

South East London Treatment Access Policy

2014

This Policy has been produced by the South East London Individual Funding Requests Strategy and Policy Group.

A collaboration of the six CCGs in south east London – Bexley, Bromley, Greenwich, Lambeth, Lewisham, and Southwark.

South East London

Treatment Access Policy

This policy deals with treatments and procedures for which restricted access criteria have been agreed.

Background

The six Clinical Commissioning Groups (CCGs) in the South East London Sector have been working with CCGs in South West London on developing a joint policy and process for dealing with Individual Funding Requests (IFRs). There are a number of reasons for a sector-wide process for dealing with IFRs.

Limited Resources

There will always be competing calls for limited resources and therefore a need for a clearly defined and co-ordinated approach to ensure that the resources are used in an equitable and effective way and that clear, consistent and fair procedures are in place. These are based on the principles of cost effectiveness found in the IFR policy.

Local Variations

Local variations in treatment funding decisions (postcode prescribing) are clearly undesirable, but there has been very little guidance at national level on the process of setting priorities for funding. The National Institute for Clinical Excellence (NICE) has been established to provide guidelines on the implementation and introduction of new drugs and technologies. However, for a majority of requests for funding that are submitted to commissioners, no guidelines are available. Development of joint policies and processes across the SE and SW London will clearly be beneficial in terms of reducing the variations between the CCGs.

Efficiency

Joint working will avoid duplication of work and efforts across the area. It will also maximize the use of expertise and skills, building upon previous experience. This joint process will also enhance joint working and communication between the CCGs.

Review

This policy will be reviewed and updated annually.

PLEASE NOTE

The treatments and interventions listed in Section 1 of this document will not receive funding from the funding commissioner unless they have been reviewed by the relevant Individual Funding Request Panel and prior funding agreed. Those listed in Section 2 will not require prior agreement, however the commissioners will monitor this activity and audit as required.

Equality Statement:

“This document demonstrates the organisations’ commitment to create a positive culture of respect for all individuals, including staff, patients, their families and carers as well as community partners. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to use the Human Rights Act 1998 and to promote positive practice and value the diversity of all individuals and communities”.

Services Now Commissioned By NHS England

Some services previously included in the TAP from April 2013 are now commissioned by NHS England (NHSE). These are:

- Implantable cardiac defibrillators (ICDs)
- Cochlear Implants,
- Treatment of Gender dysphoria,
- Bariatric Surgery,
- Hyperbaric oxygen for decompression sickness.

Details of services commissioned by NHSE can be found on their website

<http://www.england.nhs.uk/resources/spec-comm-resources/>

Specific details of the 143 services can be found in The Manual

<http://www.england.nhs.uk/wp-content/uploads/2012/12/pss-manual.pdf>

Whilst paediatric dentistry is included in The Manual commissioning for adult Dental and Orthodontic procedures is now through the dental team of NHSE, they can be contacted on

England.lon-ne-dental@nhs.net

Should you wish to submit an IFR for a service commissioned by NHSE please email them at

England.ifrlondon@nhs.net

ELIGIBILITY CRITERIA FOR SPECIFIC PROCEDURES

<u>SECTION</u>	<u>CONTENTS</u>	<u>PAGE</u>
	BACKGROUND	2
	CONTENTS	4
1.	<u>PROCEDURES WITH RESTRICTED ACCESS CRITERIA REQUIRING PRIOR AGREEMENT</u>	
1.1	COSMETIC PROCEDURES	5
1.2	NON-MEDICAL CIRCUMCISIONS	8
1.3	ALTERNATIVE THERAPIES	8
1.4	REVERSAL OF VASECTOMY OR FEMALE STERILISATION	9
1.5	FUNCTIONAL ELECTRICAL STIMULATION	9
1.6	CAESAREAN SECTION FOR NON CLINICAL REASONS	9
1.7	SURGERY FOR ASYMPTOMATIC GALLSTONES	10
2.	<u>PROCEDURES WITH RESTRICTED ACCESS CRITERIA NOT REQUIRING PRIOR AGREEMENT</u>	
2.1	EXCISION OF OTHER SKIN LESIONS & TUNABLE DYE LASER	11
2.2	VARICOSE VEINS	12
2.3	FERTILITY TREATMENTS	14
2.4	HYSTERECTOMY FOR HEAVY MENSTRUAL-BLEEDING	17
2.5	FILTERED / COLOURED LENSES	17
2.6	COMMON HAND CONDITIONS	18
2.7	TONSILLECTOMY	19
2.8	GROMMETS	19
2.9	ADENOIDECTOMY FOR OTITIS MEDIA IN CHILDREN	19
2.10	KNEE WASHOUTS & DEBRIDEMENT FOR OSTEOARTHRITIS	20
2.11	HAEMORRHOIDS	20
2.12	BOTULINUM TOXIN TYPE A FOR HYPERHIDROSIS	21
	Appendix - Codes	22

All patients requiring a consultant opinion for diagnostic or symptomatic advice should continue to be referred by General Practitioners e.g. skin lesions that may be malignant.

SECTION 1 – PROCEDURES REQUIRING PRIOR APPROVAL

Procedures in Section 1 will still require prior approval through the ‘Individual Funding Request Process’ even if the restricted access criteria outlined are met.

1.1 COSMETIC PROCEDURES

General Remarks

Cosmetic procedures are generally effective but they are considered to be of low priority by local commissioners and will only be funded in exceptional circumstances.

To qualify under the Treatment Access Policy the patient should be over the age of 21 and have a severe physical disfigurement with a long standing reactive psychiatric disorder that would be improved by the cosmetic surgery.

