# NORTH CEN TRAL LONDON

# EVIDENCE BASED INTERVENTIONS AND CLINICAL STANDARDS

## Procedures not routinely funded or requiring prior approval

## Barnet, Camden, Enfield, Haringey and Islington Clinical Commissioning Groups (CCGs)

This policy applies to patients 18 years of age and over unless specified in Appendix 1 or by exception in the body text of sections.

**Version 7.2**

**Issued: September 2019**

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NORTH LONDON PARTNERS in health and care

## Table of contents

# Background

The NCL Evidence Based Interventions and Clinical Standards policy is a list of treatments/interventions that are only offered on the NHS when a patient meets certain clinical criteria. This policy applies to adult patients aged over 18 only, unless specified otherwise in the body text of sections or appendix one.

Evidence Based Interventions and Clinical Standards is a clinically led and evidence based programme, which ultimately aims to improve the health of NCL residents. To achieve this aim, NCL needs to ensure the current NCL Evidence Based Interventions and Clinical Standards Policy is:

1. Consistently applied across the footprint to avoid any postcode related inequity or inequality.
2. Presented using unambiguous language, which is easy for clinicians to interpret.
3. Regularly reviewed (at least annually) revised, updated and reissued using the most up to date and validated evidence base.
4. Effectively and consistently communicated to health and care professionals within the footprint.
5. An open and transparent process, adhering to governances policies.

All five NCL CCGs have a clinically led review process for Evidence Based Interventions and Clinical Standards referrals to determine whether patients meet or do not meet the criteria for treatment. The clinicians involved in this review process are normally more familiar with the exact requirements for treatment than the referring clinicians who may only see a very small number of patients with these conditions per year.

Five core principles for decision-making are that they need to be:

- Rational
- Socially inclusive
- Clear and open to scrutiny
- Take economic factors into account
- Promote health for both individuals and community

NCL CCGs recognise that resources are finite and must be managed responsibly. Investment in one area of healthcare could divert resources away from other areas. Therefore decisions are made based on careful consideration of the balance between costs and benefits; both in the short and longer term, but also NCL CCGs recognise that this will not necessarily be reduced to simple cost-benefit calculations.

NCL CCGs have considered the extent to which the individual or patient group will gain a benefit from the treatment; and have balanced the needs of each individual against the benefit that could be gained by alternative investment possibilities to meet the needs of the community. In general, low-cost treatments with high effectiveness will be preferred; whereas high cost treatments with low effectiveness will be part of this policy.

Four CCGs have a form of clinically led Referral Management Service (RMS) with the exception being Islington CCG who utilise the IFR (Individual Funding Request) process (but not the same requirement for evidence) to process Evidence Based Interventions and Clinical Standards.

Where possible, references to the evidence/ guidelines underpinning individual clinical

policies have been added to the relevant sections. However, it should be noted that an

assumption is made that if National guidelines are updated that would impact upon this policy they will be taken into account when assessing eligibility for a particular treatment.

NCL CCGs invite feedback through a formal process ( refer to appendix four) before any review date or at the review date should one be aware of a published update to NICE guidelines, which may impact this policy.

A network of clinicians has been involved in the development of the current NCL policy and in reviewing and updating specific sections. Details of the clinicians who contributed to the development of this policy can be obtained upon written request.

The statement *NCL CCGs will not routinely fund* means it is primarily a commissioning decision not to routinely fund.

Public and patients should be reassured that NCL CCGs have undertaken a rigorous review process that is clinically led. The programmes ambition is to ensure more consistent implementation of best practice and equal access to treatment for all North London CCG residents that is clinically appropriate and based on robust evidence or with a sharp focus on patient outcomes`.

A whole policy review will occur every three years with an annual review where guidance has changed which can impact on a patient's outcome.

## Equality statement

NCL CCGs have a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved as enshrined in the Health and Social Care Act 2012. NCL CCGs have committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. In carrying out its functions, NCL CCGs will have due regard to the different needs of protected equality groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

NCL CCGs have completed an Equality Impact Assessment (EIA) for this policy update.

## Exclusions to this Policy

The policy does not apply to the following:

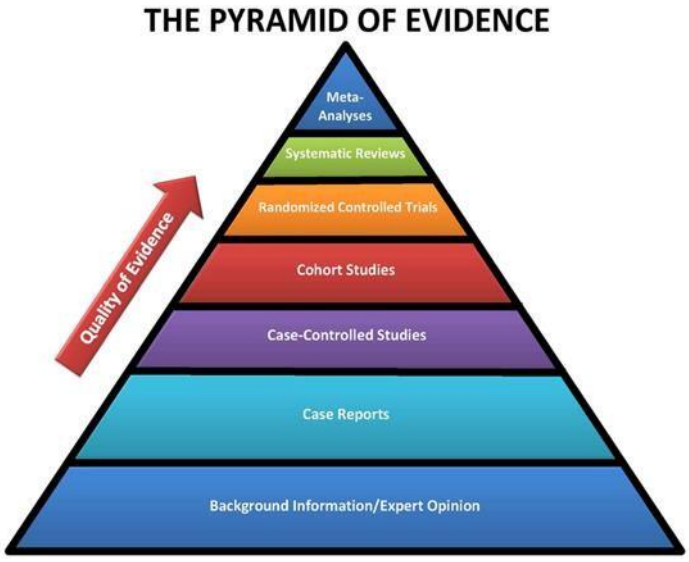
- Suspected cancer: diagnoses should be dealt with via a two-week wait referral and NOT via a Evidence Based Interventions and Clinical Standards application.
- Emergency or urgent care.

In relation to the above exclusions, the provider should be able to demonstrate the clinical need as part of the payment verification process.

## Hierarchy of evidence

The NCL Evidence Based Interventions and Clinical Standards policy is based upon category 1 evidence and by exception Royal College guidelines only in the absence of category 1 evidence.

In September 2000, the Oxford (UK) CEBM Levels of Evidence published its guidelines for 'Levels' of evidence regarding claims about prognosis, diagnosis, treatment benefits, treatment harms, and screening. It not only addressed therapy and prevention, but also diagnostic tests, prognostic markers, or harm. The original CEBM Levels was first released for Evidence-Based On Call to make the process of finding evidence feasible and its results explicit. As published in 2009 they are:




1a: Systematic reviews (with homogeneity) of randomized controlled trials

1b: Individual randomized controlled trials (with narrow confidence interval)

1c: All or none randomized controlled trials

2a: Systematic reviews (with homogeneity) of cohort studies

2b: Individual cohort study or low quality randomized controlled trials (e.g. <80% follow-up)

2c: "Outcomes" Research; ecological studies

3a: Systematic review (with homogeneity) of case-control studies

3b: Individual case-control study

4: Case series (and poor quality cohort and case-control studies)

5: Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"

NCL GPs, in particular GPs working within RMS platforms and a multitude of specialist clinicians from across NCL have been utilised to review the evidence base relating to policy areas. By consensus the wording for specific policy sections are agreed using the hierarchy of evidence as defined by CEBM. A primary outcome is to produce a policy that is free from ambiguity, allowing ease of interpretation for clinicians and supporting ease of explanation to residents. Clinicians and other stakeholders can request reviews of specific policy sections and the inclusion/exclusion of sections based upon the submission of evidence to substantiate such a request. The policy in effect is under a constant cycle of review due to the ever-changing evidence upon which is it based. In order to manage this process an annualised work plan and a specialised policy management team manage the policy.

As a result, annualised policy updates are expected. The continued engagement and support of NCL clinicians to review the evidence and agree policy wording remains the basis of Evidence Based Interventions and Clinical Standards policy management.

## Application process for obtaining Prior Approval

For guidance on the process of obtaining prior approval GPs should refer to their individual CCGs and local contractual agreements.

For Providers, please refer to the terms and conditions of your contract for the process to obtain prior approval for all procedures within the Evidence Based Interventions and Clinical Standards policy.

| Borough | Email |
|---|---|
| Barnet | RMS.BARNET@nhs.net |
| Camden | PoLCE.CAMDEN@nhs.net |
| Enfield | PoLCE.ENFIELD@nhs.net |
| Haringey | HARCCG.HaringeyPoLCETriageService@nhs.net |
| Islington | PoLCE.ISLINGTON@nhs.net |

It is expected that GPs will be familiar with the policy and check patients' eligibility for treatment against the criteria. Only in the circumstances where a patient is solely managed by secondary care for a Evidence Based Interventions and Clinical Standards related condition, may the application for the procedure be made by the patient's secondary care Consultant.

## Process for Individual Funding Requests (IFR)

There are some procedures that are not routinely funded by the NHS and applications for these treatments should go through an Individual Funding Request (IFR) process if appropriate. Please refer to your local CCG for the agreed IFR Application process. The NCL IFR form can be found in appendix two.

## Performance monitoring arrangements

Performance measures and audits will be introduced to monitor Evidence Based Interventions and Clinical Standards activity across all sectors within NCL. There is currently a mixed economy in NCL using prior approvals processes and provider self-regulation through audit. These will be carried out by individual CCGs and Providers will be given appropriate notice. CCGs and Providers will work collectively to agree, maintain and review coding to support current versions of policies.

All providers will be asked to clarify any activity or procedure code that fail to comply with those set out within the policy. These will be brought to the attention of the relevant commissioners for NCL and any procedure not in line with this policy will be investigated and, where appropriate, challenged for non-payment.

