NHS
Sandwell and West Birmingham
Clinical Commissioning Group

Procedures of Limited Clinical Value Commissioning Policies

healthcare
without boundaries

Introduction

This policy describes the exclusions and access criteria in respect of procedures of limited clinical priority and its application in accordance to both the clinical and administrative adherence protocols detailed in this policy.

This policy does not apply to cosmetic treatments and procedures; they are covered by a separate policy. This policy incorporates the evidence relating to clinical and cost-effectiveness.

Background

This policy has been produced by Sandwell and West Birmingham CCG as part of a harmonisation process for policies where due to the convergence of two PCTs (Sandwell PCT and Heart of Birmingham PCT), patients were being treated under two different sets of policies.

Since the Clinical Commissioning Group operates within finite budgetary constraints the policies detailed in this document makes explicit the need for Sandwell and West Birmingham CCG to prioritise resources and provide interventions with the greatest proven health gain. The intention is to ensure equity and fairness in respect of access to NHS funding for interventions and to ensure that interventions are provided within the context of the needs of the overall population and the evidence of clinical and cost effectiveness.

To do this the policy provides:

- The list of interventions not normally funded by Sandwell and West Birmingham CCG
- The specified criteria required for the funding of certain other interventions

Please note that the policy guidance relating to these interventions should be read with reference to the principles detailed below.

The CCG explicitly recognise that for each of the interventions listed in this policy there may be exceptional clinical circumstances in which to fund these interventions. Whilst it is not feasible to consider every possible scenario within this document, they will be considered on a case by case basis to enable due consideration of the individual merits of each case. Thus, funding for interventions not normally funded and for interventions where specified criteria are not met will be considered by the CCG following application to the individual Funding Request (IFR) Panel.

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

Implementation

Commissioners, General Practitioners, Service Providers and Clinical Staff treating residents of Sandwell and West Birmingham CCG are expected to implement this policy. When interventions are undertaken on the basis of meeting criteria specified within the policy, this should be clearly documented within the clinical notes. Failure to do so will be considered by Sandwell and West Birmingham CCG as lack of compliance.

Patients with problems or conditions that require treatments included in this policy should only be referred to a Consultant or Specialist;

- **After a clinical assessment is made by the GP, AND**
- **The patient meets all the criteria set out in the policy AND**
- **There is a symptomatic or functional requirement for surgery.**

GPs wishing to seek a specialist opinion for patients who meet this policy criterion should ensure that when making a referral to secondary care, the basic clinical information is included in the referral letter that assures that the patient has been assessed in line with this policy.

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

This is not a blanket ban. The CCG recognises there will be exceptional, individual or clinical circumstances when funding for treatments designated as low priority will be appropriate.
Individual treatment requests should only occur in exceptional circumstances where the patient does not meet the core criteria. In this instance the completion of an Individual Funding Request is required.

Individual Funding Request cases where referral on the NHS is being requested should ONLY be sent to the respective NHS.net accounts:

Sandwell and West Birmingham CCG Individual Funding Request Case Manager
Floor Two, Kingston House
438 High Street
West Bromwich
West Midlands
B70 9LD
Telephone: 0121 612 1408
Email: ifr.swb@nhs.net

Monitoring

It is envisaged that this policy will be subject to continued monitoring using a mix of the following approaches:

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

Definitions

Exceptional clinical circumstances refers to a patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients with the same medical condition and at the same stage of progression as the patient.

There can be no exhaustive definition of the conditions which may potentially fall within the definition of an exceptional case. The word “exception” means “a person, thing or case to which the general rule is not applicable”. The following criteria, however, are indicative of the presence or absence of exceptionality in the present context:

- To be an exception, there must be unusual or unique clinical factors about the patient that suggest that he or she is;
  I. Significantly different from the wider group of patients with the same condition; or
  II. Likely to gain significantly more benefit from the intervention than might be expected from the average patient with the same condition.

- The fact that a treatment is likely to be effective for a patient is not, in itself, a sufficient basis for establishing an exception.

- If a patient’s clinical condition matches the ‘accepted indications’ for a treatment, but the treatment is not funded, then the patient’s circumstances are not, by definition, exceptional.

It is for the requesting clinician (or patient) to make the case for exceptional circumstances.

Social value judgments are rarely relevant to the consideration of exceptional status.

An ***Individual Funding Request (IFR)*** is a request received from a provider or a patient with explicit support from a clinician, which seeks funding for a single identified patient for a specific treatment.

An electronic copy of this policy can be found
https://www.sandwellandwestbhamccg.nhs.uk/freedom-of-information/cat_view/46-freedom-of-information/51-our-policies-and-procedures

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Procedures of Limited Clinical Value Commissioning Policy

Adenoidectomy

March 2013

Version: 1
Date: March 2013

Summary
Sandwell and West Birmingham CCG do not normally fund adenoidectomy unless patients meet the criteria set out in the policy below and the procedure is undertaken in conjunction with Tonsillectomy and/or Grommets.

1. Background

1.1 An adenoidectomy is an operation to remove the adenoids.

1.2 It is usually done if the adenoids become so enlarged that children cannot breathe through their noses properly, or if they are thought to be causing health problems such as 'glue ear'.

1.3 Removal of the adenoids is often combined with tonsillectomy and/or grommet insertion.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG will only fund adenoidectomy for the following conditions if the procedure is undertaken in conjunction with Tonsillectomy and/or Grommets.

- Nasal obstruction (enlarged adenoids)
- Recurrent otitis media with effusion (OME)
- Chronic rhinosinusitis
- Obstructive sleep apnoea (OSA)
- Chronic sinusitis.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

Myringotomy and Grommets

February 2013

Version: 1
Date: February 2013

Summary

Sandwell and West Birmingham CCG do not normally fund Myringotomy and Grommets (insertion of Ventilation Tube through the Tympanic Membrane) unless patients meet the criteria set out in the policy below.

1. Background

1.1 A grommet is a small bobbin-shaped tube used to keep open the incision made in the ear drum as a ventilation for otitis media with effusion (OME, glue ear). It acts as a ventilation tube by allowing the Eustachian Tube to recover its normal function.

1.2 A Cochrane review on grommets for hearing loss associated with otitis media with effusions in children (2005) came to the conclusion that:

"The benefits of grommets in children appear small. The effect of grommets on hearing diminished during the first year. Potentially adverse effects on the tympanic membrane are common after grommet insertion. Therefore an initial period (3 months) of watchful waiting seems to be an appropriate management strategy for most children with OME. As no evidence is yet available for the subgroup of children with speech or language delays, behavioural and learning problems of children with defined clinical syndromes (generally excluded from the primary studies included in this review), the clinician will need to make decisions regarding treatment for such children based on other evidence and indications of disability related to hearing impairment."

1.3 In 2008 NICE produced clinical guidelines on the assessment of children with OME and their surgical management.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG will only fund myringotomy (incision through the Tympanic Membrane or 'ear drum') with/without Grommets in children (up to age 12) when patients meet the following criteria:

• The child has had persistent hearing loss***** detected on two occasions separated by 3 months or more

Or
• Five or more episodes of acute otitis media in the past 12 months

2.3 Exceptionally, surgical intervention****** will be funded in children with persistent bilateral OME for 6 months or more 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 or the child has a second disability e.g. Down's syndrome or cleft palate.

2.4 Adjuvant adenoidectomy may be undertaken in cases of OME that recur following grommet insertion.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

* Persistent hearing loss = 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)
** Surgical intervention is appropriate in 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.

4. Procedures Covered by the Policy

NICE clinical guidance 60 Surgical management of Otitis media with effusion in children.

OPCS Codes (One of)

D151	DRAINAGE OF MIDDLE EAR	MYRINGOTOMY WITH INSERTION OF VENTILATION TUBE THROUGH TYMP
D158	DRAINAGE OF MIDDLE EAR	OTHER SPECIFIED
D159	DRAINAGE OF MIDDLE EAR	UNSPECIFIED

AND ICD-10 Codes (One of)

H65	Nonsuppurative otitis media
H650	Acute serous otitis media
H651	Other acute nonsuppurative otitis media
H652	Chronic serous otitis media
H653	Chronic mucoid otitis media
H654	Other chronic nonsuppurative otitis media
H659	Nonsuppurative otitis media, unspecified
H66	Suppurative and unspecified otitis media
H660	Acute suppurative otitis media
H661	Chronic tubotympanic suppurative otitis media
H662	Chronic atticoantral suppurative otitis media
H663	Other chronic suppurative otitis media
H664	Suppurative otitis media, unspecified
H669	Otitis media, unspecified
H67	Otitis media in diseases classified elsewhere
H670A	Otitis media in bacterial diseases classified elsewhere
H671A	Otitis media in viral diseases classified elsewhere
H678A	Otitis media in other diseases classified elsewhere
B053	Measles complicated by otitis media

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Routine Ear Irrigation

March 2013

Version: 1
Date: March 2013

Summary

Sandwell and West Birmingham CCG do not fund routine ear irrigation in a secondary care setting.

