a programme of conservative management* has been unsuccessful or is not possible due to coexisting physical or mental illness or frailty.

*Conservative management must include the following from a NHS commissioned service: advice and information on back pain management; group or customized exercise programme and where appropriate (according to specialist reassessment) manual therapy or hydrotherapy.

On referral to the specialist multidisciplinary pain clinic, patients must be informed that the referral is for assessment and development of a pain management plan. Patients should not be under the impression that the decision to provide an injection has already been made or that repeat injections are routinely available.

(2) Therapeutic epidural injections, sacroiliac injections and nerve root blocks in patients with acute episodes of pain (including acute or chronic)

Commissioning of single injections is restricted to the following indications:

The patient needs urgent relief of severe acute spinal pain.

OR

A specialist pain clinician judges that a single injection is necessary and appropriate to enable participation in a conservative pain management programme.

OR

The patient is unable to participate effectively in conservative pain management due to coexisting physical or mental illness or frailty.

Repeat injections should not be routinely provided as there is a lack of high quality supporting evidence for long term pain relief and clinical advice suggests diminishing returns with increased risk of adverse events.

Repeat injections are commissioned only:

If a specialist pain clinician taking account of multi-disciplinary team assessment, concludes that benefits outweigh harms:

AND

The patient has been clinically assessed as having a substantial and sustained benefit from their first injection;

AND

The patient has been assessed as continuing to be unable to benefit from conservative management;

AND

Up to a maximum of 3 injections in 6 months.

On referral to the specialist multidisciplinary pain clinic, patients must be informed that the referral is for assessment and development of a pain management plan. Patients should not be under the impression that the decision to provide an injection has already been made or that repeat injections are routinely available.

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

Policy statement:	Spinal Surgery for Non-Acute Lumbar Conditions
Status:	Individual Prior Approval

Recent changes in who commissions which aspects of back surgery are outlined below.

NHS England commissions:

- All spinal deformity surgery (adults and children)
- All spinal reconstruction surgery (adults and children)
- Palliative or curative spinal oncology surgery (adults and children)
- Revision surgery for which the primary surgery is specialist, i.e. revision surgery with instrumentation for over 2 levels
- All primary thoracic and primary anterior lumbar surgery
- Posterior cervical decompression surgery using instrumentation
- Cervical corpectomy

CCGs may commission;

- Revision surgery for which the primary surgery is non-specialist, i.e. revision surgery with instrumentation for 2 levels or under
- Posterior cervical decompression surgery without instrumentation
- Anterior cervical decompression surgery (discectomy or fusion)
- All spinal injections
- Primary lumbar decompression/discectomy
- Posterior lumbar un-instrumented fusions
- Lumbar instrumented fusion for 2 levels or less
- Revision, instrumented lumbar fusion for 2 levels or less

NEE CCG only commissions spinal surgery for non-acute lumbar conditions on a restricted basis.

Patients will only receive funding for non-acute⁺ spinal surgery under the following circumstances:

Surgical discectomy (standard or microdiscectomy) in selected patients with sciatica secondary to disc prolapse where conservative management for at least 4-6 weeks has failed.

It is recommended that **Primary Care Referral** for assessment for spinal surgery or other invasive intervention should only be considered if radicular pain has not responded to non-invasive treatment after 4-6 weeks.

NHS England does not routinely fund spinal surgery for lower back pain.

NEE CCG does not accept requests to fund spinal surgery for lower back pain.

Patients with a BMI over 35 will have to go through a weight management programme before being referred for spinal surgery to support evidence of attempted weight loss.

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

⁺Acute conditions include back pain due to fracture, dislocation, complications of tumour or infection and/or nerve root or spinal compression responsible for progressive neurological deficit.

OPCS

V22.1 – V27.9, V29.1 – V35.9, V37.1 – V38.9, V54.4

Policy statement	Sterilisation (female)
Status:	Exceptional Clinical Circumstances

NEECCG does not routinely commission female sterilisation.

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

Policy statement:	Surrogacy
Status:	Not funded

NEE CCG does not routinely fund Surrogacy.

Policy statement:	Tattoo Removal
Status:	Exceptional Clinical Circumstances

NEE CCG does not routinely fund procedures for the removal of tattoos.

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

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request.

Tattoo removal OPCS S60.1, S60.2

Policy statement:	Temporomandibular Joint Replacement
Status:	Individual Prior Approval

This should not be routinely funded.

Indications for intervention in rare cases with prior approval.