The psychiatric problem should clearly be caused by the relevant physical problem. A psychiatric opinion undertaken by an NHS Consultant Psychiatrist / Clinical Director of the specialty should be provided, confirming that the problem is still ongoing despite being appropriately addressed by a psychiatric or psychological intervention. The psychiatrist should also confirm that the cosmetic procedure would improve the patient’s underlying psychiatric condition. NHS Mental Health Trusts will not accept referrals for assessment purely for cosmetic surgery. The referral has to be for assessment and appropriate treatment of a psychiatric condition.

Individual Procedures

Detailed exceptions to the general restriction on cosmetic surgery are listed here:

i) Blepharoplasty (Eyelid Reduction)

This procedure is not available on cosmetic grounds. An exception may be made if the upper eyelid skin interferes with the visual field or if there is evidence that eyelids impinge on visual fields reducing field to 120° laterally and 40° vertically.

ii) Cosmetic Breast Surgery

This does not refer to breast reconstruction following treatment for cancer.

iii) Breast Augmentation

This procedure is not available on cosmetic grounds. An exception may be made for congenital absence or gross asymmetry (difference in size minimum 2 cup sizes).

iv) Breast Reduction

This procedure is not available on cosmetic grounds. An exception may be made for true virginal hyperplasia when the proposed volume of reduction is greater than 500g per side, gross asymmetry or if the patient has at least one of the following:

- unresponsive to treatment for ulceration of the shoulder from the bra straps
- unresponsive to treatment for intertrigo between the breasts and the chest wall
- severe pain, unresponsive to treatment and directly related to breast size
- ulnar pain from the thoracic nerve root compression

The patient should also meet the following criteria:

- Body Mass Index (BMI) of 25 (kg/m²) or less
- bra cup size of H or more

v) **Mastopexy (relocating the nipple and improving the shape of the breast)**

This procedure is not available on cosmetic grounds. Breast ptosis is inevitable in most women due to a combination of maturity, gravity and pregnancy/lactation. An exception may be made in gross cases when a nipple areola lies below the infra-mammary fold (Grade 3 ptosis).

vi) **Revision Mammoplasty**

This procedure is not available on cosmetic grounds unless the original procedure was performed locally on the NHS because of health reasons, and the patient now has a gross deformity.

vii) **Breast Implants**

Breast implants and instant replacements are not available on the NHS. Ruptured breast implants, however, will be removed on the NHS if they are considered to be of danger to the patient. Replacement implants must not be inserted as part of the same procedure even if the patient wishes to self-fund this part of the treatment.

viii) **Gynaecomastia**

This procedure is not available on cosmetic grounds. Exceptional cases brought to the individual funding request panel for consideration would need to meet the following criteria:

- True gynaecomastia (i.e. breast tissue is present as opposed to adipose tissue) has been diagnosed.
- Gynaecomastia is classified as Grade III (marked breast enlargement with major skin redundancy¹)
- The BMI is less than or equal to 25
- Screening for endocrinological or drug related causes has taken place
- Underlying malignancy should be excluded, clinically or otherwise.

ix) **Correction of Congenital Nipple Inversion**

This procedure is not available on cosmetic grounds. Nipple inversion is a common condition which responds well to conservative treatment, e.g. use of Niplette device.

x) **Body Contouring (Abdominoplasty or Tummy Tuck, Thigh Lift and Buttock Lift, Excision of Redundant Skin or Fat Liposuction)**

These procedures are not available on cosmetic grounds. An exception may be made for post-traumatic surgery for contouring at diabetes injection sites or for lymphoedema.

¹ Simon BE, Hoffman S, Kahn S. Classification and surgical correction of gynecomastia. *Plast Reconstr Surg.* 1973 Jan; 51(1):48-52.

xi) **Dermabrasion (Chemical Peel)**

This procedure is not available for skin rejuvenation. It does have a place in the treatment of severe scarring following acne or sometimes following trauma.

xii) **Face or Brow Lift**

This procedure is not available on cosmetic grounds. An exception may be made for the treatment of facial palsy.

xiii) **Male Pattern Baldness (Hair Grafting and Flaps with or without Tissue Expansion)**

This procedure is not available on cosmetic grounds. Baldness is a natural condition.

xiv) **Female baldness and alopecia – Hair replacement**

This procedure is not available on cosmetic grounds.

xv) **Pinnoplasty (Correction of prominent or Bat Ears)**

This procedure is not available on cosmetic grounds to adults. An exception may be made for children under the age of 18 at the time of referral for significant prominent or bat ears.

xvi) **Repair of Lobe of External Ear**

This procedure is not available on cosmetic grounds.

xvii) **Septo-rhinoplasty (Reshaping of the Nose)**

This procedure is not available on cosmetic grounds. Septo-rhinoplasty will be considered in cases involving severe nasal deformity with chronic and complete obstruction of at least one nostril due to congenital or traumatic causes with demonstrable functional limitations.

xviii) **Scar Revision**

This procedure is not available on cosmetic grounds. An exception may be made with certain scars which interfere with function (e.g. following burns) or for treatment of keloid and post-surgical scarring.

xix) **Tattoo Removal**

This procedure is not available on cosmetic grounds.

xx) **Removal of Birthmarks**

Available for children up to the age of 18 for permanent large or prominent lesions on face or neck.

xxi) **Other Benign Skin Lesions**

Other benign skin lesions e.g. skin tags, fibroepithelial polyps, dermatofibromata; seborrhoeic warts will not be removed on cosmetic grounds. However, if symptomatic and inflamed at the time of consultation, removal will be considered.