1. Background

1.1 Ear irrigation is undertaken for the purpose of removing wax from the external auditory meatus where this is thought to be causing a hearing deficit and/or discomfort, or restricts vision of the tympanic membrane preventing examination, in the adult patient

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Routine ear syringing is not a procedure normally carried out in a secondary care setting.

2.3 Treatment should be delivered in primary care prior to referral to secondary care.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

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Tonsillectomy

February 2013

Version: 1
Date: February 2013

Summary

Sandwell and West Birmingham CCG do not usually fund Tonsillectomy unless patients meet the criteria set out in the policy below.

1. Background

1.1 Tonsillitis is a common illness in children, during which children experience severe discomfort as well as unpleasant malaise.

1.2 Frequency and severity of tonsillitis usually reduces with time and tonsillectomy (with or without adenoidectomy) is not usually required. The clinical benefits of tonsillectomy are small, resulting in just 2.8 fewer days taken off school on average (days of school being the accepted outcome indicator for tonsillectomy). The modest benefit along with a small but real risk of death from surgery (between 1 in 8,000 and 1 in 35,000 cases) means that surgery should usually be avoided.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG will only fund tonsillectomy when patients meet the following criteria:

• Seven or more episodes of documented as clinically significant, adequately treated sore throats in the preceding year that have been disabling and that have prevented normal functioning
or
• Five or more episodes of documented as clinically significant, adequately treated sore throats in each of the preceding two years
or
• Three or more episodes of documented as clinically significant, adequately treated sore throats in each of the preceding three years.

2.3 Each of the episodes should be documented in the patient's medical records and characterised by at least one of the following:

- Aural temperature of at least 38.3°C
- Tender anterior cervical lymph nodes

- Tonsillar exudates
- Positive culture of group A beta haemolytic streptococci
- Tonsillar enlargement giving rise to symptoms of upper airways obstruction

2.4 Or

- There is suspicion of malignancy or
- Tonsillitis or quinsy results in two or more hospital admissions

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

4. Procedures Covered by the Policy

Primary_Operative_Procedure	Primary_Operative_Procedure_Description
E201	Total adenoidectomy
F341	Bilateral dissection tonsillectomy
F342	Bilateral guillotine tonsillectomy
F343	Bilateral laser tonsillectomy
F344	Bilateral excision of tonsil NEC
F345	Excision of remnant of tonsil
F346	Excision of lingual tonsil
F347	Bilateral coblation tonsillectomy
F348	Other specified excision of tonsil
F349	Unspecified excision of tonsil

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Carpal Tunnel

February 2013

Version: 1
Date: February 2013

Summary

Sandwell and West Birmingham CCG do not usually fund carpal tunnel surgery for patients with intermittent or mild to moderate symptoms unless conservative treatment has been tried and failed during a period of more than 3 months.

1. Background

1.1 Carpal tunnel syndrome is a relatively common condition that affects the nerves of the hand causing pain, numbness and a burning or tingling sensation in the hand and fingers. Symptoms can be intermittent, and range from mild to severe. Patients typically present with nocturnal dysaethesia in the hand, which wears off with activity. If considered necessary to aid diagnosis, orthopaedic specialists may undertake nerve conduction studies/electromyography.

1.2 It is estimated that up to 5% of women and 3% of men have carpal tunnel syndrome. Most cases are in people aged 45-64 years. Carpal tunnel syndrome is also common in pregnant women, possibly due to fluid retention. The likely prognosis of carpal tunnel syndrome seems to depend on the severity of symptoms.

1.3 A trial of conservative therapy offers the opportunity to avoid surgery for some patients. Corticosteroid injections and nocturnal splinting are effective conservative therapies, offering short-term benefit (at least 1-3 months in more than 50% of patients). Many patients' symptoms may resolve for at least a year after conservative treatment. Patients should not normally be referred for carpal tunnel syndrome unless they have been managed using conservative treatment for 6 months.

1.4 There is uncertainty about whether one or two corticosteroid injections should be given, but there is a lack of evidence for more than two injections.

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

1.5 Surgery is better than conservative therapy with patients who fail to respond to conservative treatment and with advanced/severe symptoms. Up to 90% of patients reporting complete or much improvement at 18 months.

1.6 The evidence supports the effectiveness of some conservative therapies including injection and wrist splinting.

1.6.1 Local corticosteroid injection in relieving symptoms, but effectiveness after one month and to 12 months appears to decrease.

1.6.2 Local injection is more effective than oral steroids.

1.6.3 After the initial period of effectiveness of conservative treatment surgery becomes more effective at treating continuing symptoms.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Surgical treatment for carpal tunnel syndrome can be made where patients meet all of the following criteria

• Symptoms persisting longer than three months despite conservative treatment (by injection and/or wrist splint)

• Positive clinical signs OR positive nerve conduction studies

2.3 It is appropriate to proceed straight to decompression surgery if severe symptoms are present at presentation i.e. constant numbness or pain, wasting or weakness of the thumb muscles.

3. Implementation

3.1 The implementation of this policy will be monitored as per the agreed process defined within the acute services contract.

4. Procedures Covered by the Policy

Primary Operative Procedure	Primary Operative Procedure Description
A651	Carpal Tunnel Release
T522	Revision of palmar Fasciectomy
A658	Other Specified
A659	Unspecified

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Arthroscopy of the Knee Joint

February 2013

Version: 1
Date: February 2013

Summary

Sandwell and West Birmingham CCG does not usually fund arthroscopy of the knee joint unless patients meet the criteria set out in the policy below.

1. Background

1.1 Arthroscopy is a surgical procedure for inspection and treatment of problems arising in the knee joint.

1.2 It has been used extensively in the past to diagnose knee problems but this is no longer appropriate due to the invasive nature of the procedure and the increasing access to less invasive diagnostic methods.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CCG will fund arthroscopy of the knee only for one of the following indications:

• Removal of loose body
• Repair of resection of meniscal tear
• Reconstruction or repair of ligament
• Synovectomy
• Urgent clinical circumstances such as infection, carcinoma, nerve root impingement, bony fracture, avascular necrosis.

2.3 Sandwell and West Birmingham CCG will not fund arthroscopy of the knee for the investigation of knee pain, with an expectation that less invasive MRI scanning should be used. The only exception is when there is diagnostic uncertainty following a MRI scan.

2.3 Arthroscopy only pursued if clinical examination by a consultant specialist or an MRI scan 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

2.4 Sandwell and West Birmingham CCG will not usually fund arthroscopic washout for the treatment of osteoarthritis.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

4. Procedures Covered by the Policy

OPCS Codes (One of)

W871	DIAGNOSTIC ENDOSCOPIC EXAMINATION OF KNEE JOINT	DIAGNOSTIC ENDOSCOPIC EXAMINATION OF KNEE JOINT AND BIOPSY
W878	DIAGNOSTIC ENDOSCOPIC EXAMINATION OF KNEE JOINT	OTHER SPECIFIED
W879	DIAGNOSTIC ENDOSCOPIC EXAMINATION OF KNEE JOINT	UNSPECIFIED

Procedures of Limited Clinical Value Commissioning Policy

Hip and Knee Replacement for patients with osteoarthritis

February 2013

Version: 1
Date: February 2013

Summary

Sandwell and West Birmingham CCG will only fund hip and knee replacement operations for individuals with osteoarthritis who meet the eligibility criteria set out in the policy below.

1. Background

1.1 There is a national trend toward increasing demand for joint replacement surgery, with total number of operations growing from approximately 105,000 procedures in 2005 to approximately 160,000 in 2009). While the vast majority (over 90%) of interventions are primary joint replacements, the proportion of operations which were revision procedures more than doubled between 2005 and 2009. An aging population means that this trend is likely to increase.

1.2 National data also shows that there is a marked difference in access to joint replacement surgery between most and least deprived populations. For example, rate of primary hip replacement in males ranges from 50 per 100,000 in most deprived populations to 80 per 100,000 in least deprived populations[i]. This is despite the evidence of greater need in deprived populations. A robust policy would avoid unnecessary referrals whilst providing a more standardised service to the whole cluster population.

1.3 The success of both hip and knee replacement surgery depends crucially on the appropriate selection of patients and this is relevant to GP referral practices.