The affected patients usually have severe disease of the temporomandibular joint which may be more serious if patients cannot open their mouths adequately, as dentistry, anaesthesia and resuscitation may be severely complicated and even life-threatening. In such rare cases, TMJ replacement may be considered.

Contraindications are:

1. active or chronic infection
2. patient conditions where there is insufficient quantity or quality of bone to support the components
3. systemic disease with increased susceptibility to infection
4. patients with extensive perforations in the mandibular fossa and/or bony deficiencies in the articular eminence or zygomatic arch that would severely compromise support for the artificial fossa component
5. partial TMJ joint reconstruction
6. known allergic reaction to any materials used in the components
7. patients with mental or neurological conditions who are unwilling or unable to follow post-operative care instructions
8. skeletally immature patients
9. patients with severe hyper-functional habits (e.g. clenching, grinding etc.)

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

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

Temporomandibular joint replacement OPCS V20.1 – V20.9

Policy statement:	Temporalmadibular Joint Retainers and Appliances
Status:	Exceptional Clinical Circumstances

NEE CCG does not routinely fund TMJ appliances e.g. Therabite. GPs should not accept requests to prescribe such appliances on FP10s.

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

Policy statement:	Tier 3 Weight Management
Status:	Threshold Approval/ Individual Prior Approval

Please see Bariatric Surgery.

NEECCG commissions tier 3 **specialist multidisciplinary obesity services** on a restricted basis.

Patients must have completed a course of treatment at a Tier 2 service (or equivalent) before being referred to the tier 3 **specialist multidisciplinary obesity service provider service**.

Referrals to the service will be made by the patient's GP. However referrals **must be** made via the North East Essex CCG Individual funding Requests team. The service **should not** accept direct referrals from GPs or other practitioners

As part of the acceptance criteria for tier 3 weight management **all patients will have to complete tier 2 weight management before tier 3**; otherwise patients will not be motivated and may continue to gain weight to ensure a referral to the higher tiered service. Any patients that are already eligible for tier 3 should still gain benefit from a tier 2 service, those patients not able to take part in classes will be those not able to attend even a tier 3 service (immobile or unable to travel) so a good provider should be able to tailor the sessions appropriately.

In addition to the above requirement to have first attended tier 2 weight management, referrals will be accepted for:

- Patients aged 18 years or over
- Registered with a Practice within North East Essex,
- Referrals that are part of a group of referrals identified and accepted by North East Essex CCG in line with its Clinical Priorities Policy
- Meeting the following criteria:
 - a BMI of 40 or $\geq 35 \text{ kg/m}^2$ and obesity-related comorbidity e.g. metabolic syndrome, hypertension, obstructive sleep apnoea (OSA), functional disability, infertility and depression if specialist advice is needed regarding overall patient management
 - Willingness to commit to changing their behaviours

Exclusions

The service will not accept referrals for:

- Direct GP referrals
- Patients aged 17 years or under
- BMI $<40 \text{ kg/m}^2$ or BMI $\geq 35 \text{ kg/m}^2$ without comorbidities
- Pregnant women
- Bulimia Nervosa
- Patients who have undergone bariatric surgery in the last 12 months

There may also be other exceptions that are not listed which may prevent individuals from being admitted to the service on the grounds that their ability to successfully lose and sustain weight loss is inhibited.

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

Policy statement:	Tinnitus
Status:	Threshold Approval

Refer if

- Consistent bilateral tinnitus (persistent for over 20 weeks) and hearing loss.
- Unilateral tinnitus (persistent over 2 months)

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

ICD10 H93.1

Policy statement:	Tonsillectomy
Status:	Threshold Approval

NEE CCG commissions tonsillectomy on a restrictive basis for those patients who meet the SIGN Guidance 117 (April 2010) <http://www.sign.ac.uk/pdf/sign117.pdf> or one of the conditions listed below.

A period of 6 months watchful waiting by the GP is recommended prior to tonsillectomy to establish firmly the pattern of symptoms and allow the patient to consider fully the implications of operation.

Patients should meet all of the following criteria:

- Sore throats that are due to acute tonsillitis.

AND

- Episodes of sore throat that are disabling and prevent normal functioning.

AND

- Seven or more well 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

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

OR the patient should have one of the following conditions:

- intractable cough with a high level of streptococcal antibody for longer than one year;
- Severe halitosis which has been demonstrated to be due to tonsil crypt debris for longer than one year (diagnosed by an ENT surgeons).
- Lymphoma and Ca tonsil.
- Obstructive sleep apnoea.
- Peritonsillar abscess not responding to antibiotics and incisional drainage.