## To whom this Policy is applicable to

This section specifies the stakeholder organisations to whom the application of the NCL Evidence Based Interventions and Clinical Standards policy applies:

| | |
|---|---|
| Referral Management Services: | North Central London -Referral Management Services (Primary Care) |
| | Barnet - Referral Management Service (RMS) |
| | Camden - Referral Management Service (CCAS) |
| | Enfield - Referral Management Service (RMS) |
| | Haringey - Referral Management Service |
| | Islington - Individual Funding Request Team |
| North Central London Boroughs: | Barnet CCG |
| | Camden CCG |
| | Enfield CCG |
| | Haringey CCG |
| | Islington CCG |
| North Central London Primary Care Stakeholders: | Clinical Cabinet |
| | Clinical Commissioning Groups (CCG) |
| | GP Federations |
| | Local Medical Committee (LMC) |
| | Local Dental Committee (LDC) |
| | Local Optical Committee ( LOC) |
| | North Central London - GP Practices |
| | North Central London - Dental Practices |
| North Central London Hospital Sites (Secondary Care Providers): | Barnet and Chase Farm Hospital |
| | Great Ormond Street Hospital |
| | Moorfields Eye Hospital |
| | North Middlesex University Hospital |
| | Royal Free Hospital |
| | Royal National Throat, Nose and Ear Hospital |
| | Whittington Health Hospital |
| | University College London Hospital |
| All out of sector Secondary Care Providers who see NCL patients | |
| Private and Independent Providers of NHS Healthcare services (this includes ALL community providers) | |

# 1 Dental procedures

## 1.1 Temporo-Mandibular Joint (TMJ) surgery

### Criteria

This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. TMJ surgery referred to in this document excludes arthroscopy as it may be performed for diagnostic reason.

Temporo-mandibular joint disorder (TMD), or TMJ syndrome, is an umbrella term covering acute or chronic inflammation of the temporo-mandibular joint, which connects the mandible to the skull. This disorder transcends the boundaries between several health-care disciplines in particular Dentistry and Neurology.

***Criteria for eligibility***

It is suggested that before any dentist or surgeon commences any plan or approach involving surgery, a thorough search for inciting para-functional jaw habits have been performed with the correction of any discrepancies from normal as the primary goal. Application for approval must evidence the following treatments:

1. Jaw rest

**AND**

2. Medications: non-steroidal anti-inflammatory medications such as aspirin, ibuprofen to control inflammation. Muscle relaxants, such as diazepam may decrease muscle spasms

**AND**

3. Physiotherapy

**AND**

4. Local anaesthetic

**AND**

5. Occlusal therapy: a custom made acrylic appliance which fits over the teeth prescribed for night and day to balance the bite, reduce and eliminate teeth grinding or clenching (bruxism)

**AND**

6. Botulinum toxin injections.

Surgery is only indicated and approved after these medical therapies have failed and is done as a last resort. TMJ ligament tightening, joint restructuring, and joint replacement are only considered in the most severe cases of joint damage or deterioration.

***Absolute contraindications to surgery are:***

- Active or chronic infection;
- Insufficient quantity or quality of bone to support the components;
- Systemic disease with increased susceptibility to infection;

| |
|---|
| • Patients with extensive perforations in the mandibular fossa and/or bony deficiencies in the articular eminence or zygomatic arch that would severely comprise support for the artificial fossa component;<br>• Partial TMJ joint reconstruction;<br>• Known allergic reaction to any materials used in the components;<br>• Patients with mental or neurological conditions who are unwilling or unable to follow post-operative care instructions;<br>• Skeletally immature patients;<br>• Patients with severe hyper-functional habits (e.g. clenching, grinding etc.) |
| **Reference** |
| NICE Guidance<br>http://www.nice.org.uk/guidance/ipg500/resources/guidance-total-prosthetic-replacement-of-the-temporomandibular-joint-pdf |

# 2 Dermatology and related plastic surgery

## 2.1 Cosmetic surgery (aesthetic) – Overview

### Definition

In this guidance aesthetic or cosmetic surgery is defined as surgery undertaken to improve one's appearance or reshape normal body parts to improve appearance. This differs from reconstructive surgery that is undertaken to reshape abnormal structures of the body, from accidents, injuries, infections, cancers or other diseases, as well as congenital deformities.

NCL CCGs will not normally fund aesthetic surgery for cosmetic purposes. All applications need to be approved via an Individual Funding Request where exceptional circumstances are clearly demonstrated.

**Note: Benign skin lesions are covered in a separate section of this document.** National aesthetic surgery guidelines were published in Action on Plastic Surgery 'Information for Commissioners of Plastic Surgery Services: Referrals and Guidelines in Plastic Surgery'.

### General principles

Below describes the indicative criteria/ guidelines for aesthetic procedures.

- This policy does not apply to any lesions where cancer is suspected – these should be investigated/ treated through the appropriate pathway.
- Patients should be counseled about the complications of surgery and the potential risk of scarring, infection and potential recurrence.

**Psychological distress will not be accepted as a reason to fund surgery.**

### Reference

http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2

## 2.2 Apronectomy or abdominoplasty (tummy tuck)

### Criteria

This cosmetic procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced:

**The patient should be 18 or over at the time of application.**

1. Patient is at least two years post bariatric surgery

**AND**

2. Patients has not smoked or used nicotine replacement therapy for the preceding 3 months.

**AND**

3. At the time of the application patients should have a BMI of between 18 to 30kg/$m^2$

**AND**

4. Must have maintained a BMI in this range for at least two years.

For patients who have had very significant weight loss post bariatric surgery who have lost at least 75% of their original excess weight at the time of the application;

- The patient should have a BMI equal or less than 35 kg/$m^2$

**AND**

- Maintained this weight for two years at the current level

**AND**

- Further weight loss is unlikely.

This policy applies to patients who have lost the equivalent amount of weight and maintained it for the similar amount of time without the need for bariatric surgery.

- Have severe functional problems which should include at least one of the following:
  - Severe difficulties with daily living (i.e. walking, dressing and ambulatory restrictions), which has been formally assessed and for which abdominoplasty will provide a clear resolution.
  - Documented record of recurrent intertrigo beneath the skin folds that recursor fails to respond despite appropriate medical therapy for at least six months.
  - The flap (panniculus) hangs at below the level of symphysis pubis.
  - Poorly fitting stoma bags.
  - Surgery is required as part of an abdominal hernia correction orother abdominal wall surgery.

Consider treatment prior to referral for patients with active psychiatric or psychological condition that would contraindicate surgery.

### Reference

Recommendations from Royal College of Surgeons – British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS) 2017
http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/rewrite-for-2017--final-version.pdf?sfvrsn=4

## 2.3 Benign skin lesions (removal of) (applies to age 2 +)

### Criteria

***Exclusions to the policy***

Any lesion suspicious of malignancy is not included within the scope of this policy and should be managed via the two-week wait pathway (or the relevant local pathway for the management of basal cell carcinoma).

In addition, the following lesions are excluded from the scope of this policy:

- Any lesion not listed in the 'scope of the policy' section below
- Malignant lesions – patients should be managed via the two-week wait pathway

- Pigmented lesions with malignant potential
- Lesions with diagnostic uncertainty
- Lesions undergoing rapid growth
- Actinic keratosis
- Café au lait patches – see policy on treatment of skin hyper-pigmentation
- Congenital naevi
- Genital warts – patients should be referred to sexual health clinic
- Naevus of Ota/ Naevus of Ito
- Scars (hypertrophic, keloid) – see policy on keloidectomy or revision of hypertrophic scars
- Vascular birth marks in children – see policy on treatment of vascular lesions

Note, this is not an exhaustive list. Please review relevant policies relating to these lesions to establish when/ if treatment is funded.

Procedures and interventions for benign skin lesions will not be commissioned for solely cosmetic reasons.

### *Scope of the policy*

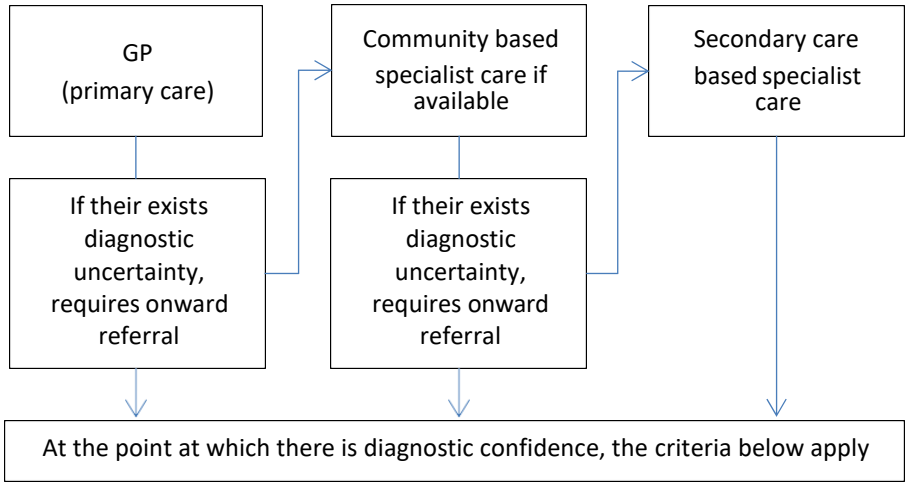
This policy should be applied where there is diagnostic confidence that lesions are of a benign nature.

This policy relates to both adults and children aged 2+.