1.4 Musculoskeletal surgical intervention has the ability to restore the injured and disabled to normal or near-normal function in a large number of cases. Hip and knee replacements have been shown to be some of the most cost effective medical interventions in society[ii] despite the significant use of resources, making a significant contribution to improving quality of life for individuals.

1.5 Literature review has identified a number of different indications and criteria for joint replacement. National guidance has been published by NOICE regarding the management of osteoarthritis and selection of joint prosthesis.

1.6 Surgery should only be considered after conservative, non-surgical interventions have been tried unsuccessfully. It is also recommended that pain level measured by need for medication, and sleep or night disturbance, as well as absolute pain intensity.

1.7 The initial non-surgical management of knee pain due to osteoarthritis should provide a package of care that may include weight reduction, activity modification, patient specific exercise programme, adequate doses of NSAIDS and analgesics, joint injection, walking aids and other forms of physical therapies.

1.8 In addition to the general recommendations regarding the risks associated with surgery in patients classified as morbidly obese; there is some evidence that morbid obesity is associated with prolonged wound
drainage after joint replacement. Patients with BMI over 35 have a proven significantly lower survival rate for knee joint replacements.

1.9 The appropriateness of all of the above criteria has recently been revalidated with respect to both hip and knee joint replacement.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CCG will fund the procedure if all the following criteria are met

• Patient's symptoms have failed to respond to all safe conservative treatments that can be offered prior to OA referral (e.g. analgesia, non-steroidal anti-inflammatory drugs, physiotherapy, walking aids, home adaptations and general counselling).

• Moderate or severe osteoarthritic changes have been confirmed radiographically (weightbearing films for knees)

• Symptoms (eg pain, functional impairment) are significantly impacting on day-to-day activities

• For hips, the patient has a BMI below 40 OR if the BMI is 40 or above there is documented participation in a comprehensive weight management programme for at least 6 months prior to surgery.

• For knees, the patient has a BMI of below 35

2.3 Other issues

• Co-morbidities (including but not limited to hypertension, atrial fibrillation, diabetes, obesity) should have been appropriately evaluated and control optimised

• As a supporting criterion - a New Oxford score of *less* than 30 if case is non-complex (i.e. patient with no major complications or co-morbidities). Oxford scores are not validated for diagnostic use, although data from the PROMS study support its alignment with other patient selection criteria.

2.4 As per NICE guidance prostheses should only be used if the evidence shows they require revision at a rate of less than 1 in 10 (10%) in 10 years or equivalent. It is expected that providers will have adequate governance arrangements to implement this requirement and to manage the adoption of new technologies including prostheses.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

4. Procedures Covered by the Policy

Hip Replacement

W37.1 Primary total prosthetic replacement of hip joint using cement;
W37.2 Conversion to total prosthetic replacement of hip joint using cement
W37.8 Other specified total prosthetic replacement of hip joint using cement;
W37.9 Unspecified total prosthetic replacement of hip joint using cement;
W38.1 Primary total prosthetic replacement of hip joint not using cement;
W38.2 Conversion to total prosthetic replacement of hip joint not using cement
W38.8 Other specified total prosthetic replacement of hip joint not using cement;
W38.9 Unspecified total prosthetic replacement of hip joint not using cement;
W39.1 Primary total prosthetic replacement of hip joint NEC;
W39.2 Conversion to total prosthetic replacement of hip joint NEC
W39.8 Other specified total prosthetic replacement of hip joint NEC;
W39.9 Unspecified total prosthetic replacement of hip joint NEC;
W93.1 Primary hybrid prosthetic replacement of hip joint using cemented acetabular component;
W93.2 Conversion to hybrid prosthetic replacement of hip joint using cemented acetabular component
W93.8 Other specified hybrid prosthetic replacement of hip joint using cemented acetabular component;
W93.9 Unspecified hybrid prosthetic replacement of hip joint using cemented acetabular component;
W94.1 Primary hybrid prosthetic replacement of hip joint using cemented femoral component;
W94.2 Conversion to hybrid prosthetic replacement of hip joint using cemented femoral component
W94.8 Other specified hybrid prosthetic replacement of hip joint using cemented femoral component;
W94.9 Unspecified hybrid prosthetic replacement of hip joint using cemented femoral component;
W95.1 Primary hybrid prosthetic replacement of hip joint using cement NEC;
W95.2 Conversion to hybrid prosthetic replacement of hip joint using cement NEC
W95.8 Other specified hybrid prosthetic replacement of hip joint using cement NEC;
W95.9 Unspecified hybrid prosthetic replacement of hip joint using cement NEC.

Knee Replacement

W40.1 Primary total prosthetic replacement of knee joint using cement;
W40.2 Conversion to total prosthetic replacement of knee joint using cement
W40.8 Other specified total prosthetic replacement of knee joint using cement;
W40.9 Unspecified total prosthetic replacement of knee joint using cement;
W41.1 Primary total prosthetic replacement of knee joint not using cement
W41.2 Conversion to total prosthetic replacement of knee joint not using cement
W41.8 Other specified total prosthetic replacement of knee joint not using cement;
W41.9 Unspecified total prosthetic replacement of knee joint not using cement;
W42.1 Primary total prosthetic replacement of knee joint NEC;
W42.2 Conversion to total prosthetic replacement of knee joint NEC
W42.8 Other specified total prosthetic replacement of knee joint;
W42.9 Unspecified total prosthetic replacement of knee joint.
O18.1 Primary hybrid prosthetic replacement of knee joint using cement
O18.2 Conversion to hybrid prosthetic replacement of knee joint using cement
O18.8 Other specified hybrid prosthetic replacement of knee joint using cement
O18.9 Unspecified hybrid prosthetic replacement of knee joint using cement

5. References

National Institute for Health and Clinical Excellence (2008) Clinical Guideline 59. Osteoarthritis – The care and management of osteoarthritis in adults. NICE 2008, London.
NICE Technology Appraisal Guidance – No 2 (2000) Guidance on the Selection of Prostheses for Primary Total Hip Replacement. NICE 2000, London.
Quintana JM et al (2000) Evaluation of explicit criteria for total hip joint replacement. Journal of Clinical Epidemiology 53(2000) 1200-1208
Lequesne M. (1991) Indices of severity and disease activity for osteoarthritis. Sem Arthritis Rheu 1991;20:48-54
National Institute of Clinical Excellence (2003). Primary Care Referral Guidelines for Common Conditions. NICE 2003; London.
National Institute of Health. Consensus development program. (Dec 2003). See also the National Guideline Clearing House (www.guideline.gov).

British Orthopaedic Association. (2001)Total Knee Replacement; A Guide to Best Practice.

Schneider AJ (1983) Assessment of risk factors and surgical outcome. Surg Clin North Am 1983;63:113-1126

Vipul P. Patel, Michael WalsH, Bantoo Sehgal, (2007) Factors Associated with Prolonged Wound Drainage After Primary Total Hip and Knee Arthroplasty *The Journal of Bone and Joint Surgery (American)*. 2007;89:33-38.

Dieppe P, Basler HD, Chard P et al. Knee replacement surgery for osteoarthritis: effectiveness, practice variations, indications and possible determinants of utilisation. Rheumatology 1999; 28:73-83

Quintana et al (2006) Health-related quality of life and appropriateness of knee or hip joint replacement. Arch Intern Med. 2006;166:220-226

Escobar A, Quintana JM, Arostehui I, Azkarate J, Güenaga, Arenaza JC, Garai I. (2003) Development of explicit criteria for total knee replacement. International Journal of Technology Assessment in Healthcare, 2003; 19: 57-70.

Procedures of Limited Clinical Value Commissioning Policy

Hip Resurfacing Techniques (Primary Resurfacing Arthroscopy of Joint)

March 2013

Version: 1
Date: March 2013

Summary

Sandwell and West Birmingham CCG do not normally fund Metal on Metal Hip Resurfacing Arthroscopy unless patients meet the criteria set out in the policy below.

1. Background

1.1 Metal on metal (MoM) hip resurfacing arthroplasty involves removal of the diseased or damaged surfaces of the head of the femur and the acetabulum.

1.2 The femoral head is fitted with a metal surface and the acetabulum is lined with a metal cup to form a pair of metal bearings.

1.3 There is sufficient evidence to conclude that hip resurfacing is clinically and cost effective but the studies have been undertaken in people aged 65 years. NICE guidance recommends their use in those likely to outlive the conventional THR (i.e. young and active) but advises surgeons' to discuss the lack of long term evidence on safety and reliability with patients.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG will only fund Metal on Metal Hip Resurfacing Arthroscopy when the procedure meets current Medicines and Healthcare Products Regulatory Agency (MHRA) guidance and patients meet the following criteria;

• The patient qualifies for primary total hip replacement **AND**
• The patient is likely to outlive conventional primary hip replacements

2.3 As per NICE guidance, prosthesis should only be used if the evidence shows they require revision at a rate of less the 1 in 10 (10%) in 10 years.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

Spinal Fusion for Chronic Low Back Pain

March 2013

Version: 1
Date: March 2013

Summary

Sandwell and West Birmingham CCG do not normally fund Spinal Fusion for Chronic Low Back Pain unless patients meet the criteria set out in the policy below.