Epidermoid (Sebaceous) cysts are always benign and are not removed in the Dermatology Department. Some may become infected and symptomatic and referral to General Surgeons is indicated in these cases.

xxii) **Viral Warts and Molluscum Contagiosum in Children under 16 Years of Age**

These are self-limiting viral infections. Warts are appropriately treated in Primary Care by topical keratolytics. Cryotherapy is too painful and no other treatment is offered in Secondary Care for either condition.

xxiii) **Viral Warts in Adults**

Properly compliant treatment with keratolytics is as effective as cryotherapy.

xxiv) **Cosmetic Genital Surgery**

This procedure is not routinely funded by the NHS.

1.2 **NON-MEDICAL CIRCUMCISIONS**

General Remarks

Circumcision is an effective operative procedure with a range of medical indications. Some circumcisions are also requested for social, cultural or religious reasons, these procedures will not be funded on the NHS.

Medical Indications

Circumcisions should continue to be performed for medical indications only

- phimosis seriously interfering with urine flow and/or associated with recurrent infections
- some cases of paraphimosis
- suspected cancer or balanitis xerotica obliterans
- congenital urological abnormalities when skin is required for grafting
- interference with normal sexual activity in adult males

1.3 **ALTERNATIVE THERAPIES**

Osteopathy

- Osteopathy remains a low priority treatment due to the limited evidence of clinical effectiveness
- Future referral for osteopathy is not available on the NHS.

Acupuncture

- Acupuncture remains a low priority treatment due to the limited evidence of clinical effectiveness
- Future referrals for acupuncture should be made in exceptional circumstances only. Funding for cases of cases of dental pain, nausea and vomiting and back pain shall be considered by the local Individual Funding Request (IFR) Panels.

Homeopathy

- Homeopathy should remain a low priority treatment due to the authoritative evidence that homeopathy has no biological effectiveness.

- South London CCGs that hold contracts with the Royal London Homeopathic Trust may wish to consider terminating these but with arrangements to honour funding for existing patients currently being treated and patients currently on the waiting list
- Future requests for homeopathy will only be agreed by the local IFR Panels in exceptional circumstances.

All Other Complementary Therapies

The CCGs will not purchase these services in the Acute Sector.

1.4 REVERSAL OF VASECTOMY OR FEMALE STERILISATION

The decision to be sterilized is taken by mature adults on the understanding that it is an irreversible contraceptive choice. Therefore, any reversal or subsequent fertility treatment should be the responsibility of the individual and will not be funded by the CCG. Any requests with possible exceptions may be referred to the IFR Panel for consideration. There should be no live children from either of the partners.

Female

- ◆ The woman should not be older than 35 years
- ◆ The procedure should be conducted in a Regional Centre by a surgeon performing sufficient procedures to report a success rate of over 50%

Male

- ◆ The reversal of vasectomy should not be performed more than 10 years after the original sterilization procedure.
- ◆ The female partner should not be more than 36 years old

1.5 FUNCTIONAL ELECTRICAL STIMULATION

There is uncertainty about clinical effectiveness of this procedure and it will not be commissioned on a routine basis.

Note – non PBR Device not procedure, therefore coding unavailable

1.6 CAESAREAN SECTION FOR NON-CLINICAL REASONS

Caesarean section is only available for clinical reasons. Elective Caesarean section for non-clinical reasons, including maternal request, will not be funded on the NHS unless prior approval has been obtained. Such approval will only be granted if such an elective section is justified using recently published NICE guidelines². Applicants will have to document carefully how the case fulfils those guidelines.

1.7 SURGERY FOR ASYMPTOMATIC GALLSTONES³

² National Institute for Health and Clinical Excellence. NICE Clinical Guideline 132: Caesarean Section. NICE, November 2011.

³ Gurusamy KS, Samraj K. *Cholecystectomy for patients with silent gallstones*. Cochrane Database of Systematic Reviews 2007, Issue 1.

Gurusamy KS, Davidson BR. *Surgical treatment of gallstones (review)*. Gastroenterol Clin North Am. 2010 Jun;39(2):229-44, viii.

Approximately 10-20% of people in western countries have gallstones, and some 50-70% are asymptomatic at the time of diagnosis. Asymptomatic disease has a benign natural course and progression to symptomatic disease is relatively low, ranging from 10-25%. The majority of patients rarely develop gallstone-related complications without first having at least one episode of pain.

There is no evidence, and in particular no evidence from randomized controlled trials that surgery for asymptomatic gallstones is beneficial and it will not therefore be routinely funded.

SECTION 2 – PROCEDURES NOT REQUIRING PRIOR AGREEMENT

The following procedures do not require prior agreement providing the restricted access criteria are met. An audit of these procedures will be undertaken routinely.

If the patient does not meet the relevant access criteria, but the clinician feels he/she has exceptional clinical circumstances, the request for funding should be taken through the Individual Funding Request process (IFR).

2.1 EXCISION OF OTHER SKIN LESIONS

General Remarks

If a GP or consultant is concerned that any skin lesion may be malignant the patient should continue to be referred and treated promptly. The general remarks about other cosmetic procedures also apply to the excision of benign skin lesions. Some benign skin lesions will continue to be excised in the acute sector for differential diagnosis. Some GPs also offer these procedures as part of their general practice, although not all patients currently have access to these services.

i) Pigmented Lesions

Removal of obviously clinically benign moles is not available on cosmetic grounds. In most cases the distinction between suspicious and purely benign moles is clear cut but suspicious pigmented lesions should always be subjected to excision biopsy.

ii) Tunable Dye Laser

This treatment is offered for the removal of vascular birthmarks (port wine stains) often present on the neck and face and is the only successful treatment for this type of birthmark. The criteria for patients requiring this type of treatment will be:

- On the face or neck above the collar line in children up to the age of 18 years
- Chest area on women

Patients above the age of 18 years will be considered on an individual basis taking into account psychological and psychiatric effects of the birthmarks on the patient.