The following lesions are included within the scope of this policy:

- Benign pigmented moles/ melanocytic naevus
- Capilliary haemangioma/ Campbell de Morgan
- Comedones
- Corn/ callous
- Cysts (epidermal, pilar, trichodermal, sebaceous)
- Dermatofibroma
- Lipoma
- Milia
- Molluscum contagiosum
- Neurofibromata
- Seborrhoeic keratoses (basal cell papillomata)
- Skin tags including anal tags (acrochordon)
- Telangiectasia/ thread veins
- Warts including plantar warts, mosaic warts
- Xanthelasma

***Commissioning criteria***




- This policy only applies to the lesions included within the scope of this policy, at the point at which there is diagnostic confidence.
- NCL CCGs do not routinely fund removal of benign skin lesions unless the following criteria are met:
  - The lesion is unavoidably and significantly traumatised on a *regular* basis,

    **AND**
  - The location of the lesion obstructs an orifice, impairs vision or significantly restricts usual function, causes *regular* pain

    **OR**
  - has been significantly infected, requiring more than 2 courses of antibiotics (oral or IV)

    **AND**
  - Recurrence and complication rates have been discussed with the patient.

- NCL CCGs do not routinly fund secondary care procedures and interventions for warts unless conservative treatments have failed and warts are:
  - Extensive

    **OR**
  - Facial

    **OR**
  - The patient is immunocompromised

## Advice for clinicians

Clinicians are expected to apply reason to the criteria which will always have an element of subjectivity:

- e.g. catching on clothes daily, regularly disturbed by combing of hair, under the waistband or bra strap causing clothes to be unwearable.
- Relevant to the patient e.g. lesions preventing children playing sport, lesions affecting ability to write/ type

Education does not constitute consent for the procedure, rather ensures the need and desire for onward referral.

### Reference

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-2a-Benign-Skin-Lesions-Policy.pdf

## 2.4 Body contouring (other skin excision for contour e.g. buttock lift, thigh lift, arm lift [brachioplasty])

**Not including breast procedures. Please see the relevant section.**

### Criteria

This cosmetic procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced:

**The patient should be 18 or over at the time of application.**

1. Patient is at least 18 months post bariatric surgery

**AND**

2. At the time of the application patients should have a BMI of between 18 and equal or less than 30 kg/$m^2$ and must have maintained a BMI in this range for at least18 months.

For patients who have had very significant weight loss post bariatric surgery who have lost at least 50% of their original excess weight at the time of the application the patient should have a BMI equal or less than 35 kg/$m^2$ and maintained this weight for two years at the current level and further weight loss is unlikely.

**AND**

3. Have severe functional problems which must include:

- Severe difficulties with daily living (i.e. walking, dressing and ambulatory restrictions) which has been formally assessed, and/or
- Documented record of recurrent intertrigo beneath the skin folds that recurs orfails to respond despite appropriate medical therapy for at least six months.

## 2.5 Breast procedures – Bilateral breast augmentation (breast enlargement)

### Criteria

NCL CCGs will not routinely fund bilateral breast augmentation.

In rare situations and with prior approval, funding for breast augmentation may be considered if the criteria below is met and evidenced:

1. Congential amastia – developmental failure resulting in bilateral absence of breast tissue.
2. Bilateral loss of breast tissue due to treatment for breast cancer or as the result of burns or trauma.

## 2.6 Breast procedures – Breast reduction (bilateral and unilateral)

### Criteria

***Breast reduction – Overarching criteria (applicable to both bilateral and unilateral breast reduction)***

NCL CCGs do not routinely fund breast reduction unless all of the following criteria are met (see also additional criteria for bilateral and unilateral breast reduction below):

- Breast size results in functional symptoms with at least two of the following for at least one year:
  - Pain in the neck
  - Pain in the upper back
  - Pain in the shoulders
  - Painful kyphosis documented by X-rays
  - Pain/ discomfort/ ulceration from bra straps cutting into shoulders

  There should be documented evidence of GP visits for these problems.
- Pain symptoms persist despite a six month trial of therapeutic measures including all of the following:
  - Supportive devices (e.g. proper bra/ support bra fitted by a trained bra fitter, wide bra straps)
  - Analgesic/ non-steroidal anti-inflammatory drugs (NSAIDs) interventions
  - Physical therapy/ exercises/ posturing manoeuvres

  The above should be documented by the clinician.
- In cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided
- Body mass index (BMI) is <27 and stable for at least twelve months.
- The patient must be provided with written information to allow her to balance the risks and benefits of breast surgery.
- The patient should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking.
- The patient should be informed that breast reduction can cause permanent loss of lactation.

**Surgery will not be funded for cosmetic reasons.**

### *Exclusions to the policy*

This policy does not apply to therapeutic mammoplasty for breast cancer treatment or contralateral surgery following breast cancer surgery.

### *Bilateral breast reduction – Additional criterion*

In addition to the above overarching criteria, women undergoing bilateral breast reduction must also meet the following criterion in order to be eligible for surgery:

- Breast reduction planned to be 500 gms or more per breast or at least 4 cup sizes.

Resection weights should be recorded for audit purposes.

### *Unilateral breast reduction – Additional criterion*

In addition to the above overarching criteria, women undergoing unilateral breast reduction must also meet the following criterion in order to be eligible for surgery:

- There is breast asymmetry leading to a difference of 150 -200 gms size between breasts, as measured by a specialist.

Resection weight should be recorded for audit purposes.

Unilateral breast reduction is considered for asymmetric breasts as opposed to breast augmentation.

### Reference

NHS England Evidence-based interventions guidance
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

## 2.7 Breast procedures – Mastopexy (breast lift)

This cosmetic procedure is not routinely funded by the NCL CCGs.

NB: For asymmetry; please see section relating to **breast augmentation**. For back pain as a result of breast size: please see section relating to **breast reduction**.

## 2.8 Breast procedures – Revision of breast augmentation

### Criteria

This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced:

**The patient should be 18 or over at the time of application.**

Removal of implants (including implants carried out in the private sector) will be considered, **but not replacement,** if at least ONE of the following criteria is met:

- Rupture of silicone-filled gel.
- Implants complicated by recurrent infections.
- Extrusion of implant through skin.
- Implants with Baker Class IV contracture associated with severe pain.
- Implants with severe contracture that interferes with mammography.

Replacement of implants will be considered for clinical reasons, if the original implants were funded by the NHS for non-cosmetic purposes. Documented evidence is required to demonstrate this.

If augmentation is approved please see the Augmentation/Mammoplasty (Breast enlargement) section in the Evidence Based Interventions and Clinical Standards policy.

## 2.9 Breast procedures – Surgery for gynaecomastia

### Criteria

NCL CCGs will not routinely fund surgery for gynaecomastia.

This policy does not apply to surgery for gynaecomastia caused by medical treatments (e.g. treatments for prostate cancer).

### Reference

NHS England Evidence-based interventions guidance
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

## 2.10 Breast procedures – Surgical correction of nipple inversion

This cosmetic procedure is not routinely by the NCL CCGs.

## 2.11 Breast procedures – Unilateral breast augmentation (breast enlargement)

### Criteria

Reduction of the larger breast should be regarded as the first line treatment for patients seeking to correct breast asymmetry – see separate section on breast reduction

NCL CCGs do not routinely fund unilateral breast augmentation unless one of the following criteria are met:

- Developmental failure resulting in unilateral absence of breast tissue (unilateral congenital amastia).

**OR**

- Breast asymmetry ≥ 2 cup sizes due to mastectomy, excision breast surgery for cancer/lumpectomy, prophylactic mastectomy for cancer prevention in high risk cases.

**OR**

- For breast asymmetry ≥ 2 cup sizes due to trauma or burns, or endocrine abnormalities.

**OR**

- Patients with gross asymmetry (defined as a difference greater than 2 standard cup sizes) to the extent that they cannot get a bra to fit.

### Reference

NICE guidance
http://www.nice.org.uk/guidance/ipg417/resources/guidance-breast-reconstruction- using-lipomodelling-after-breast-cancer-treatment-pdf

## 2.12 Ear procedures – Pinnaplasty/ otoplasty

### Criteria

This cosmetic procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced.

Initial referrals should be for assessment only.

- The patient must be under the age of 19 years at the time of referral.
- Patients seeking pinnaplasty should be seen by a plastic surgeon or appropriate ENT surgeon and following assessment, if there is any concern, assessed by a psychologist.
- Patients under 5 years of age at the time of referral may benefit from referral with their family for a multi-disciplinary assessment that includes a childpsychologist.
- Requests for patients over 19 years old will be considered as an IFR application

## 2.13 Ear procedures – Repair of external ear lobes

This procedure is not routinely funded by NCL CCGs.

## 2.14 Facial procedures – Brow lift

### Criteria

This cosmetic procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced.

After assessment by a specialist; evidence must be provided demonstrating the severity and clinical need for surgery in these instances:

- Impairment of vision.
- To correct impairment of the visual field.

## 2.15 Facial procedures – Injection of botulinum toxin

### Criteria

Cosmetic injection of botulinum toxin is not routinely funded by the NCL CCGs

NB: For hyperhidrosis: Please see section relating to **hyperhidrosis**.

Botulinum toxin treatments are commissioned by NHS England this includes focal spasticity in children and intravescial use in spinal cord injury as indicated in their drugs lists https://www.england.nhs.uk/wp-content/uploads/.../nhs-england-drugs-list-v12.pdf published April 2017

NB: For use of botulinum toxin in urinary incontinence please refer to the latest NICE guidance: https://www.nice.org.uk/guidance/cg171

## 2.16 Facial procedures – Rhytidectomy (face lift)

This cosmetic procedure is not routinely funded by the NCL CCGs.