1. Background

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

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG will only fund spinal fusion for chronic low back pain when the following criteria are met;

- The patient is referred to a specialist spinal surgical service
- Due consideration has been given to the possible risks of the procedure for that patient.

• The patient has completed an optimal package of care, including a combined physical and psychological treatment programme
and

• Still has severe non-specific low back pain for which they would consider surgery.

2.3 Patients should not be referred for any of the following procedures;

- intradiscal electrothermal therapy (IDET)
- percutaneous intradiscal radiofrequency thermocoagulation (PIRFT)
- radiofrequency facet joint denervation.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

Joint injections (Non Spinal)

February 2013

Version: 1
Date: February 2013

Summary

Sandwell and West Birmingham CCG will fund non spinal joint injections as an outpatient procedure for patients aged 19 and over. There is a separate policy for the funding of spinal injections.

1. Policy

1.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

1.2 Non spinal joint injections in adults do not need to be done in a sterile theatre unless general anaesthetic or an image intensifier is required.

1.3 They will normally be funded as an outpatient procedure. (This policy statement relates only to adults (i.e. aged 19 and over), as it is recognised that children often require joint injections under general anaesthesia.)

Procedures of Limited Clinical Value Commissioning Policy

Cholecystectomy for asymptomatic gallstones

February 2013

Version: 1
Date: February 2013

Summary

Sandwell and West Birmingham CCG do not usually fund cholecystectomy for asymptomatic gallstones unless patients meet the criteria set out in the policy below.

1. Background

1.1 Asymptomatic gallstones are defined as the presence of gallstones detected incidentally in patients who do not have any abdominal symptoms.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CCG will not fund cholecystectomy for asymptomatic gallstones unless one of the following criteria is met:

• Acute symptomatic onset

• Patient has Diabetes Mellitus, is a transplant recipient or has Cirrhosis, and has been managed conservatively within Primary Care but subsequently develops symptoms which cause significant functional impairment.

• Where there is clear evidence from an ultrasound scan that the patient is at risk of Gallbladder Carcinoma.

• Confirmed episode of gall stone induced pancreatitis.

• Confirmed recurrent episodes of abdominal pain typical of biliary colic.

• Confirmed episode of obstructive jaundice in the presence of gallstones where the gallstones are thought to be the cause.

2.3 The preferred procedure is laproscopically unless clinical indications suggest otherwise

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

Haemorrhoidectomy

February 2013

Version: 1
Date: February 2013

Summary

Sandwell and West Birmingham CCG do not normally fund haemorrhoidectomy for haemorrhoids (piles) unless patients meet the criteria set out in the policy below.

1. Background

1.1 Surgical intervention is considered appropriate as an option for the treatment of prolapsed internal haemorrhoids.

1.2 Haemorrhoidal tissue is a normal component of the anal canal and is composed predominantly of vascular tissue, supported by smooth muscle and connective tissue. It functions as a compressible lining that allows the anus to close completely. Internal haemorrhoids (also known as piles) are located beneath the lining of the anus and occur when the haemorrhoidal tissue of the distal rectum and anal canal prolapses. Internal haemorrhoids are usually classified according to the degree of prolapse, although this may not reflect the severity of the person's symptoms. First-degree haemorrhoids bleed but do not prolapse. Second-degree haemorrhoids prolapse on straining during bowel movements, and reduce spontaneously. Third-degree haemorrhoids prolapse on straining and require manual reduction. Fourth-degree haemorrhoids are prolapsed and cannot be manually reduced.

1.3 A number of factors are known to be associated with the development of haemorrhoids, including increasing age, pregnancy and childbirth, chronic constipation, chronic diarrhoea, and family history of haemorrhoids. Estimates of the proportion of the UK population affected range from 4.4% to 24.5%. In 2004–5, approximately 23,000 haemorrhoidal procedures were carried out in England, of which approximately 8000 were excisional interventions.

1.4 Internal haemorrhoids may cause anal itching and irritation, bleeding during bowel movements and perianal pain. They sometimes protrude from the anus during bowel movements or may prolapse or extend outside the anus. External haemorrhoids can also occur. These are located near the anus and, although they cannot prolapse, may bleed if ruptured.

1.5 First- and second-degree internal haemorrhoids are generally treated by changing bowel habit, diet and lifestyle, and by using stool softeners or laxatives. Surgical haemorrhoidectomy is usually the treatment of choice for third- and fourth-degree haemorrhoids, prolapsed second-degree haemorrhoids that have not responded to non-surgical interventions and second-degree haemorrhoids with full circumferential involvement. Surgical haemorrhoidectomy is usually performed by the Milligan-Morgan (open) or Ferguson (closed) procedure. The Milligan-Morgan procedure involves dissection of the haemorrhoid and ligation of the vascular pedicle. The wounds are left open to heal naturally. The Milligan-Morgan procedure is thought to be relatively safe and effective for managing advanced haemorrhoidal disease, but because the anodermal wounds are left open healing is delayed, which may result in discomfort and prolonged postoperative morbidity. The Ferguson procedure is a modified version of the Milligan-Morgan technique, in which the wound is closed with a continuous suture to promote healing. A number of postoperative complications are associated with surgical haemorrhoidectomy. The short-term complications include pain, urinary retention, bleeding and perianal sepsis. Long-term complications may include anal fissure, anal stenosis, incontinence, fistula, and the recurrence of haemorrhoidal symptoms.

1.6 First and second degree haemorrhoids are classically treated with some form of non-surgical ablative/fixative intervention, third degree are treated with rubber band ligation or haemorrhoidectomy, and fourth degree with haemorrhoidectomy.
(Source: NICE TAG 128)

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Haemmorrhoidectomy will not normally be funded for 1st and 2nd degree haemorrhoids.

2.3 Haemorrhoidectomy will only be funded for 3rd and 4th degree haemmorrhoids in cases where one of the following criteria has been met:

• Recurrent haemorrhoids (3rd and 4th degree haemorrhoids that have recurred after previous treatment)
• Persistent bleeding
• Failed conservative treatment
• Irreducibility

2.4 Surgical intervention, if indicated under the above criteria will take account of NICE TAG 128.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

4. Procedures Covered by the Policy

Primary Operative Procedure	Primary Operative Procedure Description
H511	Haemorrhoidectomy
H513	Staple haemorrhoidectomy
H518	Other Specified
H519	Unspecified

Procedures of Limited Clinical Value Commissioning Policy

Varicose Veins

February 2013

Version: 1
Date: February 2013

Summary

Sandwell and West Birmingham CCG will not normally fund interventional procedures for varicose veins unless patients meet the criteria set out in the policy below.

1. Background

1.1 Varicose veins are common affecting 15% to 30% of the adult population.

1.2 They are tortuous distended bulging veins lying beneath the skin in the legs.

1.3 They commonly arise from incompetence in the long and short saphenous veins and their branches, though they may be secondary varicosities with associated deep venous disease.

1.4 They are not to be confused with intra-dermal spider veins or thread veins which lie within the skin.

1.5 Complications from varicose veins include eczema, induration [lipodermatosclerosis], pigmentation, bleeding, thrombophlebitis and ulceration.

1.6 Patients complain both of the appearance and report symptoms such as aching in the leg, pains in the leg, restlessness, cramps, itchiness, heaviness and swelling.

1.7 A link between symptoms and varicose vein severity can be difficult to establish. Referral advice has been issued by NICE in a guide to appropriate referral from general to specialist services [NICE 2001]. The advice from NICE is reiterated in the 18 Week Patient Pathway on Varicose Veins.

1.8 Most varicose veins need no treatment and many with complications can be managed in Primary Care by offering:

• Graduated compression stockings. These control most symptoms attributable to varicose veins, including aching and ankle swelling in addition to reducing the risk of ulceration. Stockings are available on FP10 or can be purchased from pharmacists. *Class one* stockings are suitable for mild symptoms whilst significant ankle oedema or prevention of ulcer recurrence requires a *class two* stocking. Below-knee stockings are usually effective but some patients find them uncomfortable or ineffective if varicosities are in the thigh. Thigh-length stockings may be prescribed but many patients report difficulty keeping them up. Suspender belts are effective and some manufacturers now offer graduated compression stockings with “stay-ups”.