GPS should not refer unless the above criteria have been met, and referrals must include objective information to demonstrate this.

Once a decision is made for tonsillectomy, this should be performed as soon as possible, to maximise the period of benefit before natural resolution of symptoms might occur (without tonsillectomy).

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

All patients who are smokers (where applicable) should be referred to smoking cessation services before referring for an initial assessment appointment.

Note: Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that

warrant deviation from the rule of this policy. Individual cases will be reviewed as per the CCG policy.

OPCS

F34.1 – F34.9, F36.1

Policy statement:	Trigger Finger
Status:	Threshold Approval

Referral for trigger finger in secondary care is commissioned on a restricted basis. Cases will only be funded if they meet the criteria below:

- Who fail to respond to conservative treatment, including up to 2 corticosteroid injections OR
- Who have a fixed flexion deformity that cannot be corrected

For audit purposes, the referral letter and hospital records should note the dates of the corticosteroid injections and any other conservative management.

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

ICD10: M65.3

Policy statement:	Vaginal Labia Reduction/Refashioning
Status:	Individual Prior Approval

If a clinician wishes to refer the patient to secondary care then funding must be approved by the CCG and will only be considered in the following circumstances.

In all cases, medical photography will be required for the individual prior approval

Labiaplasty

Labiaplasty is generally a cosmetic procedure to improve appearance alone and is not routinely funded. Requests for labiaplasty will be considered for the following indication:

- Where repair of the labia is required after significant trauma.

Vaginoplasty

Non-reconstructive vaginoplasty or "vaginal rejuvenation" is used to restore vaginal tone and appearance and is not routinely funded. Requests for vaginoplasty will be considered for the following indications:

- Congenital absence or significant developmental/endocrine abnormalities of the vaginal canal,
- Where repair of the vaginal canal is required after trauma.

Hymenorrhaphy

Hymenorrhaphy, or hymen reconstruction surgery, is a cosmetic procedure and is not routinely funded.

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

Please refer also to the cosmetic surgery general principles prior to submitting an exceptional funding request.

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

OPCS

P05.5 – P05.7,
P21.3 – P21.5
P32.4 – P32.7

Policy statement:	Varicose Veins
Status:	Threshold Approval

Treatments for varicose veins are considered as procedures of low clinical priority and therefore not routinely funded by the Commissioner.

Conservative management is the first line of treatment and applications will not normally be accepted without evidence that conservative management of asymptomatic and symptomatic varicose veins has been tried, and failed, for a period of at least six months.

Prior to consideration for intervention patients should be given information regarding

- Weight loss if they have a raised BMI
- Light to moderate physical activity
- Avoiding factors which are known to make their symptoms worse, if possible
- Use of compression stockings for a 6 month duration, where this is considered appropriate
- When and where to seek further medical help

NEE CCG commissions treatment or surgery for varicose veins on a restrictive basis.

Funding for treatment or surgery will only be made available for Grade III and above varicose veins.

Grade III: Varicose veins with complications, including bleeding, recurrent phlebitis or eczema.

- Patients who have had bleeding associated with varicose veins should be referred urgently.
- Patients with recurrent thrombophlebitis and persistent varicose veins may be referred, especially if phlebitis has affected veins above the knee.
- Patients with eczema near the ankle or associated with varicose veins below the knee should be referred for specialist advice.



VARICOSE ECZEMA



STASIS GRAVITATIONAL ECZEMA

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

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

OPCS L83.1 – L88.9

Policy statement:	Vasectomies
Status:	Exceptional Clinical Circumstances

NEECCG does not routinely fund vasectomies.

All patients who are smokers should be referred to smoking cessation services before referring for an initial assessment appointment.

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

OPCS
N17.1 – N17.9

Policy statement:	Wigs, Hairpieces and Hair Transplant/Replacement Systems
Status:	Exceptional Clinical Circumstances

NEE CCG does not commission treatments for the correction of male or female pattern baldness as it is a normal process of ageing and any treatment would be considered cosmetic.

For other causes of hair loss, NEE CCG does not routinely commission hair transplantation or the use of the 'Interlace' or other hair systems, regardless of gender, for cosmetic reasons.

NEE CCG commissions treatment for the correction of hair loss only where the hair loss is the result of previous surgery or trauma, including burns. (e.g. reconstruction of the eyebrow following cancer or trauma). Hair pieces and wigs for patients experiencing total or severe hair loss as a result of alopecia totalis, cancer treatment, previous surgery or trauma are available from local NHS Trusts through commissioned pathways.

Hair Transplant OPCS S33.1 –S33.9