## 2.17 Hair epilation (hair removal by electrolysis and/or laser)

### Criteria

This cosmetic procedure is not routinely funded by NCL CCGs.

Funding for hair epilation may be approved by the IFR Panel for patients who:

1. Have undergone reconstructive surgery leading to abnormally located hair-bearing skin to the face, neck or upper chest (areas not covered by normal clothing)

**OR**

2. Are undergoing treatment for pilonidal sinuses to reduce recurrence.

## 2.18 Hair loss – Correction of hair loss (including male pattern baldness) (alopecia)

This cosmetic procedure is not routinely funded by the NCL CCGs.

This includes hair grafting; flaps with/without tissue expansions, non-NHS provided interlace system.

## 2.19 Hyperhidrosis

### Criteria

Hyperhidrosis is a condition that causes excessive sweating. There are two types of hyperhidrosis:

1. Focal hyperhidrosis, where only certain parts of the body are affected, such as the armpits, hands, feet or face, and
2. Generalised hyperhidrosis, where the entire body is affected.

Severe generalised hyperhidrosis is often the result of an underlying health condition, such as an overactive thyroid gland, treatment to address this must be attempted before requesting prior approval.

Treatment for **severe generalised hyperhidrosis**, where the entire body is affected, may be funded where there is evidence of severe functional impairment including difficulties with daily living.

Treatment for **focal hyperhidrosis**, where only certain parts of the body are affected, such as the armpits, hands, feet or face, is not routinely funded by the NCL CCGs.

Treatment of FOCAL hyperhidrosis is considered a low priority, requiring prior approval, and will only be commissioned by the NCL CCGs on an individual case basis. The CCG will only fund treatment of primary hyperhidrosis if the followingcriteria are met:

- The patient has documented medical complications due to hyperhidrosis, i.e. skin maceration with secondary skin infections;

**AND**

- Documentation that the patient has failed a 6 month trial of conservative management including the use of topical aluminium chloride or extra strength antiperspirants, e.g.;
    - Lifestyle measures including; avoiding crowded rooms, caffeine, or spicy foods, using antiperspirant (as opposed to deodorant), avoid tight clothing, appropriate footwear, etc.
    - First line medication: Aluminium Chloride Hexahydrate 20% (OTC)
    - Treatment of underline anxiety e.g. with CBT

Botulinum toxin injections: For patients in whom botulinum toxin injections fail or is contraindicated, surgical excision of sweat glands may be considered if the policy criteria are met. For these patients, the clinician carrying out the procedure needs to apply for exceptional approval of funding by completing the IFR Funding Request Form.

The following treatments will also not be funded

- Iontophoresis (can be bought over the counter {OTC} )
- Surgical sympathectomy
- Laser surgery (Transcutaneous microwave ablation for severe axilliary)

Note: Patients who smoke should be advised to attempt to stop smoking and referred to smoking cessation services - see smoking cessation policy.

### References

NICE Guidance

https://cks.nice.org.uk/hyperhidrosis 2013

https://www.nice.org.uk/guidance/ipg601 2017 ( microwave ablation)

https://www.nice.org.uk/guidance/ipg487 2017 ( thoracic sympathectomy)

https://www.nice.org.uk/advice/es10/chapter/Key-points 2017 ( use of oxybutynin)

https://www.nice.org.uk/advice/esuom16/chapter/Key-points-from-the-evidence 2013

## 2.20 Keloidectomy [keloid scars] or revision of hypertrophic scars (applies to age 2+)

### Criteria

NCL CCGs will not routinely fund procedures to revise keloid scars or hypertrophic scars for cosmetic purposes.

All patients seeking treatment should be advised of the risk of scar recurrence. Patients should only be referred for surgical treatment once conservative approaches have been exhausted, including:

- Haelan tape (Fludroxycortide tape) – patient should be informed the need towear the tape for 12 hours per day
- Silicone gel
- Steroid injections administered by dermatologist.

Patients should be referred to a dermatologist when the scar is symptomatic and conservative management has been tried (dermatologist will administer steroid injections). This does not include psychological distress.

Surgical intervention may be funded if the following criteria are met and evidenced. If the keloid:

Has been present for at least 18 months (post injury or post-surgery) and have failed 6 months of conservative methods (defined above)

**AND**

- Results in significant functional impairment;

**OR**

- Causes significant pain requiring chronic analgesic medication for at leastsix months;

**OR**

- Bleeding or recurrent infection;

**OR**

- Obstruction of orifice or vision;

**OR**

- Is a facial lesion causing disfigurement.

Patients should be informed that having surgery on a scar will in itself leave a new scar that will take up to two years to improve in appearance. If surgery is used to treat a hypertrophic scar, there is a risk that the scarring may be worse after the surgery.

Low-dose, superficial radiotherapy may reduce the recurrence rate of hypertrophic and keloid scars after surgery. Because of the possibility of long-term side effects, it is only reserved for the most serious cases. IFR applications should be submitted for this intervention describing the clinical exceptionality in any case.

### References


Best Practice with local NCL clinicians

https://patient.info/doctor/keloid-pro

http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD003826.pub3/abstract;jsessionid=7173C486D46AA4CCE18B4E1B3ADA1DD6.f04t01

http://www.bad.org.uk/shared/get-file.ashx?id=216&itemtype=document

http://journals.sagepub.com/doi/full/10.1177/2059513117690937

http://www.pcds.org.uk/clinical-guidance/scars


## 2.21 Liposuction

This cosmetic procedure is not routinely funded by the NCL CCGs.

## 2.22 Skin resurfacing and other surgical interventions for scarring

**(including laser, dermabrasion and chemical peels)**

This cosmetic procedure is not routinely funded by the NCL CCGs.

## 2.23 Tattoo removal

This cosmetic procedure is not routinely funded by the NCL CCGs.

## 2.24 Treatment of skin hyper-pigmentation

**(including laser therapy, chemical peels, and referrals for prescriptions for topical treatments etc.)**

| |
|---|
| This cosmetic procedure is not routinely funded by the NCL CCGs. |

## 2.25 Treatment of vascular lesions (port wine stains on the head and neck) (vascular lesions)

NCL CCGs will not routinely fund treatments for vascular lesions as most interventions are for cosmetic purposes and there is a limited evidence of effectiveness.

IFR applications must be submitted for any proposed treatment clearly describing the proposed intervention, evidence for clinical effectiveness, and a description of the individual patient's clinical exceptionality by the clinician who will be carrying out the treatment.

# 3 Ear, Nose and Throat (ENT)

## 3.1 Grommets for glue ear in children

### Criteria

***Exclusions from the policy***

This policy only relates to children with glue ear (otitis media with effusion [OME]) and should not be applied to other clinical conditions where grommet insertion should continue to be routinely funded, these include:

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

***Commissioning criteria***

NCL CCGs do not routinely fund grommets for the treatment of glue ear in children unless patients meet the criteria set out in NICE Clinical Guideline 60:

- Children must have:
  - Had specialist audiology and ENT assessment
  - Persistent bilateral otitis media with effusion documented over a period of 3 months
  - Hearing level in the better ear of 25-30dbHL or worse averaged at 0.5, 1, 2, & 4 kHz
- Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25-30dbHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant.
- Healthcare professionals should also consider surgical intervention in children who cannot undergo standard assessment of hearing thresholds where there is clinical and tympanographic evidence of persistent glue ear and where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant.
- The guidance is different for children with Down's Syndrome and Cleft Palate; children with these conditions may be offered grommets after a specialist MDT assessment in line with recommendations made in NICE Clinical Guideline 60.
- It is good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum.

### References

NHS England Evidence-based interventions guidance
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

NICE Guidance

https://www.nice.org.uk/Guidance/CG60.

## 3.2 Rhinoplasty (surgery to reshape the nose)

### Criteria

This cosmetic procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced.

1. Nasal airway obstruction causing significant symptoms (e.g., chronic rhinosinusitis, difficulty breathing, post traumatic deformity)

**OR**

2. Obstructive symptoms persist despite conservative management for three months or greater, which includes, where appropriate, nasal steroids or immunotherapy as per local clinical/national guidelines.

**OR**

3. Correction of complex congenital conditions unless covered by specialised commissioning arrangements.

## 3.3 Surgery for sleep related breathing disorder (SRDB)

### Criteria

Surgical procedures to remove, refashion or stiffen the tissues of the soft palate in an attempt to improve the symptoms of simple snoring in the absence of obstructive sleep apnoea (OSA) is not routinely funded by NCL CCGs.

NCL CCGs do not routinely fund surgery for sleep related breathing disorders unless the patient has OSA and all six of the following criteria are met and evidenced:

1. Before consideration for surgery patient has had:

- Trial of weight loss (Failure to lose weight should not prevent access to treatment)
- Alcohol consumption is within recommended safe limits and patterns and avoided late at night
- Exclude and treat appropriately: rhinitis, nasal polyposis, hypothyroidism and anaemia

2. Sleep study result

- AHI greater than FIVE

**OR**

- AHI less than 5 but flow limitation index greater than 15 AND Epworth sleepiness score greater than 12

3. CPAP failure (minimum three month trial)

- All patients who use CPAP should be reassessed in a CPAP clinic where a smart card can give information on parameters such as reduction of AHI, mask leak and pressure requirements, allowing for analysis of efficacy and compliance of CPAP

**OR**

- Obvious obstructive upper airway pathology compromising CPAP use

**OR**

- Claustrophobia

4. Failed use of Mandibular Advancement Device (MAD)

- Repeat sleep study with use of MAD has failed to demonstrate a reduction in AHI

**OR**

- The patient begins to encounter dental problems or TMJ dysfunction

5. Sleep nasendoscopy demonstrates significant anatomical problem:

- Nasal, oropharyngeal or hypopharyngeal

6. The aim of surgery is to:

- Partially improve upper airway obstruction to facilitate CPAP use

**OR**

- Completely resolve upper airway obstruction

Cautious consideration for surgery in those with a BMI greater than 35 unless significant anatomical abnormality is present compromising CPAP use.