Referrals should be made on a tertiary basis usually by a Consultant Dermatologist.

2.2 VARICOSE VEINS

General Remarks

Varicose veins are dilated superficial veins in the leg which are caused by incompetent venous valves. The clinical presentation of varicose veins differs and some people are symptomatic. National Institute of Clinical Excellence (NICE) provides referral advice from primary care to specialist service for varicose veins. It stratifies patients into groups based on clinical criteria and advises GPs on the urgency for specialist referral.

Although treatment for varicose veins is generally effective, recurrence is estimated at around 50% within five years. Surgical treatment of asymptomatic or mild varicose veins is not recommended in the Department of Health's Healthcare Needs Assessment document⁴. In view of the lack of evidence for any prophylactic benefit of varicose vein surgery, high rates of recurrence and the current financial situation, treatment of asymptomatic, mild and moderate varicose veins is considered to be a low priority.

Most patients can be managed in primary care. Surgical treatment of asymptomatic, mild and moderate varicose veins will therefore only be purchased in individual exceptional circumstances. Severe cases may be referred routinely

Surgery (excision of the vein) or sclerotherapy (injection of irritant substances into the vein, which collapses and thus destroys the vein) can improve symptoms in the short term rather than long term. Sclerotherapy is less effective than surgery at improving symptoms and cosmetic appearance.

NICE has recently developed new guidelines for varicose veins in the legs: the diagnosis and management of varicose veins (<http://guidance.nice.org.uk/CG168>). This will be taken into account within the next revision of the Treatment Access Policy.

i) Asymptomatic and Mild Varicose Veins

- Asymptomatic or mild varicose veins present as a few isolated, raised palpable veins with no associated pain, discomfort or any skin changes.
- The main problems with asymptomatic varicose veins are likely to be cosmetic anxiety.
- Mild varicose veins are associated with moderate ankle swelling, feelings of heaviness, pain and other discomfort, with local or generalised dilation of subcutaneous veins.
- Generally, only the superficial veins are involved

Surgical treatment of asymptomatic and mild varicose veins or referral to specialist services will not be available routinely.

ii) Moderate Varicose Veins

- Moderate varicose veins present as local or generalised dilatation of subcutaneous veins with associated pain or discomfort and slight ankle swelling.
- Moderate varicose veins are associated with the symptoms described above for mild varicose veins with prominent local or generalised dilation of subcutaneous veins.
- Moderate varicose veins are more likely to be associated with skin changes but not actual ulceration or pre-ulcerative changes.

Surgical treatment of moderate varicose veins or referral to specialist services will not be available routinely.

⁴ Robbins MA, Frankel SJ, Nanchal K, Coast J, Williams MH. *Varicose Vein Treatment in Health Care Needs Assessment : The Epidemiologically Based Needs Assessment Reviews*. Edited by A Stevens and J Raftery. Oxford. Radcliffe Medical Press 1994.

iii) **Severe Varicose Veins**

- Severe varicose veins: may present with phlebitis, ulceration and haemorrhage.
- Surgical treatment will be available if one or more of the following criteria are met:
 - Persistent ulceration
 - Recurrent phlebitis where there is significant pain and disability from this condition and after unsuccessful 6 month trial of conservative management (compression stockings, exercise and daily elevation 2-3 times a day)
 - Significant haemorrhage from a ruptured superficial varicosity, for instance serious enough to consider transfusion/admission associated with obvious skin changes including lipodermatosclerosis, moderate to severe oedema (itching is insufficient for referral)
 - Intractable ulceration secondary to venous stasis
 - More than one episode of minor haemorrhage from a ruptured superficial or significant haemorrhage from a ruptured superficial varicosity, eg if serious enough to consider transfusion

Surgical treatment for severe varicose veins will be available routinely.

Please note that a referral to specialist services does not necessarily imply surgical management. The Specialist services can do a number of things which include investigate, diagnose and reassure, offer advice on, and/or provide, treatment, supplement advice given in primary care on the application of compression hosiery and bandaging or undertake surgery if indicated.

Conservative management of varicose veins, as detailed in the Department of Health funded Healthcare Needs Assessment should continue to be offered to all appropriate patients² Treatment should be in line with the recommendations of the NHS R & D Health Technology Assessment (2006).⁵

⁵ Michaels JA, Campbell WB, Brazier JE, MacIntyre JB, Palfreyman SJ, Ratcliffe J, Rigby K. *Randomised clinical trial, observational study and assessment of cost-effectiveness of the treatment of varicose veins (REACTIV trial)*. Health Technology Assessment 2006; Vol. 10: No. 13

2.3 FERTILITY TREATMENTS⁶

Infertility is a condition that requires investigation, management and treatment in accordance with national guidance. As part of the provision of prevention, treatment and care Commissioners are committed to ensuring that access to NHS fertility services is provided fairly and consistently.

Initial Assessment

It will be the responsibility of the General Practitioners to initially assess that the person meets the local CCG's criteria for treatment for NHS funded cycles. Further support and advice is available from the Pharmaceutical advisor, Public Health Department and Commissioning team in implementing this guidance.