• Lifestyle support and advice. Losing weight helps and there are specific exercise including leg elevation at rest that also helps.

• Reassurance. In most cases varicose veins will not result in harm, though advice about DVT prevention when flying should be given.

1.9 Varicose eczema if severe or inflamed can be treated effectively with topical steroids.

1.10 Thrombophlebitis usually responds to leg elevation, topical or systemic NSAID’s and stockings. Antibiotics are occasionally required for secondary infection.

2. Eligibility criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CCG will fund intervention for varicose veins in the following circumstances;

• Varicose veins which have bled and are at risk of bleeding again OR
• A history of varicose ulceration OR

• Signs of prolonged venous hypertension (haemasiderin pigmentation, eczema, induration [lipodermatosclerosis], or significant oedema associated with skin changes) OR
• Superficial thrombophlebitis in association with varicose veins OR
• Significant symptoms attributable to chronic venous insufficiency which are having a significant impact on quality of life

2.3 Evidence for eligibility has been gathered from the RSM guidelines http://www.rsm.ac.uk/academ/downloads/venous_referral_guidelines_jan11.pdf

2.4 The RSM guidelines have a grading system for chronic venous insufficiency (which includes varicose veins):

• C0 No visible or palpable signs of venous disease
• C1 Telangiectasias or reticular veins
• C2 Varicose veins; diameter >3mm
• C3 Oedema
• C4 Changes in skin and subcutaneous tissue: pigmentation, eczema, lipodermatosclerosis or atrophie blanche
• C5 Healed venous ulcer
• C6 Active venous ulcer

2.5 The guidelines recommend for uncomplicated C1 – C3 disease this should be managed in primary care with reassurance, advice on exercise, weight loss, elevation and the use of compression hosiery.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

Anal Skin Tags

February 2013

Version: 1
Date: February 2013

Summary

Sandwell and West Birmingham CCG do not usually fund surgery for the removal of anal skin tags unless patients meet the criteria set out in the policy below.

1. Background

1.1 Anal skin tags are extra skin that hangs from the peri anal area.

1.2 Anal skin tags can be a nuisance, itchy and uncomfortable.

1.3 They may coexist with other anal conditions such as haemorrhoids or anal fissure though skin tags do not normally need to be removed.

1.4 When co existing with other conditions those conditions should be treated on merit.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CCG will not routinely fund this procedure unless the following criterion is met:

- Suspicion/risk of malignancy
- Where there are underlying pathologies such as inflammatory bowel disease

2.3 Referral for non-urgent assessment and treatment

2.3.1 This policy supports referral where there are underlying pathologies such as inflammatory bowel disease

2.3.2 This policy supports the commissioning of surgery for patients with anal skin tags where this forms part of the treatment of an underlying pathology such as inflammatory bowel disease.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

4. Procedures Covered by the Policy

Primary Operative Procedure	Primary Operative Procedure Description
H482	Excision of skin tag of anus
H488	Other specified
H489	Unspecified

Procedures of Limited Clinical Value Commissioning Policy

Hysterectomy for Heavy Menstrual Bleeding

February 2013

Version: 1
Date: February 2013

Summary

Sandwell and West Birmingham CCG do not normally fund Hysterectomy for Heavy Menstrual Bleeding unless patients meet the criteria set out in the policy below.

1. Background

1.1 Surgical removal of the womb (hysterectomy) is an essential procedure in some clinical circumstances such as malignancy.

1.2 However, there are conditions such as heavy menstrual bleeding or presence of fibroids where the effectiveness of this procedure is less clear cut and alternative treatments are generally preferable.

1.3 NICE guidance (2007) states Hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding.

1.4 A Cochrane systematic review concluded that levonorgestrel intrauterine system/Mirena coil improved the quality of life of women with menorrhagia as effectively as hysterectomy.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG will only fund hysterectomy for heavy menstrual bleeding when patients meet the following criteria;

• There has been a prior trial with a levonorgestrel intrauterine system (e.g. Mirena®) (unless contraindicated) which has not successfully relieved symptoms
AND
• Other treatments (such as non-steroidal anti-inflammatory agents, tranexamic acid, endometrial ablation, uterine-artery embolisation) have failed, are not appropriate or are contra-indicated in line with NICE guidelines i.e.
• There is a desire for amenorrhoea
• The woman (who has been fully informed) requests it.
• The woman no longer wishes to retain her uterus and fertility.

2.3 Contraindications to the levonorgestrel intrauterine system are

• Severe anaemia, unresponsive to transfusion or other treatment, whilst a levonorgestrel intrauterine system 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

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

Hysteroscopy for Menorrhagia

March 2013

Version: 1
Date: March 2013

Summary

Sandwell and West Birmingham CCG do not normally fund Hysteroscopy for Menorrhagia unless patients meet the criteria set out in the policy below.

1. Background

1.1 There are a number of studies and systematic reviews examining the investigation and management of menorrhagia.

1.2 The following policy statements for the funding of hysteroscopy in this condition are based upon 2007 NICE guidance.

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2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG will only fund Hysteroscopy for Menorrhagia when the following criteria are met;

- There is structural abnormality or cancer is suspected unless patient is:
- Above the age of 40 after simple treatment fails
- After the age of 45, before treatment

2.3 Hysteroscopy is not normally funded for the management of menorrhagia.

2.4 It is recognised that hysteroscopy may be required to confirm placement of devices for ablative procedures, but this will not attract additional funding.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

Reversal of male Sterilisation

March 2013

Version: 1
Date: March 2013

Summary

Sandwell and West Birmingham CCG do not normally fund the reversal of male sterilisation.

1. Background

1.1 Reversal of male sterilisation is a surgical procedure that involves the reconstruction of the vas deferens.

1.2 Sterilisation procedures are available on the NHS and couples seeking sterilisation should be fully advised and counselled that the procedure is intended to be permanent.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG will not normally fund the reversal of male sterilisation.

2.3 Male sterilisation is provided by the NHS as an irreversible procedure. This should be made clear to patients at referral and prior to treatment.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

Reversal of female Sterilisation

March 2013

Version: 1
Date: March 2013

Summary

Sandwell and West Birmingham CCG do not normally fund the reversal of female sterilisation.

1. Background

1.1 Reversal of sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes.

1.2 One study of 85 women concluded that reversal of sterilisation is a safe and effective method of restoring fertility.

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

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2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG will not normally fund the reversal of female sterilisation.

2.3 Female sterilisation is provided by the NHS as an irreversible procedure. This should be made clear to patients at referral and prior to treatment.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

Cataract Surgery

March 2013

Version: 1
Date: March 2013

Summary

Sandwell and West Birmingham CCG do not normally fund cataract surgery and unless one or more of the following criteria are met, a best corrected visual acuity of better than 6/12 in the affected eye will not normally be funded.

1. Background

1.1 Since the level of visual acuity that an individual requires to function without altering their lifestyle varies, measurements of visual acuity do not necessarily reflect the degree of visual disability patients may experience as a result of cataracts. The criteria set out below attempt to explicitly take that into account.

1.2 The legal visual requirement for driving falls somewhere between 6/9 and 6/12 (strictly speaking it is based on the number plate test) and it is anticipated that the thresholds set out below will **not** render the majority of people unable to drive.

1.3 This policy also recognises the increasing body of evidence that second eye surgery does benefit patients

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 This applies to both first and second eyes, with a best corrected visual acuity of 6/12 or worse in the affected eye used as the threshold for cataract surgery.

2.3 Treatment is usually considered a treatment of lower clinical value and unless one or more of the following criteria are met, a best corrected visual acuity of better than 6/12 in the affected eye will not normally be funded:

• Patients who are still working in an occupation in which good acuity is essential to their ability to continue to work (e.g. watchmaker)

OR
• Patients with posterior subcapsular cataracts and those with cortical cataracts who experience problems with glare and a reduction in acuity in daylight or bright conditions

OR
• Patients who need to drive at night who experience significant glare due to cataracts which affects driving

OR
• Difficulty with reading due to lens opacities

OR
• Patients with visual field defects borderline for driving, in whom cataract extraction would be expected to significantly improve the visual field

OR
• Significant optical imbalance (anisometropia or anisekonia) following cataract surgery on the first eye

OR
• Patients with glaucoma who require cataract surgery to control intra ocular pressure

OR
• Patient with diabetes who require clear views of their retina to look for retinopathy

OR
• Patients with wet macular degeneration or other retinal conditions who require clear views of their retina to monitor their disease or treatment (e.g. treatment with anti-VEGFs)

2.4 The reasons why the patient's vision and lifestyle are adversely affected by cataracts and the likely benefit from surgery, or other exceptional circumstances, must be clearly documented in the clinical records. Where referrals are not of a quality, the Provider will reserve the right to return to the referring organisation for greater clarity.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

Laser Surgery for Short – Sightedness (Myopia)

March 2013

Version: 1
Date: March 2013

Summary

Sandwell and West Birmingham CCG do not normally fund laser surgery for correction of short sight (myopia).