### Reference

NHS England Evidence-based interventions guidance
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

## 3.4 Surgical treatment of chronic rhinosinusitis

### Criteria

This procedure is not routinely funded by the NCL CCGs.

Suspected sino-nasal tumours should be referred to ENT via the agreed urgent pathway.

CCG will only fund surgical treatment for chronic rhino sinusitis (>12 weeks) when all stepped interventions described in local clinical guidelines/latest EPOS guidelines have been exhausted, including:

1. Twelve week trial of intranasal corticosteroids

**AND**

2. Four week trial of oral macrolide antibiotics

**AND**

3. Consideration and trial of other oral and intravenous therapy as stated in latest EPOS guideline specific to patient needs, symptoms and severity.

Good patient concordance with each of points 1-3 should be clearly documented and demonstrated before surgery is considered.

### Reference

European Position Paper on Rhinosinusitis and Nasal Polyps [2012]
http://ep3os.org/EPOS2012.pdf

## 3.5 Tonsillectomy (with or without adenoidectomy) (applies to age 2+)

### Criteria

Tonsillectomy is a clinically effective and cost-effective procedure when performed for appropriate indications. It should be approved for funding if the criteria below are met and evidenced. These criteria refer to tonsillectomy with or without adenoidectomy. Adenoidectomy alone, for clinical reasons, are routinely funded.

**Suspected tonsil neoplasms should be referred via the agreed urgent pathway.**

#### *Criteria for eligibility*

A. Tonsillectomy for recurrent acute tonsillitis:

NCL CCGs do not routinely fund tonsillectomy for recurrent acute tonsillitis unless the following criteria are met:

- Seven or more, documented, clinically significant, adequately treated sore throats in the preceding year

**OR**

- Five or more such episodes in each of the preceding two years

**OR**

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

**AND**

- Sore throats are due to acute tonsillitis and episodes are disabling and prevent normal functioning.

B. Tonsillectomy for obstructive sleep apnoea (OSA) in children:

The diagnosis may be based on a clear parental history of snoring, obstructed, laboured breathing, apnoea and disturbed sleep, together with anatomical evidence of upper airway obstruction.

N.B. Daytime neuro behavioural abnormalities or sleepiness are not always present in children with significant OSA.

A lower threshold for considering surgery if the patient has habitual snoring with laboured breathing and falls into one of the following complex high risk categories for sleep apnoea:

- Down's syndrome
- Cerebral palsy
- Craniofacial disorders
- Chronic lung disease
- Sickle cell disease
- Neuromuscular disorders
- Genetic/metabolic/storage disease
- Central hyperventilation syndromes

C. Tonsillectomy for quinsy/ other tonsillitis

1. ONE quinsy or ONE or more episodes of tonsillitis requiring admission to hospital where there has been a previous history of recurrent tonsillitis

**OR**

2. One year or more of chronic tonsillitis with tonsoliths causing halitosis and significant social embarrassment

**OR**

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

· Acute and chronic renal disease resulting from acute bacterial tonsillitis.

· As part of the treatment of severe guttate psoriasis.

· Metabolic disorders where periods of reduced oral intake could be dangerous to health.

· PFAPA (Periodic fever, Apthous stomatitis, Pharyngitis, Cervical adenitis)

· Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous

## Reference

NHS England Evidence-based interventions guidance
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

SIGN Guidelines
http://www.sign.ac.uk/assets/sign117.pdf

# 4 Gender reassignment

## 4.1 Gender reassignment

This procedure is not routinely funded by NCL CCGs.

For this treatment to be considered patients must be on a recognised programme of care and the NCL CCG should check the specialised commissioning arrangements in their area.

Note: Patients should be referred to a recognised NHS programme of care for management of these cases.

Treatment is covered by specialised commissioning arrangements. Any treatments not covered by specialised commissioning arrangements are to be considered under the relevant section of the aesthetic surgery guidelines, e.g. breast augmentation and hair removal.

# 5 General surgical procedures and vascular

## 5.1 Cholecystectomy for gallstones

### Criteria

NCL CCGs will not routinely fund cholecystectomy for asymptomatic gallstones. Funding will be available if one of the following criteria is met:

- Confirmed episode of gallstone 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.
- Confirmed acute cholecystitis.
- Where there is clear evidence from an ultrasound scan that the patient is at risk of gall bladder carcinoma.
- Patient with diabetes, chronic liver disease or cirrhosis or is a transplant recipient when a secondary care opinion should be sought even if asymptomatic

### Reference

NICE Gallstones disease CG188 [2014]
https://www.nice.org.uk/guidance/cg188

## 5.2 Divarication of recti

NCL CCGs will not routinely fund this surgery.

## 5.3 Haemorrhoid surgery

### Criteria

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

NCL CCGs do not routinely fund surgical treatment for haemorrhoids unless:

- The haemorrhoids do not respond to non-operative measures

**OR**

- The haemorrhoids are severe, specifically:
  - Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding

**OR**

- Irreducible and large external haemorrhoids

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

### References

NHS England Evidence-based interventions guidance
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

## 5.4 Hernia

### Criteria

#### Femoral hernia

These do not come under the scope of this policy and do not require prior funding approval.

#### Inguinal hernia

NCL CCGs will not fund inguinal hernia repair where the patient is asymptomatic or has a mildly symptomatic inguinal hernia. NCL CCGs will fund the surgical repair of inguinal hernia if the following criteria are met and evidenced:

- Difficulty in reducing the hernia

**OR**

- An inguino-scrotal hernia

**OR**

- Pain with strenuous activity, prostatism or discomfort significantly interfering with activities of daily living.

#### Groin pain with clinical suspicion of hernia (obscure pain or swelling)

These patients may undergo diagnostic testing (e.g. ultrasound scan) to assess whether hernia or other pathology and managed accordingly. Funding criteria for hernia surgery are then applied as laid out in this policy.

#### Recurrent and bilateral hernia

These are considered in the same way as primary hernias and funding criteria for surgery will be applied as described in this policy. Referral should be made to appropriate specialists with expertise in open and laparoscopic surgery.

#### Abdominal (including incisional and umbilical) hernia

NCL CCGs will not routinely fund this treatment unless the following criteria are met:

- there is pain/discomfort significantly interfering with activities of daily living (this must be documented and described).

**OR**

- There is also documented increase in size month on month.

**AND**

- for patients with BMI 35kg/m$^2$, there have been attempts at weight reduction for 6 months and these have not resolved the pain/discomfort.

## References


European Hernia Society Guideline
https://www.europeanherniasociety.eu/sites/www.europeanherniasociety.eu/files/medias/PDF/HerniaSurgeGuidelinesPART1TREATMENT.pdf

BMJ Best Practice 2016, updated May 2018
https://bestpractice.bmj.com/topics/en-gb/723?q=Inguinal%20hernia%20in%20adults&c=suggested

https://emedicine.medscape.com/article/189563-overview#a0104

NICE guidelines: TA83 (Sept 2004) – Laparoscopic surgery for hernia
https://www.nice.org.uk/guidance/ta83

McIntosh, Hutchinson, Roberts, Withers (2000). Evidence based management of groin hernia in primary care - a systematic review. Family Practice; 17:442-447
https://www.ncbi.nlm.nih.gov/pubmed/11021907

Friedrich, Muller-Riemenschneider, Roll, Kulp, Vauth, Greiner, Willich and von der Schulenbury (2008). Health Technology Assessment of laparoscopic compared to conventional surgery with and without mesh for incisional hernia repair regarding safety, efficacy and cost-effectiveness. GMS Health Technology Assessment ; 7/4: Doc 01
https://www.ncbi.nlm.nih.gov/pubmed/21289907

Dabbas (2011) Frequency of abdominal wall hernias: is classical teaching out of date. JRSM Short Reports: 2/5; 5
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3031184/

Fitzgibbons (2006); Watchful waiting versus repair of inguinal hernia in minimally symptomatic men, a randomised controlled trial. JAMA: 295; 285-292
https://www.ncbi.nlm.nih.gov/pubmed/16418463

Flum (2006) : The asymptomatic hernia: If it's not broken don't fix it.
https://www.ncbi.nlm.nih.gov/pubmed/16418470

BMJ clinical evidence on Inguinal Hernias; Chos, Purkayastha, Anthanasiou, Tekkis and Darzi.
https://www.bmj.com/content/336/7638/269

Rosenberg (2011). Danish hernia database recommendations for management of inguinal and femoral hernias in adults. Danish Medical Bulletin; 58/2: C4243
https://www.ncbi.nlm.nih.gov/pubmed/21299930

Simons et al. European hernia society guidelines: Treatment of inguinal hernia in adult patients. Hernia, 2009: 13(4): 343–403.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2719730/

Primatesta, Goldacre. Inguinal Hernia repair: incidence of elective and emergency surgery, readmission and mortality (1996). International Journal of Epidemiology; 25/4: 835-839
https://www.ncbi.nlm.nih.gov/pubmed/8921464

Courtney, Lee, Wilson and O'Dwyer (2003). Ventral hernia repair: a study of current practice. Hernia; 7:44-46
https://www.ncbi.nlm.nih.gov/pubmed/12612798

Surgery for Society on the Alimentary tract patient care guidelines (2004). https://www.ncbi.nlm.nih.gov/pubmed/15115007; http://www.ssat.com/

Surgical repair of incisional hernia. Journal of Gastrointestinal surgery; 8/3: 369-70 https://www.sciencedirect.com/science/article/abs/pii/S1091255X0300310X

## 5.5 Penile procedures (penile implants)

### Criteria

NCL CCGs will not routinely fund penile implants as first or second-line treatment for erectile dysfunction (Grade C recommendation).