Referral to Hospital

Assisted conception services are provided by agreed providers. The units must comply with the Human Fertilisation and Embryology Authority (HFEA) regulations and follow appropriate protocols. Couples must take up the offer of Intracytoplasmic sperm injection (ICSI)/Invitro Fertilisation (IVF) within 3 months or risk being removed from the NHS waiting list.

Prescribing of medication

- ◆ The clinical prescribing of all drugs will be the responsibility of the providing Trust or the GP. (for local agreement)
- ◆ If a patient has started a privately funded cycle, the CCG will not fund the provision of prescribed drugs, which forms part of that treatment.

Timescale for treatment

Couples must be made aware at the time of being placed on the waiting list of the likely waiting time and the treatment for which the CCG will pay.

ELIGIBILITY CRITERIA

All couples must be registered with a General Practitioner within the boundaries of the CCG or Care Trust and be eligible for NHS treatment. Patients whose sperm or eggs have been stored prior to chemotherapy or radiotherapy will be entitled to NHS funded infertility treatment provided they meet the eligibility criteria.

The criteria for GP referrals for investigation and management of infertility should be in accordance with the following:

⁶ National Collaborating Centre for Women's and Children's Health. *NICE Clinical Guideline: Fertility. Assessment and treatment for people with fertility problems*. RCOG Press, February 2004. Available at: <http://www.nice.org.uk/nicemedia/live/10936/29267/29267.pdf>.

Badawy SZ, Lopez A, Sarkar S, Dye T. *Cumulative Pregnancy Rates and Probability of Pregnancy in Various Indications for Intrauterine Insemination*. Arch Androl. 1996 Nov -Dec;37(3):171-7.

Cohlen BJ, Vandekerckhove P, te Velde ER, Habbema JD. *Timed intercourse versus intra-uterine insemination with or without ovarian hyperstimulation for subfertility in men*. Cochrane Database Syst Rev 2000;(2):CD000360.

Department of Health. *Regulated Fertility Services: A commissioning aid*. June 2009

Kanani N. *A Review of ICSI: Indications, Cost Effectiveness and Safety*. NHS Bromley, June 2010

van Rumste MM, Evers JL, Farquhar CM, Blake DA. *Intra-cytoplasmic sperm injection versus partial zona dissection, subzonal insemination and conventional techniques for oocyte insemination during in vitro fertilisation*. Cochrane Database Syst Rev. 2000;(2):CD001301.

- Couples should be living together and in a stable relationship.
- The partner who is to receive treatment must be aged between 23 and 39 years old (up to 39 years and 364 days) at the time of treatment.*
- Couples who have been diagnosed as having male factor or female factor problems **or** have had unexplained infertility for at least 3 years, taking into consideration both age and waiting list times.
- Persons aged under 23 years old will be considered for treatment where medical investigations have confirmed that conception is impossible without fertility treatment, e.g. following unsuccessful fallopian tube surgery.
- The female partners must not have had more than 2 previous Interuterine insemination (IUI)/IVF/ICSI attempts (either NHS or privately funded).
- Women will be only considered for treatment if their BMI is between 19 and 30 (kg/m²). Women with the BMI>30 should be referred to the appropriate obesity management pathway.
- Couples should be non-smoking at the time of treatment. Couples who smoke should be referred to smoking cessation.
- IVF cannot be used as a substitute for reversal of sterilisation.
- There are no problems with signing a form concerning the welfare of the child.
- There must be no other medical problems making the chance of success less than 20%.
- This service will be only be available at agreed providers and will include all clinically prescribed drugs.
- Fertility treatment will only be offered to couples where the following two criteria are met:
 - a) Where there are no living children in the current relationship
 - b) Where neither partner has children from previous relationships

Where the eligibility criteria are not met but clinicians feel there are exceptional reasons, a case should be referred to the Individual Funding Requests Panel for consideration.

Eligible Couples will be offered:

3 cycles of IUI, if clinically appropriate. Criteria for IUI include: mild male factor infertility, unexplained infertility and minimal to mild endometriosis.

Or.

1 full cycle of IVF +/- ICSI. Indications for ICSI include severe deficits in semen quality, obstructive azoospermia and non-obstructive azoospermia. The proportion of couples undergoing IVF who require ICSI would not be expected to exceed 40%.

*NICE Guidance (CG 156, Feb 2013) has been noted but, due to resources prioritization, assisted conception will continue to be funded according to the current criteria.

Surrogate Pregnancy

The implications of a number of important legal points related to surrogate pregnancy mean that fertility treatment involving a surrogate mother will not be funded⁷.

Same Sex Couples

As the consequence of the above legal opinion related to surrogacy, assisted conception for couples where both partners are male will not be provided by the SE London CCGs.

Where both partners are female, funding can be provided as long as the above criteria are met. Infertility needs to be demonstrated in the partner who is seeking to become pregnant. That

⁷ Cheshire and Merseyside Specialised Services Commissioning team Addendum to the Cheshire and Merseyside fertility Policy. May 07 Appendix 1 Legal Advice from Hill Dickenson

partner has to have undergone at least three attempts of IUI. An additional criterion for these couples is that they meet the HFEA requirements for parenthood and that both partners consent to be parents of the child. The HFEA guidance and a suitable statement for both partners to sign are available on request

Single Women

Because of the known disadvantage that providing assisted conception to a single woman would cause both the child and the mother, funding of assisted conception for single women is not available in SE London.⁸

Definition of one full cycle (NICE 2004):

'Embryos not transferred during a stimulated in vitro fertilisation treatment cycle may be suitable for freezing. If two or more embryos are frozen then they should be transferred before the next stimulated treatment cycle because this will minimise ovulation induction and egg collection, both of which carry risks for the woman and use more resources'.