1. Background

1.1 Current evidence suggests that photorefractive (laser) surgery for the correction of refractive errors is safe and efficacious in appropriately selected patients.

1.2 Refractive errors are usually corrected by wearing spectacles or contact lenses, and these treatments are currently not available on the NHS.

1.3 Both have limitations and contact lens wear is associated with an increased risk of sight-threatening corneal infection.

1.4 Surgical treatments have been developed to permanently improve refraction by re-shaping the cornea.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG will not normally fund laser surgery for correction of short sight (myopia)

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

Botulinum Toxin Type A for Hyperhidrosis

March 2013

Version: 1
Date: March 2013

Summary

Sandwell and West Birmingham CCG will only fund Botulinum toxin type A when medically necessary for intractable, disabling focal primary hyperhidrosis, when patients meet the criteria set out in the policy below.

Sandwell and West Birmingham CCG will not fund Botulinum Toxin Type A for the following treatments;
-Cosmetic reasons
-Treatment during pregnancy

BOTOX A is only licensed for axillary hyperhidrosis (in the UK)

1. Background

1.1 In humans, sweating is induced by heat or exercise and is part of thermoregulation.

1.2 Sweat is a weak salt solution produced by the eccrine sweat glands. These are distributed over the entire body but they are most numerous on the palms and soles, with about 700 glands per square centimetre.

1.3 Primary hyperhidrosis is defined as excessive, uncontrollable sweating without any discernible cause.

1.4 Severely affected patients also develop skin maceration and secondary microbial infections, as a result of continual dampness.

1.5 Based on the literature review and costs it is recommended that at the primary care level, GPs should assess disease severity (using the HDSS).

1.6 If the score is 1-2 advice and topical treatments (aluminium chloride deodorants) should be given.

1.7 If the score is 3-4 and topical treatment is unsuccessful referral to secondary care should be made.

1.8 Treatment differs according to site of hyperhidrosis:

- For both palmar and plantar hyperhidrosis the first line of treatment in secondary care is iontophoresis.

- o BTA injection and sympathectomy are not recommended in plantar hyperhidrosis and the use of oral anticholinergics should be considered secondary to iontophoresis.

- o BTA injection is recommended as a first line treatment for Frey's syndrome (100U or 50U/cm2) and can be used in conjunction with or instead of oral anticholinergic medication.

1.9 Evidence

1.9.1 Based on two large well-designed, double-blind, placebo-controlled study there is some evidence for the efficacy of BTA in axillary hyperhidrosis and less for gustatory and palmar sweating. Other indications (forehead sweating, plantar hyperhidrosis, truncal sweating) are only anecdotally reported.

1.9.2 There are currently no studies considering cost effectiveness.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG will only fund Botulinum toxin type A when medically necessary for intractable, disabling focal primary hyperhidrosis, when all of the following criteria are met:

• Topical aluminium chloride or other extra-strength antiperspirants are ineffective or result in a severe rash;
AND Patient is unresponsive or unable to tolerate pharmacotherapy prescribed for excessive sweating (e.g., anticholinergics, beta-blockers) if sweating is episodic;
AND
• The patient has documented medical complications due to Hyperhidrosis, ie skin maceration with secondary skin infections
AND
• Significant disruption of professional and / or social life has occurred because of excessive sweating.

2.3 Pregnant women and nursing mothers should avoid treatment.

2.4 Funding will be approved on an ongoing basis however The Provider will avoid repeated injection with intervals less than four months.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

Botulinum Toxin Type A for Spasticity

March 2013

Version: 1
Date: March 2013

Summary

Sandwell and West Birmingham CCG will only fund Botulinum toxin type A when medically necessary for spasticity, when patients meet the criteria set out in the policy below.

Sandwell and West Birmingham CCG will not fund Botulinum Toxin Type A for cosmetic reasons.

1. Background

1.1 Spasticity is a significant feature of an upper motor neurone syndrome, which occurs quite commonly in many neurological conditions like stroke, multiple sclerosis, brain injury, cerebral palsy etc.

1.2 It can lead to disabling complications like contractures and pressures sores, which in turn places a huge burden on the patient, family, social services and the NHS, [£10,551 for one pressure sore].

1.3 Prompt and effective management of spasticity by a multi-modal, multi-agency approach co-ordinated by an interdisciplinary team can prevent these complications

1.4 It is estimated that approximately one-third of stroke patients (van Kuijk et al 2007; Watkins et al 2002), 60% of patients with severe multiple sclerosis (MS) and 75% of patients with physical disability following severe traumatic brain injury will develop spasticity requiring specific treatment.

1.5 Of these, approximately one-third may require treatment with Botulinum Toxin injections. (Verplancke et al 2005).

1.6 BTA has been used for Management of spasticity since 1989 and its use is further recommended in the UK National Guidelines 2009.

1.7 Effective management of spasticity using Botulinum Toxin injections can lead to benefits-

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

1.7.1 This should be supplemented by;

• Use of other pharmacological agents: oral anti-spasticity agents like baclofen, tizanidine etc, phenol nerve blockade

• Non-pharmacological interventions including effective management of noxious stimuli like constipation, bladder and skin issues

• Post injection goal-oriented therapy input and

• Liaising with and incorporating the support of allied agencies like Orthotics, Wheelchair services, Social Services etc.

1.8 The clinical benefit can persist for many months (particularly when accompanied by an appropriate physical management regimen) but wears off gradually. Repeat injections generally follow a similar course.

1.9 Experience in other neurological conditions has demonstrated that spasticity in adults may become biologically resistant to BTA as a result of antibody formation, especially with frequent, large dose injections (Greene and Fahn 1992, 1993; Hambleton and Moore1995).

1.10 This has led to the general advice to avoid repeated injection at less than three month intervals.

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

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG will only fund Botulinum toxin type A when medically necessary for spasticity when all of the following criteria are met:

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

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

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

4. To improve function in upper and lower limbs

5. To facilitate therapy/ splinting/orthotics/positioning

6. To facilitate carer input/ reduce carer burden

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

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

2.3 Botulinum Toxin Type A (BTA) **will not** be funded for cosmetic reasons.

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

2.5 Infection at the Injection Site(s) BTA is contraindicated in the presence of infection at the proposed injection site(s)

Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed

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Procedures of Limited Clinical Value Commissioning Policy

Complementary Therapies

March 2013

Version: 1
Date: March 2013

Summary

Sandwell and West Birmingham CCG will not normally fund the complementary therapies listed in this policy.

1. Background

1.1 Complementary and alternative therapy covers a wide range of therapies some of which lack evidence of effectiveness and are not supported by CCG funding.

1.2 There is no national policy for the use of complementary and alternative therapies.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG will not normally fund the following;

Active release technique
Acupressure
Aimspro

AMMA therapy
Antineoplastons
Antineoplaston therapy and sodium Phenylbutyrate
Apitherapy

Applied kinesiology

Art therapy

Auto urine therapy

Bioenergetic therapy
Biofield Cancell (Entelev) cancer therapy
Bioidentical hormones
Carbon dioxide therapy
Cellular therapy
Chelation therapy for Atherosclerosis
Chung Moo Doe therapy
Coley's toxin
Colonic irrigation

Conceptual mind-body techniques
Craniosacral therapy

Cupping
Dance/Movement therapy
Digital myography

Ear Candling
Egoscue method

Electrodiagnosis according to Voll (EAV)
Equestrian therapy
Essential Metabolics Analysis (EMA)
Essiac

Feldenkrais method of exercise therapy

Flower essence
Fresh cell therapy
Functional intracellular analysis

Gemstone therapy
Gerson therapy
Glyconutrients

Graston technique

Greek cancer cure; Guided imagery
Hair analysis

Hako-Med machine (electromedical horizontal therapy)
Hellerwork
Homeopathy

Hoxsey method
Humor therapy
Hydrazine sulphate
Hypnosis

Hyperoxygen therapy
Immunoaugmentive therapy
Infratronic Qi-Gong machine

Insulin potentiation therapy

Inversion therapy

Iridology
Iscador
Kelley/Gonzales therapy

Laetrile
Live blood cell analysis

Macrobiotic diet

Magnet therapy
Meditation/transcendental meditation
Megavitamin therapy

Meridian therapy

Mesotherapy
Misletoe therapy
Moxibustion (except for fetal breech presentation) - see MTH-68 vaccine
Music therapy
Myotherapy Neural therapy
Ozone therapy

Pfrimmer deep muscle therapy
Polarity therapy

(Poon's) Chinese blood cleaning
Primal therapy

Psychodrama
Purging

Qigong longevity exercises
Ream's testing
Reflexology (zone therapy)
Reflex Therapy

Reiki
Remedial massage
Revici's guided chemotherapy

Rolfing (structural integration)

Rubenfeld synergy method (RSM); 714-X (for cancer)

Sarapin injections
Shark cartilage products
Therapeutic Eurythmy-movement therapy
Therapeutic touch
Thought field therapy (TFT) (Callahan Techniques Training)

Trager approach

Visceral manipulation therapy
Whitcomb technique

Wurn technique/clear passage therapy
Yoga

3. Implementation

3.1 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

Extracorporeal Shockwave Therapy for Refractory Plantar Fasciitis

March 2013

Version: 1
Date: March 2013

Summary

Sandwell and West Birmingham CCG will not normally fund extracorporeal shockwave therapy for refractory plantar fasciitis.