Exceptions to this policy are patients with severe structural disease, where first and second line treatments may not be effective, are conditions such as:

- Peyronie's disease
- Post-priapism
- Complex penile malformations

### References

European Association of Urology 2015 & 2016 – https://uroweb.org/wp-content/uploads/EAU-Guidelines-Male-Sexual-Dysfunction-2016.pdf

Faculty of Sexual & Reproductive Healthcare Clinical Guidance for male and female in sterilisation September 2014 (Review Date September 2019) – https://www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-sterilisation-cpd-sep-2014/

## 5.6 Varicose vein interventions

### Criteria

NCL CCGs do not routinely fund referral to a vascular service for assessment and treatment of varicose veins* unless one of the following criteria are met:

- Symptomatic** primary or recurrent varicose veins.
- Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency.
- Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence.
- A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks).
- A healed venous leg ulcer.

* Referral for assessment does not guarantee the patient will receive treatment.

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

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

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

Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable.

The following interventions are all cost effective treatments for managing symptomatic varicose veins compared to no treatment or the use of compression hosiery: endovenous thermal (laser ablation, and radiofrequency ablation), ultrasound guided foam sclerotherapy and open surgery (ligation and stripping).

For truncal ablation there is a treatment hierarchy based on cost effectiveness and suitability, which is as follows:

- First choice is endothermal ablation
- If endothermal ablation is unsuitable, offer ultrasound-guided foam sclerotherapy
- If ultrasound-guided foam sclerotherpay is unsuitable, offer conventional surgery.

For further information, see: https://www.nice.org.uk/guidance/cg168.

## Advice to primary care practitioners

Give people who present with varicose veins information that includes:

- An explanation of what varicose veins are.
- Possible causes of varicose veins.
- The likelihood of progression and possible complications, including deep vein thrombosis, skin changes, leg ulcers, bleeding and thrombophlebitis. Address any misconceptions the person may have about the risks of developing complications.
- Treatment options, including symptom relief, an overview of interventional treatments and the role of compression.

The following lifestyle advice should be offered to all patients with varicose veins:

- Weight loss (if appropriate)
- Light to moderate physical exercise
- Avoiding factors that are known to make their symptoms worse if possible
- Smoking cessation

Pregnant women presenting with varicose vein should be given information on the effect of pregnancy on varicose veins. Interventional treatment for varicose veins during pregnancy should not be carried out other than in exceptional circumstances. Compression hosiery should be considered for symptom relief of leg swelling associated with varicose veins during pregnancy.

## References

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-7a-Varicose-Veins-Policy.pdf

NHS England Evidence-based interventions guidance
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

NICE Clinical Guideline 168
https://www.nice.org.uk/guidance/cg168/chapter/1-Recommendations

## 5.7 Vasectomy

NCL CCGs will only routinely fund vasectomies when carried out under local anaesthetic.

### References


Faculty of Sexual & Reproductive Healthcare Clinical Guidance for male and female in sterilisation September 2014 (Review Date September 2019)
https://www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-sterilisation-summary-sep-2014/

World Health Organization. Medical Eligibility Criteria for Contraceptive Use. Geneva: WHO; 3rd edition 2004. (Section on Surgical sterilization procedures pp13-15)
http://apps.who.int/iris/handle/10665/42907

NICE Clinical Knowledge Summaries. Contraception - management. Male sterilization
https://cks.nice.org.uk/contraception-sterilization

Cook LA, Pun A, van Vliet H, Gallo MF, Lopez LM. Scalpel versus no-scalpel incision for vasectomy. Cochrane Database Syst Rev. 2007 Apr 18;(2):CD004112
https://www.cochrane.org/CD004112/FERTILREG_scalpel-or-no-scalpel-approach-vas

FPA Fact sheet on male and female sterilisation.
https://www.fpa.org.uk/factsheets/contraception-patterns-use

# 6 Genitourinary medicine procedures

## 6.1 Circumcision (applies to age 14+)

### Criteria

This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced.

Circumcision is an effective operative procedure with a range of medical indications. This statement refers to circumcision (the surgical removal of the penile foreskin) in males only. Female circumcision is prohibited by law (The Prohibition of Female Circumcision Act 1995).

Circumcisions for social, religious or cultural reasons will not be funded by the NHS.

***Criteria for eligibility***

1. Pathological phimosis: The commonest cause is lichen sclerosus, balanitis xerotica obliterans (BXO) is an old fashioned descriptive term

**OR**

2. Recurrent episodes of balanoposthitis

**OR**

3. Prevention of urinary tract infection in patients with an abnormal urinary tract

**OR**

4. Recurrent paraphimosis

**OR**

5. Traumatic (e.g. zipper injury)

**OR**

6. Tight foreskin causing pain on arousal/ interfering with sexual function

**OR**

7. Congenital abnormalities

### Reference

https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/foreskin-conditions/

Review date: July 2019

## 6.2 Reversal of sterilisation

### Criteria

This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced.

***Criteria for eligibility***

- Death of only existing child.
- Remarriage following death of spouse

## 6.3 Varicocele

### Criteria

This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced.

***Criteria for eligibility***

- Documented evidence of persistent discomfort or pain despite adequate conservative management.

**OR**

- Where 2 documented semen analysis reports indicate abnormalities are present, varicocele repair should be considered.

### References

BMJ Best Practice July 2018
https://bestpractice.bmj.com/topics/en-gb/1103

Practice Committee of the American Society for Reproductive Medicine; Society for Male Reproduction and Urology. Report on varicocele and infertility: a committee opinion. Fertil Steril. 2014 Dec;102(6):1556-60.
https://www.ncbi.nlm.nih.gov/pubmed/25458620

# 7 Gynaecological procedures

## 7.1 Bartholin's cysts, treatment for

### Criteria

Acute Bartholin's cyst presentations should be referred via agreed urgent pathways.

NCL CCGs will not routinely fund the surgical treatment of non-acute cysts unless the criteria below are met and evidenced.

***Criteria for eligibility***

1. Cysts larger than 3cm in diameter

**OR**

2. Cysts of any size causing significant discomfort, which have become infected requiring anti-biotic treatment on at least two separate occasions.

### References

No relevant NICE guidelines

NCL GPs and secondary care consultants

## 7.2 Dilatation and curettage for heavy menstrual bleeding (HMB)

NCL CCGs do not routinely fund dilation and curettage for the diagnosis or treatment of HMB.

### Reference

NHS England Evidence-based interventions guidance
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

## 7.3 Hysterectomy for heavy menstrual bleeding (HMB)

### Criteria

NCL CCGs advise it is important that healthcare professionals understand what matters most to each woman and support her personal priorities and choices.

Criteria for access to treatments for HMB should be in line with NICE NG88.

Information should be provided about all possible treatment options for HMB and discussed with the women. Discussions should cover:

- The benefits and risks of the various options, including information detailed in NG88 about what discussions should cover for specific interventions

- Suitable treatments if she is trying to conceive
- Whether she wants to retain her fertility and/or her uterus

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

When agreeing treatment options for HMB with women, take into account:

- the woman's preferences
- any comorbidities
- the presence or absence of fibroids (including size, number and location), polyps, endometrial pathology or adenomyosis
- other symptoms such as pressure and pain

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

- Consider an LNG-IUS (levonorgestrel-releasing intrauterine system) as the first treatment for HMB in women with:
  - no identified pathology **OR**
  - fibroids less than 3 cm in diameter, which are not causing distortion of the uterine cavity **OR**
  - suspected or diagnosed adenomyosis.
- If a woman with HMB declines an LNG-IUS or it is not suitable, consider the following pharmacological treatments:
  - non-hormonal: tranexamic acid, NSAIDs (non-steroidal anti-inflammatory drugs)
  - hormonal: combined hormonal contraception, cyclical oral progestogens.
- Be aware that progestogen-only contraception may suppress menstruation, which could be beneficial to women with HMB.
- If treatment is unsuccessful, the woman declines pharmacological treatment, or symptoms are severe, consider referral to specialist care for:
  - investigations to diagnose the cause of HMB, if needed, taking into account any investigations the woman has already had **AND**
  - alternative treatment choices, including:
    - pharmacological options not already tried (see above)
    - surgical options: second-generation endometrial ablation, hysterectomy.
- For women with submucosal fibroids, consider hysteroscopic removal.

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

- Consider referring women to specialist care to undertake additional investigations and discuss treatment options for fibroids of 3 cm or more in diameter.
- If pharmacological treatment is needed while investigations and definitive treatment are being organised, offer tranexamic acid and/or NSAIDs.
- Advise women to continue using NSAIDs and/or tranexamic acid for as long as they are found to be beneficial.