The 'full cycle' of IVF is therefore regarded as the fresh cycle plus the transfer of frozen embryos where this is possible.

The CCGs will fund up to 2 frozen embryos per patient for 2 years. This will include the cost of freezing and storage. For unsuccessful patients, i.e. those not resulting in a live birth, the CCG will also fund the transfer of these frozen embryos (maximum 2 frozen embryo transfers per patient). The age of mother at the time that the embryos are frozen is required to be within the age limits set out in the policy. This does not apply to the age at transfer.

Egg Donation/Donor Insemination

The CCG does not currently fund these procedures

Sperm Washing (for HIV and Other Viral Infections)

As this is not a treatment for infertility sperm washing is not covered by this policy. At present any decisions regarding sperm washing should be referred to the Individual Funding Request Panel for consideration

2.4 HYSTERECTOMY FOR HEAVY MENSTRUAL-BLEEDING

Hysterectomy is an appropriate treatment for certain conditions such as malignancy. Its effectiveness in conditions such as heavy menstrual bleeding and fibroids where there are a number of treatment options is less clear cut. Funding for hysterectomy for heavy menstrual-bleeding and fibroids will be approved only when:

There has been a prior trial with a LNG-IUS (levonorgestrel intra-uterine system) intra-uterine device (unless contraindicated) or other hormonal treatments in line with NICE guidance, which has not successfully relieved symptoms

AND

Other treatments (such as NSAIDs, Tranexamic Acid, Endometrial ablation and uterine-artery embolisation) have failed, are not appropriate or are contra-indicated in line with NICE guidelines.

⁸

Contraindications to LNG-IUS are:

- Severe anaemia, unresponsive to transfusion or other treatment whilst a LNG-IUS trial is in progress
- Distorted or small uterine cavity (with proven ultrasound measurements)
- Genital malignancy
- Active trophoblastic disease
- Pelvic inflammatory disease
- Established or marked immunosuppression
- In relation to a fibroid uterus above 12 weeks size, the LNG IUS or ablation techniques are unlikely to work.
- For those who for ethical reasons cannot accept the use of Mirena®, they should have tried at least two of the alternative treatments (NSAIDs, Tranexamic Acid, Endometrial ablation, uterine-artery embolisation).

Rationale

- The Mirena® device has been shown to be effective in the treatment of heavy menstrual-bleeding.
- It is considerably cheaper than performing a hysterectomy, even if required for many years.

A number of effective conservative treatments are available as second line treatment after failure of Mirena or where Mirena is contra-indicated.

2.5 FILTERED / COLOURED LENSES

These are not offered for specific reading difficulties.

2.6 COMMON HAND CONDITIONS

◆ Ganglion

Cystic degeneration from joint capsule or tendon sheath. Lesions at the base of the digits are often small but very tender (Seed Ganglion). Mucoïd cysts arise at the distal interphalangeal joint and may disturb nail growth. Ganglions arising at the level of the wrist are rarely painful and most will resolve spontaneously within 5 years. The recurrence rate after excision of wrist ganglia is between 10-45%.

Refer:

- Painful seed ganglia
- Mucoïd cysts that are disturbing nail growth or have a tendency to discharge (risk of septic arthritis in distal interphalangeal joint)

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

◆ **Carpal Tunnel Syndrome**

Patients typically present with nocturnal dysaesthesia in the hands which wears off with activity. The presence of a positive Phalen's (wrist flexion test) or Tinel's sign confirms the diagnosis. 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). Refer:

- Acute severe symptoms (fewer than 5% of patients) uncontrolled by conservative measures, particularly pregnancy
- Mild to moderate symptoms with failure of conservative management (4 months)
- Neurological deficit ie sensory blunting or weakness of thenar abduction (APB)

◆ **Dupuytren's Disease**

Nodular or cord-like thickening of the palmar skin. May tend to cause tethering of the digits with loss of extension range. Refer:

- Loss of extension in one or more joints exceeding 25 degrees
- Young patients (under 45 years) with disease affecting 2 or more digits and loss of extension exceeding 10 degrees.

◆ **Trigger Finger**

Snapping of the fingers as they are extended from a fully flexed posture, associated with a tender nodule in flexor tendon at base of finger or thumb. Conservative treatment may include rest from precipitating activities or NSAIDs. Injection of hydrocortisone into the tissue in front of the tendon at the level of the distal palmar crease (MCPJ) will often settle early cases (requires clinical experience). Refer:

- Failure to respond to conservative treatment (maximum 2 injections)
- Fixed flexion deformity that cannot be corrected

2.7 TONSILLECTOMY

Tonsillectomy will not be funded except in cases of suspected malignancy or significant severe impact on quality of life indicated by:

- 5 or more episodes of sore throat per year
- symptoms for at least a year
- the episodes of sore throat are disabling and prevent normal functioning
- documented evidence of absence from school or attendance at GP or other health care setting.

Rationale:

Tonsillectomy offers relatively small clinical-benefit, measured best in terms of time taken away from school. The benefit in the year after the operation is roughly 2.8 days less taken away from school. Tonsillectomy carries a risk of mortality estimated to lie between 1 in 8,000 and 1 in 35,000 cases

2.8 GROMMETS⁹

CCGs will fund insertion of grommets (ventilation tubes) in

- Children with persistent bilateral Otitis media with effusion (OME) documented over a period of 3 months with a hearing level in the better ear of 25-30 dBHL or worse, averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available)
- Children with persistent bilateral OME with a hearing loss less than of 25-30 d BHL where the impact of the hearing loss on the child's developmental, social or educational status is judged to be significant (e.g. documented absence from school)
- Children with Down's syndrome or cleft palate if this is considered clinically appropriate by a multidisciplinary team of professionals with expertise in assessing and treating such children

2.9 ADENOIDECTOMY FOR OTITIS MEDIA IN CHILDREN

Adenoidectomy combined with grommets may be considered in children who fulfil the criteria for grommets (see 2.8).