1. Background

1.1 Plantar fasciitis is characterised by chronic degeneration of the plantar fascia, which causes pain on the underside of the heel.

1.2 It is usually caused by injury or biomechanical abnormalities and may be associated with microtears, inflammation or fibrosis.

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

1.4 Extracorporeal shockwave therapy (ESWT) is a non-invasive treatment in which a device is used to pass acoustic shockwaves through the skin to the affected area.

1.5 Ultrasound guidance can be used to assist with positioning of the device.

1.6 Extracorporeal shockwave therapy may be applied in one or several sessions.

1.7 Local anaesthesia may be used because high-energy ESWT can be painful.

1.8 Different energies can be used and there is evidence that local anaesthesia may influence the outcome of ESWT.

1.9 The evidence on extracorporeal shockwave therapy (ESWT) for refractory plantar fasciitis raises no major safety concerns; however, current evidence on its efficacy is inconsistent.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG will not normally fund extracorporeal shockwave therapy for refractory plantar fasciitis

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

Extracorporeal Shockwave Therapy for Refractory Achilles Tendinopathy

March 2013

Version: 1
Date: March 2013

Summary

Sandwell and West Birmingham CCG will not normally fund extracorporeal shockwave therapy for refractory achilles tendinopathy

1. Background

1.1 Achilles tendinopathy is characterised by chronic degeneration of the Achilles tendon and is usually caused by injury or overuse.

1.2 Symptoms include pain, swelling, weakness and stiffness over the Achilles tendon and tenderness over the heel (insertional tendinopathy).

1.3 Conservative treatments include rest, application of ice, non-steroidal anti-inflammatory drugs, orthotic devices, physiotherapy (including eccentric loading exercises) and corticosteroid injection.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG will not normally fund extracorporeal shockwave therapy for refractory achilles tendinopathy

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

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

March 2013

Version: 1
Date: March 2013

Summary

Sandwell and West Birmingham CCG will not normally fund Cognitive Behavioural Therapy Residential Placements for Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME)

1. Background

1.1 Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME) comprises a range of symptoms including fatigue, headache, sleep disturbance, difficulty in concentration and muscle pain. An individual's symptoms may vary in severity and there is variation between patients.

1.2 Although many patients improve over time, others do not.

1.3 The cause of CFS/ME is unknown. Many different interventions for CFS/ME have been investigated in clinical trials of varying quality. There is increasing evidence from good quality trials to support CBT and/or GET in the management of CFS/ME.

1.4 CBT with or without GET is more effective than standard medical care and does not appear to be more expensive. There is evidence for effectiveness in both adults and children.

1.5 There is currently insufficient evidence to support any other intervention in terms of clinical or cost effectiveness. This includes immunological treatments, anti-viral therapy, pharmacological treatments, dietary supplements, complementary or alternative medicine, multi-treatment regimes, buddy-mentor schemes, group therapy and 'low sugar low yeast' diets.

1.6 There is currently no evidence relating to patients with severe CFS/ME (who are house or bed-bound)'.

1.7 There is currently no evidence to support the use of in-patient or residential settings to deliver effective interventions for CFS/ME. There is currently no evidence to suggest that any group or sub-group of patients with CFS/ME will benefit particularly from any specific intervention or that patients who have failed to improve on one intervention may do better on another.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG will not normally fund cognitive Behavioural Therapy (Residential Placements) for chronic fatigue syndrome.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

Asymptomatic inguinal hernias in adults

March 2013

Version: 1
Date: March 2013

Summary

Sandwell and West Birmingham CCG do not usually fund surgery for asymptomatic inguinal hernias in adults.

1. Background

1.1 An inguinal hernia is a protrusion of a sac of peritoneum (often containing intestine or other abdominal contents) through a weakness in the abdominal wall in the groin. It usually presents as a lump, with or without some discomfort that may limit daily activities and the ability to work.

1.2 Around 98% of inguinal hernias are found in men because of the vulnerability of the male anatomy to the formation of hernias in this region.

1.3 Inguinal hernias can occasionally be life-threatening if the bowel within the peritoneal sac strangulates and/or becomes obstructed.

1.4 Surgical repair (herniorraphy) is undertaken in most individuals presenting with inguinal hernia in order to close the defect, alleviate symptoms of discomfort, prevent serious complications (that is,obstruction or strangulation of the bowel) and reduce the risk of recurrence

1.5 Most hernia repairs are undertaken as elective procedures. However, 4.8% of primary repairs and 8.6% of recurrent hernias present as an emergency with a complication. Some individuals present with bilateral hernias, which may be repaired during the same operation or at a later date, and up to 30% of people with a primary unilateral hernia subsequently develop a hernia on the opposite side.

1.6 Traditional methods of open repair (e.g. the Bassini method), which repair the hernia defect by suturing, have not changed significantly since their introduction in the late 19th century. Recently, the availability of prosthetic meshes has led to an increase in the number of ‘tension-free’ methods of reinforcing the inguinal region.

1.7 Open mesh methods of repair are classified as
• open flat mesh (OFM; e.g. the Lichtenstein method),
• open preperitoneal mesh (OPPM; e.g. the Stoppa and Nyhus methods)
• open plug and mesh repair (OPM; e.g. the Rutkow method)

1.8 Open methods of hernia repair are associated with postoperative pain and numbness because of the large inguinal incision. OFM repairs are thought to be the principal surgical method of hernia repair in the UK.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG do not usually fund surgery for asymptomatic inguinal hernias in adults unless patients meet one of the following criteria;

- Incarcerated hernia or not amenable to simple reduction,
- symptomatic inguinal hernia,
- strangulated hernia (emergency surgery)

2.3 The above eligibility criteria is in line with the European Hernia Society Guidelines, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2719730/

2.4 It is worth noting that hernia repair is not without complications, and therefore the risk/benefit for prophylactic surgery needs to be carefully considered.

2.5 Randomised Controlled Trial evidence supports the option of watching and waiting in a patient with no or minimum symptoms or reducible hernia.

2.6 This policy does not apply to femoral hernias.

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

4. Procedures Covered by the Policy:

4.1 NB: policy covers only asymptomatic and minimally symptomatic inguinal hernias

Primary Operative Procedure	Primary Operative Procedure Description
T201	Primary Repair / Inguinal Hernia using insert/ natural material
T202	Primary Repair / Inguinal Hernia using insert/ prosthetic matter
T203	Primary Repair of Inguinal Hernia using sutures
T204	Primary Repair / Inguinal Hernia and reduction of sliding hernia
T208	Other Specified
T209	Unspecified
T211	Repair of recurrent inguinal hernia using insert of natural
T212	Repair of recurrent inguinal hernia using prosthetic matter
T213	Repair of recurrent inguinal hernia using sutures
T214	Removal of prosthetic material from previous repair of inguinal hernia
T218	Other specified
T219	Unspecified

Procedures of Limited Clinical Value Commissioning Policy

Eyelid Surgery

March 2013

Version: 1
Date: March 2013

Summary

Sandwell and West Birmingham CCG do not usually fund eyelid surgery unless patients meet the criteria set out in the policy below.

1. Background

1.1 Much routine eyelid surgery can be avoided as in general, blepharochalazia, styes, meibomian cysts, blepharitis etc will recover without intervention, or with conservative management.

1.2 It is helpful if GPs allow lesions a good amount of time to recover (e.g. 2 years for meibomian cyst).

1.3 Where there are LES or DES in place for minor procedures, referral should in the first instance be within Primary Care/ Community Care.

1.4 Referral to secondary care should only take place for such lesions after conservative management has failed following a reasonable time period and no primary care based service is available.