- For women with fibroids of 3 cm or more in diameter, take into account the size, location and number of fibroids, and the severity of the symptoms and consider the following treatments:
  - pharmacological:
    - non-hormonal: tranexamic acid, NSAIDs
    - hormonal: LNG-IUS, combined hormonal contraception, cyclical oral progestogens
  - uterine artery embolization
  - surgical: myomectomy, hysterectomy
- Be aware that the effectiveness of pharmacological treatments for HMB may be limited in women with fibroids that are substantially greater than 3 cm in diameter.
- Prior to scheduling of uterine artery embolisation or myomectomy, the woman's uterus and fibroid(s) should be assessed by ultrasound. If further information about fibroid position, size, number and vascularity is needed, MRI should be considered.
- Consider second-generation endometrial ablation as a treatment option for women with HMB and fibroids of 3 cm or more in diameter who meet the criteria specified in the manufacturers' instructions.
- If treatment is unsuccessful:
  - consider further investigations to reassess the cause of HMB, taking into account the results of previous investigations **AND**
  - offer alternative treatment with a choice of the options described above.
- Pretreatment with a gonadotrophin-releasing hormone analogue before hysterectomy and myomectomy should be considered if uterine fibroids are causing an enlarged or distorted uterus.

### References

NICE Guidance
https://www.nice.org.uk/guidance/ng88

NHS England Evidence-based interventions guidance
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

## 7.4 Labiaplasty

Labiaplasty is not routinely funded by NCL CCGs unless surgery to the labia is in relation to a malignancy. IFR applications for other indications should be made by a gynaecologist and describe the clinical circumstances which necessitate surgery.

## 7.5 Uterovaginal prolapse

### Criteria

NCL CCGs will only fund surgical interventions for uterovaginal prolapse when conservative management has failed and when one of the following criteria has been met:

1. In cases of mild to moderate symptomatic prolapse where a comprehensive, documented course of pelvic muscle exercises has been unsuccessful and a trial of pessary has either failed or is inappropriate for long term management.
2. Moderate or severe symptomatic prolapse (including those combined with urethral sphincter incompetence or urinary/faecal incontinence).

Note: Patients who smoke should have attempted to stop smoking 8 to 12 weeks before referral to reduce the risk of surgery and the risk of post-surgery complications.

# 8 Ophthalmology

## 8.1 Blepharoplasty (surgery on the lower or upper eyelid, correction of ptosis)

### Criteria

This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced:

- Formal visual field results will be required, (either by an optician or in secondary care) and procedure will only be considered if visual field reduced to 120 degrees laterally and 40 degrees vertically.
- Clinical evidence of chronic compensation of ptosis through elevation of the brow.
- Significant ectropion or entropion that requires correction.
- All other causes of visual field defect have been excluded.

### References

Correlation of the Vision-related Functional Impairment Associated with Blepharoptosis and the Impact of Blepharoptosis Surgery, Thomas J. Federici,et al
https://www.aaojournal.org/article/S0161-6420(99)90354-8/abstract

Brow ptosis: are we measuring the right thing. The impact of surgery and the correlation of objective and subjective measures with postoperative improvement in quality-of-life, F Mellington and R Khooshabeh
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3396178/

## 8.2 Cataract surgery

### Criteria

***Exclusions from the policy***

- Patients with confirmed or suspected malignancy.
- Patients with acute trauma or suspected infection.
- Paediatric patients.

***Commissioning criteria***

NCL CCGs do not routinely fund cataract surgery unless patients meet the following criteria:

- Patient has a best corrected visual acuity of 6/9 or worse in either the first or second eye

**AND**

- Patient has impairment in lifestyle such as substantial effect on activities of daily living, leisure activities, and risk of falls.

All patients should be given the opportunity to engage with shared decision making at each point in the pathway to cataract surgery (e.g. optometrists, GPs, secondary care), to ensure they are well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration.

- Surgery is also indicated for management of cataract with co-existing ocular comorbidities*.
- Where patients have a best corrected visual acuity better than 6/9, specialist assessment should still be considered where there is a clear clinical indication or the patient has impairment in lifestyle such as substantial effect on activities of daily living, leisure activities, or risk of falls
- For NHS treatment to be provided, there needs to be mutual agreement between the provider and the **responsible** (i.e. paying) commissioner about the rationale for cataract surgery **prior to undertaking the procedure** (for example via the individual funding request [IFR] service).

*List of ocular comorbidities:

- Glaucoma
- Conditions where cataract may hinder disease management or monitoring, including diabetic and other retinopathies including retinal vein occlusion, and age related macular degeneration; neuro-ophthalmological conditions (e.g. visual field changes); or getting an adequate view of fundus during diabetic retinopathy screening
- Occuloplastics disorders where fellow eye requires closure as part of eyelid reconstruction
- Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty)
- Corneal or conjunctival disease where delays might increase the risk of complications (e.g. cicatrising conjunctivitis)
- Severe anisometropia in patients who wear glasses
- Posterior subcapsular cataracts

### Reference

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-9a-Cataract-Surgery-Policy.pdf

## 8.3 Chalazia removal (applies to age 13+)

### Criteria

NCL CCGs will not routinely fund incision and curettage (or triamcinolone injection for suitable candidates) of chalazia unless at least one of the following criteria have been met:

- The chalazion has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks
- The chalazion interferes significantly with vision

- The chalazion interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy
- The chalazion is a source of infection that has required medical attention twice or more within a six month time frame
- The chalazion is a source of infection causing an abscess which requires drainage
- If malignancy (cancer) is suspected e.g. Madarosis/recurrence/other suspicious features, in which case the lesion should be removed and sent for histology as for all suspicious lesions

Consider management of co-existing risk factors:

- Chronic blepharitis
- Seborrhoeic dermatitis
- Acne rosacea

## References

NHS England Evidence-based interventions guidance
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

# 9 Orthopaedic procedures

## 9.1 Autologous Chondrocyte Implantation (ACI)

### Criteria

Autologous chondrocyte implantation (ACI) is recommended as an option for treating symptomatic articular cartilage defects of the knee, only if:

- the person has not had previous surgery to repair articular cartilage defects

**AND**

- there is minimal osteoarthritic damage to the knee (as assessed by clinicians experienced in investigating knee cartilage damage using a validated measure for knee osteoarthritis)

**AND**

- the defect is over 2 $cm^2$
- The procedure is done at a tertiary referral centre and the referral **must** be initiated by a specialist

### Reference

https://www.nice.org.uk/guidance/ta477
Review October 2020

## 9.2 Bunions and hallux valgus

### Criteria

CCGs will not routinely fund bunion surgery for prophylactic or cosmetic reasons for asymptomatic bunions. Bunion and hallux valgus surgery is justified and appropriate when:

- The patient experiences persistent pain and significant disturbance to lifestyle or activities of daily living and/or the second toe is involved

**AND**

1. Appropriate conservative measures have been tried over a 6 month period and failed to relieve symptoms, including: evidence based non-surgical treatments, i.e. analgesia, bunion pads, footwear modifications (e.g. accommodative footwear and orthoses)

**AND**

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

**AND**

3. Patient understands that surgery may relieve pain and improve the alignment of the toe in most people; however, there is no guarantee that the foot will be perfectly straight or pain-free after surgery

*There is a higher risk of ulceration or other complications, in patients with neuropathy or diabetes. Such patients should be referred for an early assessment.*

*It is important to note that this policy does not cover Hallux rigidus (osteoarthritis of the first metatarsophalangeal joint) because the management is different to that of a bunion.*

### Reference

NICE Guidelines
https://www.nice.org.uk/guidance/ipg332

## 9.3 Carpal tunnel syndrome release

### Criteria

- Mild cases with intermittent symptoms causing little or no interference with sleep or activities require no treatment.
- Cases with intermittent symptoms which interfere with activities or sleep should first be treated with:
  - Corticosteroid injection(s)*

    **OR**
  - Nocturnal splinting**
- NCL CCGs do not routinely fund surgical treatment of carpal tunnel unless one of the following criteria are met:
  - Symptoms significantly interfere with daily activities and sleep and have not settled to a manageable level with either one local corticosteroid injection and/ or nocturnal splinting for a minimum of 8 weeks

    **OR**
  - There is either:
    - a permanent reduction in sensation in the median nerve distribution

      **OR**
    - muscle wasting or weakness of thenar abduction.
- Nerve Conduction Studies if available are suggested for consideration before surgeryto predict positive surgical outcome or where the diagnosis is uncertain.

* There is good evidence for the short term effectiveness (8-12 weeks) of steroid injections.

** Wrist splints worn at night are less effective than steroid injections.

### Reference

NHS England Evidence-based interventions guidance
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

## 9.4 Dupuytren's contracture release

### Criteria

- Treatment is not indicated in cases where there is no contracture, and in patients with a mild (less than 20°) contracture, or one which is not progressing and does not impair function.
- NCL CCGs do not routinely fund surgical treatment (needle fasciotomy, fasciectomy and dermofasciectomy) for Dupuytren's contracture unless the following criteria are met:
  - finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint.

  **OR**
  - severe thumb contractures which interfere with function
- Collagenase clostridium histolyticum for treating Dupuytren's contracture is funded according to criteria set out in NICE TA459.
- Radiation therapy will not be funded due to a lack of evidence of clinical effectiveness.