⁹ National Institute for Health and Clinical Excellence. *NICE clinical guideline 60: Surgical management of otitis media with effusion in children*. NICE. February 2008. Available at: <http://www.nice.org.uk/nicemedia/pdf/CG60NICEguideline.pdf>

2.10 KNEE WASHOUT AND DEBRIDEMENT FOR OSTEOARTHRITIS¹⁰

NICE Guidance (2008) states that “exercise should be a core treatment for people with osteoarthritis, irrespective of age, comorbidity, pain severity or disability”. Analgesia for pain relief is also important and is detailed in the NICE document. Neither Cochrane reviews nor NICE found benefits from knee washout or debridement for the treatment of osteoarthritis. Therefore, as recommended by NICE 2008:

Referral for arthroscopic lavage and debridement should not be offered as part of treatment for knee osteoarthritis, *unless* the person has a clear history of mechanical locking (not gelling, 'giving way' or X-ray evidence of loose bodies).

2.11 HAEMORRHOIDS¹¹

First or second-degree internal haemorrhoids (or third-degree haemorrhoids that are quite small) usually respond to conservative treatments such as changing bowel habit, diet and lifestyle, and by using stool softeners or laxatives. Only about 10% of people eventually require surgery to alleviate their symptoms.

Non-conservative treatments include rubber band ligation, sclerotherapy, infra-red photocoagulation and surgery (e.g. haemorrhoidectomy, stapled haemorrhoidectomy, haemorrhoidal artery ligation). These are indicated for:

- Failure to respond to conservative treatment.
- Fourth-degree haemorrhoids, or third-degree haemorrhoids that are either too large for non-operative measures or have not responded to them.
- Thrombosed haemorrhoids when bleeding is problematic, or there is chronic irritation or leakage.
- People with large skin tags that need removing.

¹⁰ National Institute for Health and Clinical Excellence. *NICE Clinical guideline 59: The care and management of osteoarthritis in adults*. NICE, February 2008. Available at: <http://www.nice.org.uk/nicemedia/live/11926/39557/39557.pdf>. (Accessed 1.12.2010).

National Institute for Health and Clinical Excellence. *Interventional procedures guidance: Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis*. NICE, August 2007. <http://www.nice.org.uk/nicemedia/live/11326/35856/35856.pdf>. (Accessed 1.12.2010).

Reichenbach S, Rutjes AWS, Nüesch E, Trelle S, Jüni P. Joint lavage for osteoarthritis of the knee. *Cochrane Database of Systematic Reviews* 2010, Issue 5.

Laupattarakasem W, Laopaiboon M, Laupattarakasem P, Sumananont C. Arthroscopic debridement for knee osteoarthritis. *Cochrane Database of Systematic Reviews* 2008, Issue 1.

¹¹ NHS evidence. Clinical Topics: Haemorrhoids. Available at: http://www.cks.nhs.uk/haemorrhoids/view_whole_topic. (Accessed 2.12.2010)

National Institute for Health and Clinical Excellence. NICE technology appraisal 128. Stapled haemorrhoidopexy for the treatment of haemorrhoids. NICE, September 2007. <http://www.nice.org.uk/nicemedia/live/11835/36250/36250.pdf>. (Accessed 2.12.2010)

National Institute for Health and Clinical Excellence. *Interventional procedures guidance: Haemorrhoidal artery ligation*. NICE, May 2010. <http://www.nice.org.uk/nicemedia/live/12236/48673/48673.pdf>. (Accessed 2.12.2010)

2.12 BOTULINUM TOXIN TYPE A FOR HYPERHIDROSIS

Botulinum toxin therapy for the treatment of Hyperhidrosis is considered a low priority treatment and funding will only be considered for **severe** (defined as HDSS score 3 or 4) **focal primary hyperhidrosis** of the **axillae**, when the patient has had a documented, 6 month trial of conservative management, including all the following:

- The use of topical aluminium chloride or extra-strength antiperspirants, which has been ineffective **or** resulted in a severe rash which does not resolve with topical steroids/recommended treatment;
- General measures have been addressed, including wearing light coloured, non tight fitting clothing, identifying and avoiding triggers e.g. spicy food, consider treating any underlying anxiety.

Funding for further treatments, at intervals of no less than 16 weeks, will only be approved provided at least a 2 point reduction on HDSS score can be shown during the 4 months following initial treatment.

The Hyperhidrosis Disease Severity Scale (HDSS) is a validated 4-point scale in which the patient rates the tolerability of their underarm sweating and the resulting interference with daily activities, as follows:

Score 1: My underarm sweating is never noticeable and never interferes with my daily activities

Score 2: My underarm sweating is tolerable but sometimes interferes with my daily activities

Score 3: My underarm sweating is barely tolerable and frequently interferes with my daily activities

Score 4: My underarm sweating is intolerable and always interferes with my daily activities

Please note: Botulinum toxin preparations are not interchangeable. Botox® is the only preparation licensed for severe, axillary hyperhidrosis

Pregnant women and nursing mothers should avoid treatment.