1.5 This policy covers:

- Blepharoplasty of upper lid
- Blepharoplasty of lower lid
- Xanthelasmata

1.6 The following procedures will not be funded:

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

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Sandwell and West Birmingham CGG do not usually fund eyelid surgery unless patients meet the criteria set out in the policy below.

2.3 Surgery on the upper eyelid (Upper lid blepharoplasty)

Surgery funded to correct functional impairment (not purely for cosmetic reasons) where the lesion produces a secondary eye condition.

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

2.3.2 Upper lid functional impairment is demonstrated by:

• impairment of visual fields in the relaxed, non-compensated state which interfere significantly with function.

• clinical observation of poor eyelid function,

• evidence of chronic compensation through elevation of the brow

2.4 Surgery on the lower eyelid (Lower lid blepharoplasty)

Surgery funded for correction of ectropion or entropion or for the removal of a lesion of the lid or lid margin where the lesion produces a secondary eye condition.

2.4.1 Excessive skin in the lower lid may cause “eyebags” but does not affect function of the eyelid or vision and therefore does not need correction. Blepharoplasty type procedures however may form part of the treatment of disorders of the lid or overlying skin.

4. Procedures Covered by the Policy

Primary Operative Procedure	Primary Operative Procedure Description
C131	Blepharoplasty of Both Eyelids
C132	Blepharoplasty of Upper Eyelid
C133	Blepharoplasty of Lower Eyelid
C134	Blepharoplasty NEC
C138	Other Specified
C139	Unspecified
C161	Central Tarsorrhaphy
C162	Lateral Tarsosshaphy
C163	Medial Tarsorrhaphy
C164	Tarsorrhaphy NEC
C165	Revision of Tarsorrhaphy
C168	Other Specified
C169	Unspecified
C121	Excision of lesion of eyelid NEC
C122	Cauterisation of lesion of eyelid
C123	Cryotherapy to lesion of eyelid
C124	Curettage of lesion of eyelid
C125	Destruction of lesion of eyelid NEC
C126	Wedge excision of lesion of eyelid
C128	Other Specified
C129	Unspecified
ICD-10 Codes	
H00	Hordeolum and chalazion
H000	Hordeoleum and other deep inflammation of eyelid
H001	Chalazion
H01	Other inflammation of eyelid
H026	Xanthelasma of eyelid
H027	Other degenerative disorders of the eyelid and periocular a
H028	Other specified disorders of eyelid
H029	Disorder of eyelid, unspecified

Procedures of Limited Clinical Value Commissioning Policy

Dupuytren's Contracture

February 2013

Version: 1
Date: February 2013

Summary

Sandwell and West Birmingham CCG do not usually fund surgery for Dupuytrens Contracture unless patients meet the criteria set out in the policy below.

1. Background

1.1 Dupuytren's contracture is a fairly common condition that causes one or more fingers to bend into the palm of the hand. The condition often occurs in later life, and is most common in men who are aged over 40. Around one in six men over the age of 65 are affected in the UK.

1.2 The symptoms of Dupuytren's contracture are often mild and painless and do not require treatment.

1.3 The condition most often starts with a firm nodule in the skin of the palm and may stay the same for months or years.

1.4 In some patients, however, it may progress to the next stage in which cords of fibrous tissue form in the palm and run into the fingers or thumb, eventually, pulling them into a permanently flexed position, making it difficult to perform activities of daily living.

1.5 In about 50% of cases the condition affects both hands, and in rare cases it can also affect the soles and toes of the feet.

1.6 Although there is great variation in the rate of progress, it is usually possible to distinguish the more aggressive form of the disease early on.

1.7 Surgery is the only effective method of treatment for Dupuytren's contracture.

1.8 However, patients should be advised that probably 40% of people will have a recurrence following surgery. Dupuytren's contracture can return to the same spot on the hand or may reappear somewhere else.

1.9 Recurrence is more likely in younger patients; if the original contracture was severe; or if there is a strong family history of the condition.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Treatment is usually considered a treatment of lower clinical value and is not

routinely funded unless the patient meets the following criteria:

Moderate to severe disease with:
• moderate metacarpo-phalangeal joint contracture (greater than 30 degrees).
• any proximal inter-phalangeal joint contracture.
• first web contracture

2.3 Treatment for Dupuytren's contracture can be made where patients meet either of the following criteria:

• moderate metacarpo-phalangeal joint contracture (greater than 30 degrees).
• any proximal inter-phalangeal joint contracture.
• first web contracture

2.4 The above eligibility criteria is in line with the BSSH - The British Society for Surgery of the Hand - Evidence for Surgical Treatment Dupuytren's Disease.
http://www.bssh.ac.uk/education/guidelines/dd_guidelines.pdf

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

4. Procedures Covered by the Policy

Primary Operative Procedure	Primary Operative Procedure Description
T521	Palmar fasciectomy

Procedures of Limited Clinical Value Commissioning Policy

Ganglion

February 2013

Version: 1
Date: February 2013

Summary

Sandwell and West Birmingham CCG do not usually fund surgical removal of ganglion unless patients meet the criteria set out in the policy below.

1. Background

1.1 Ganglia are benign fluid filled, firm and rubbery texture lumps. They occur most commonly around the wrist but also around fingers, ankles and the top of the foot. They are usually painless and completely harmless. Many resolve spontaneously especially in children (up to 80%).

1.2 Reassurance should be the first therapeutic intervention.

1.3 Aspiration alone can be successful but recurrence rates are up to 70%.

1.4 Surgical excision is the most invasive therapy but recurrence rates of up to 40% have been reports.

1.5 Complications of surgical excision include scar sensitivity, joint stiffness and distal numbness.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Unless one or more of the minimum criteria are met, surgical removal of ganglion will not normally be funded;

• Ganglia at the wrist–symptomatic (painful) or neurovascular compromised

or
• Ganglia arising in the base of the digitis –(symptomatic and/or painful)

or
• Mucoid cysts arising in the DIP joint disturbing nail growth or have a tendency to discharge

2.3 The above eligibility criteria is in line with Vroon P et al (2009) 'Interventions for Ganglion Cysts in Adults' Protocol Cochrane Neuromuscular Disease Group Cochrane Library

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

Procedures of Limited Clinical Value Commissioning Policy

Trigger Finger

February 2013

Version: 1
Date: February 2013

Summary

Sandwell and West Birmingham CCG do not usually fund surgery for trigger finger unless there is a documented failure to respond to conservative measures or a fixed deformity that cannot be corrected.

1. Background

1.1 Stenosing tenosynovitis (trigger finger) in adults is caused by thickening of the A1 pulley.

1.2 It is most common in middle aged women, is more frequent in diabetics but is usually idiopathic.

1.3 Patients complain of the finger becoming stuck bent. When the digit is straightened there is a palpable clunk which is painful.

1.4 Examination reveals a tender thickening over the A1 pulley which is at the level of the distal palmar crease in the fingers and at the base of the thumb.

1.5 Conservative treatment includes rest and avoiding precipitating activities. Non-steroidal anti-inflammatory drugs will often settle early cases. Injection of hydrocortisone is safe and can provide lasting relief in more than half of cases that have failed to resolve spontaneously.

1.6 Trigger thumb is also very common and often more painful. It also occurs in infants due to a lump in the tendon rather than pulley thickening. In adults trigger thumb seems to respond less well to injections than fingers but it is still worthwhile. In infants surgery is often required if the deformity persists after 1 year.

1.7 Evidence

1.7.1 Most studies have considered treatments other than surgery, or compared them with surgical intervention.

1.7.2 Up to 29% of cases will resolve spontaneously. It is important to avoid early intervention so that the condition has an opportunity to resolve without surgery.

1.7.3 There is no evidence to suggest that non-steroidal anti-inflammatory drugs alone have any benefit other than temporary relief of pain in the palm.

1.7.4 Combined analysis of four studies shows that corticosteroid injections are effective in 57% of patients.

2. Eligibility Criteria

2.1 This policy applies to any patient for whom Sandwell and West Birmingham CGG is the responsible commissioner.

2.2 Trigger finger release surgery is considered a procedure of low clinical value. Surgery for trigger finger will only be funded for patients who have met one of the criteria below:-

- Failure to respond to two injections of steroid into the flexor sheath
- Locked trigger finger
- Insulin dependent diabetic patient with trigger finger

3. Implementation

3.1 Emergency care patients and patients with suspected cancer are excluded. No request for treatment in these circumstances is required but the provider will be expected to demonstrate the clinical need as part of the payment verification process.

3.2 The agreed implementation process defined within the acute services contract for your trust should be followed.

4. Procedures Covered by the Policy

Primary Operative Procedure	Primary Operative Procedure Description
T723	Release of constriction of sheath of tendon
T728	Other specified
T729	Unspecified

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healthcare
without boundaries