APPENDIX: Codes

Blepharoplasty (Eyelid Reduction)

OPCS 4 Procedure codes C131 C132 C133 C134 C138 C139

Cosmetic Breast Surgery

OPCS 4 Procedure codes B301 B302 B303 B308 B309 B311 B312 B313 B314 B318 B319

Breast Augmentation

OPCS 4 Procedure codes B312 B301 B303 B308 B309

Breast Reduction

OPCS 4 Procedure code B311

Breast Reduction

OPCS 4 Procedure code B311

Mastopexy (relocating the nipple and improving the shape of the breast)

OPCS 4 Procedure code B313

Revision Mammoplasty

OPCS 4 Procedure codes B314 B302

Breast Implants

OPCS 4 Procedure codes B312 B301 B303 B308 B309

Gynaecomastia

OPCS 4 Procedure code B275

Correction of Congenital Nipple Inversion

OPCS 4 Procedure codes B354 B356 B358 B359

Body Contouring (Abdominoplasty or Tummy Tuck, Thigh Lift and Buttock Lift, Excision of Redundant Skin or Fat Liposuction)

OPCS 4 Procedure codes S021 S022 S028 S029 S031 S032 S033 S038 S039

Dermabrasion (Chemical Peel)

OPCS 4 Procedure codes S601 S602

Face or Brow Lift

OPCS 4 Procedure codes S011 S012 S013 S014 S015 S016

Male Pattern Baldness (Hair Grafting and Flaps with or without Tissue Expansion)

OPCS 4 Procedure codes S331 S332 S333

Pinnaplasty (Correction of prominent or Bat Ears)

OPCS 4 Procedure code D033

Repair of Lobe of External Ear

OPCS 4 Procedure codes D062

Rhinoplasty (Reshaping of the Nose)

OPCS 4 Procedure codes E021 E022 E023 E024 E025 E026 E028 E029 E027

Scar Revision

OPCS 4 Procedure codes S604

Tattoo Removal

OPCS 4 Procedure codes S091 S092 S065 S068 S069

ICD10 Z411 L818

Removal of Birthmarks

OPCS 4 Procedure codes S038 S039 S048 S049 S051 S052 S053 S054 S055 S058 S059 S061 S062 S063 S064 S065 S068 S069 S081 S082 S083 S088 S089 S091 S092 S093 S098 S099 S101 S102 S103 S104 S108 S109 S111 S112 S113 S114 S118 S119

ICD 10 diagnostic code Q825

Other Benign Skin Lesions

OPCS 4 Procedure codes S038 S039 S041 S042 S043 S048 S049 S051 S052 S053 S054 S055 S058 S059 S061 S062 S063 S064 S065 S068 S069 S081 S082 S083 S088 S089 S091 S092 S093 S098 S099 S101 S102 S103 S104 S108 S109 S111 S112 S113 S114 S118 S119

ICD 10 diagnostic codes D170 D171 D172 D173

ICD 10 diagnostic codes D23 D230 D231 D232 D233 D234 D235 D236 D237 D239 L720 L721 L722 L728 L729

Viral Warts and Molluscum Contagiosum in Children under 16 Years of Age

ICD 10 diagnostic codes B07X

Viral Warts in Adults

ICD 10 diagnostic codes B07X

Non-Medical Circumcisions

OPCS 4 Procedure codes N303

ICD10 Z412

Reversal of Vasectomy or Female Sterilisation

OPCS 4 Procedure codes Q291 Q292 Q298 Q299 Q371 Q378 Q379 N181

EXCISION OF OTHER SKIN LESIONS

Pigmented Lesions

ICD 10 diagnostic codes L810 L811 L812 L813 L814 L815 L816 L817 L818 L819

ICD10 diagnostic codes (moles) Q825 D220 D221 D222 D223 D224 D225 D226 D227 D228 D229 I781

Tunable Dye Laser

ICD 10 diagnostic codes Q825

Varicose Veins

OPCS 4 Procedure codes L841 L842 L843 L844 L845 L846 L848 L849 L851 L852 L853 L858 L859 L861 L868 L869 L871 L872 L873 L874 L875 L876 L878 L879

ICD 10 diagnostic codes I831 I839

Dilatation and Curettage

OPCS 4 Procedure codes Q103

Hysterectomy for Heavy Menstrual-Bleeding

OPCS 4 Q071 Q072 Q073 Q074 Q075 Q078 Q079 Q081 Q082 Q083 Q088 Q089

ICD10 N920 N921 N924

Ganglion

OPCS 4 Procedure codes T591 T592 T593 T594 T598 T599 T601 T602 T603 T604 T608 T609

ICD 10 diagnostic code M674

Carpal Tunnel Syndrome

ICD 10 diagnostic code G560

Dupuytren's Disease

ICD 10 diagnostic code M720

Trigger Finger

ICD 10 diagnostic code M653

Tonsillectomy

OPCS4 F341 F342 F344 F345 F346 F347 F348 F349

Grommets

OPCS 4 Procedure code D151

ICD 10 diagnostic code H650 H651 H652 H653 H654 H659

Adenoidectomy for Otitis Media in Children

OPCS 4 Procedure code E201 E208 E209

ICD 10 diagnostic code H650 H651 H652 H653 H654 H659

Knee Washout and Debridement For Osteoarthritis

OPCS 4 Procedure code W852;

In addition, an ICD-10 code from category M17-(arthrosis of the knee) would be recorded

Haemorrhoids

OPCS 4 Procedure codes H511 H512 H513 H518 H519 H521 H522 H523 H524 H528 H529 H531
H532 H533 H538 H539 H482

ICD10 diagnostic codes I840 I843 I847

Surgery for Asymptomatic Gallstones

OPCS 4 Procedure codes J181 J182 J183 J184 J185 J188 J189 J211

ICD10 code K802