### References


NICE technology appraisal guidance 459
https://www.nice.org.uk/guidance/ta459

NICE interventional procedures guidance 573
https://www.nice.org.uk/guidance/ipg573

NHS England Evidence-based interventions guidance
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf


## 9.5 Ganglion excision

### Criteria

Wrist ganglia:

- No treatment is required unless the ganglion is causing pain or tingling/ numbness or concern (worried it is a cancer)
- First line treatment is aspiration if the ganglion is causing pain, tingling/ numbness or concern
- NCL CCGs do not routinely fund surgical excision of wrist ganglia unless aspiration has failed to resolve the pain or tingling/ numbness and there is restricted hand function.

Seed ganglia that are painful:

- First line treatment is puncture/ aspiration of the ganglion using a hypodermic needle
- NCL CCGs do not routinely fund surgical excision of seed ganglia that are painful unless the ganglia persists or recurs after puncture/ aspiration.

Mucous cysts:

- NCL CCGs do not routinely fund surgical excision of mucous cysts unless there is recurrent spontaneous discharge of fluid or significant nail deformity.

### Reference

NHS England Evidence-based interventions guidance
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

## 9.6 (Primary) Hip arthroplasty

### Criteria

***Exclusions from the policy***

- Children.
- Patients with confirmed or suspected malignancy, acute trauma, suspected infection and inflammatory arthropathy.
- Patients with underlying disease (such as haemophilia or sickle cell) related hip disease.
- Young adults with abnormal hip anatomy.

***Commissioning criteria***

NCL CCGs do not routinely fund total hip replacement unless patients meet **ALL** of the following criteria:

- The patient has osteoarthritis with joint symptoms (pain, stiffness and reduced function) that have a substantial impact on quality of life as agreed with the patient and/ or the patient's representative, referring clinicians and surgeons

**AND**

- The symptoms are refractory to non-surgical treatment (including analgesia, exercise, physiotherapy and weight loss, where appropriate)

**AND**

- The patient's symptoms are consistent with degenerative disease, and prior to arthroplasty there is radiological confirmation of this

**AND**

- The patient has been engaged in shared decision making regarding treatment options.

### Advice to primary care practitioners

The following section is designed to aid decision making in primary care and does not form part of the commissioning criteria.

- Osteoarthritis (OA) is the most common form of arthritis in the United Kingdom and the hip is a commonly affected site. Important consequences are pain, limitation of daily activities and reduction in quality of life.
- It is important to recognise that OA may not be progressive and most patients may be successfully managed with non-surgical measures in primary or intermediate care.
- Patients should be encouraged to engage in conservative treatments, which include education and lifestyle modifications, exercise and weight loss (where appropriate).
- Primary care practitioners should encourage smoking cessation and weight reduction, offering referral to appropriate services, where required.

- An earlier referral to secondary care for those with suspected end stage hip OA may be appropriate as conservative measures are unlikely to improve the patient's pain or quality of life.
- Primary care practitioners should ensure that the patient has meaningfully engaged with conservative management, where appropriate, prior to referral for hip replacement surgery. These lifestyle changes have the potential to improve general health and wellbeing, as well as intervention success rates and enhance recovery times from surgery.
- Clinical judgement should be used to assess severity of symptoms and consideration of referral for surgical opinion, as there are currently no scoring systems validated for clinical use.
- In conjunction with this, patients should be given the opportunity to engage with shared decision making prior to referral for surgery. This may occur in primary care or interface services, such as Musculoskeletal Clinical Assessment and Treatment Service (MCATS), where applicable.
- At referral, primary care practitioners must ensure that they supply all the relevant information to secondary care, particularly concerning conservative treatments.

***Decision aids***

In line with best practice, shared decision making should involve the use of a decision-making aid. These tools can be accessed online at:
https://www.england.nhs.uk/rightcare/shared-decision-making/

### Reference

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-3a-Hip-Arthroplasty-Policy.pdf

## 9.7 Interventional treatments for back pain – Overview

### Overarching criteria

For many patients, consideration of interventional treatments for back pain only arises after conservative management in primary care or specialist musculoskeletal services.

The following exclusions apply to policies on interventional treatments for back pain:

- Children*.
- Patients thought to have/ have cancer (including metastatic spinal cord compression).
- Patients with neurological deficit (spinal cord compression or cauda equina symptoms), fracture or infection.

*Eligibility criteria for interventional treatments for back pain relate to people aged over 16 years.

### Advice for Primary Care Practitioners

- Low back pain is a very common presentation, especially to General Practice. It is a soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs. Most people's low back pain is described as 'non-specific'. Some people also get back symptoms radiating down one or both legs (radicular symptoms/ sciatica). Radicular symptoms are caused, when the nerves from the back, are irritated causing pain, numbness or tingling down the leg.
- This pain is usually self-limiting and the majority of patients will find their symptoms resolve without treatment or with conservative management. Conservative management may include reassurance, advice and guidance with a holistic assessment (where tools such as STarT Back can be helpful) and/or simple analgesia with safety netting. Patients with "red flag" pathologies should be treated on alternative pathways.
- **The commissioning criteria set out in this document should not delay referral for assessment of patients with uncontrollable pain despite conventional treatment.**
- Primary care practitioners must ensure that patients have engaged in shared decision making for potential further intervention and that they supply all the relevant information to secondary care, particularly concerning conservative treatments.
- Primary care should ensure that, where appropriate, the patient has meaningfully engaged with conservative management. These include education and lifestyle modifications, exercise and physiotherapy. Primary care practitioners should encourage smoking cessation and weight reduction (where appropriate), offering referral to appropriate services, where required. These lifestyle changes have the potential to improve general health and wellbeing, as well as, intervention success rates and enhance recovery times from surgery.

### Reference

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf

## 9.8 Interventional treatments for back pain – Acupuncture

NCL CCGs do not routinely fund acupuncture for back pain.

### Reference

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf

## 9.9 Interventional treatments for back pain – Discectomy

### Criteria

NCL CCGs do not routinely fund discectomy unless the patient fulfills the following criteria and prior approval has been obtained:

- The patient has spinal pain associated with radicular pain/ myotomal pain consistent with the level of spinal involvement

**AND**

- The patient has shown no sign of improvement despite conventional therapy for 12 weeks

**AND**

- Patients have acute, severe and unremitting sciatica concordant with disc herniation demonstrated on MRI scan within 12 weeks (unless contraindicated).

### Reference

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf

## 9.10 Interventional treatments for back pain – Epidurals

### Criteria

- NCL CCGs do not routinely fund epidural injections for neurogenic claudication in people who have central spinal canal stenosis.
- NCL CCGs do not routinely fund epidural injections of local anaesthetic and steroid unless the patient fulfills the following criteria and prior approval has been obtained:
    - The patient has spinal pain associated with radicular pain/ myotomal pain consistent with the level of spinal involvement

    **AND**

    - The patient has moderate-severe symptoms that have persisted for 12 weeks or more (earlier if there are motor symptoms or there is no access to MRI)

    **AND**

    - The patient has shown no sign of improvement despite conventional therapy of advice, reassurance, analgesia and manual therapy

    **AND/OR**

    - The MRI scan (unless contraindicated) shows pathology concordant with the clinical diagnosis.

A maximum of 3 epidural injections will be permitted, with evidence based on the following response rates:

- 30% improvement after the first injection
- 50% improvement after the second injection

| |
|---|
| For patients with persisting symptoms after 3 injections, re-approval of treatment with epidural injections will be needed through the IFR panel. This may be an older/ frailer patient who derives medium term benefit but are unsuitable or unwilling to have surgery. |
| **References** |
| London Choosing Wisely<br>https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf<br><br>NICE guideline 59<br>https://www.nice.org.uk/guidance/ng59<br><br>NHS England Evidence-based interventions guidance<br>https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf |

## 9.11 Interventional treatments for back pain – Epidural lysis

| |
|---|
| NCL CCGs do not routinely fund epidural lysis. |
| **Reference** |
| NICE Interventional procedures guidance 333<br>https://www.nice.org.uk/guidance/ipg333 |

## 9.12 Interventional treatments for back pain – Lumbar disc replacement

| |
|---|
| NCL CCGs do not routinely fund lumbar disc replacement surgery. |
| **Reference** |
| London Choosing Wisely<br>https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf |

## 9.13 Interventional treatments for back pain – Ozone discectomy

| |
|---|
| NCL CCGs do not routinely fund ozone discectomy. |
| **Reference** |

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf

## 9.14 Interventional treatments for back pain – Radiofrequency denervation

**(including non-anterior radicular cervical, thoracic and lumbar areas)**

### Criteria

NCL CCGs do not routinely fund radiofrequency denervation unless the patient fulfills the following criteria and prior approval has been obtained:

- Patient has chronic moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral

**AND**

- Conservative management including physiotherapy and multidisciplinary input has failed to achieve meaningful relief of pain

**AND**

- The main source of pain is thought to come from structures supplied by the medial branch nerve*

**AND**

- The patient has had an 80% improvement in pain from a diagnostic medial branch block, which is clearly documented in the patient's notes.

For each affected nerve level, the patient should have one diagnostic medial branch block followed by one therapeutic radiofrequency denervation procedure. If further treatment is required through radiofrequency denervation, approval should be sought through the IFR panel.

**** Clinical features suggestive of a facet joint pain component***

Although no reliable clinical features or physical signs identify 'facet joint pain' accurately, The NICE NG59 guideline development group (GDG) agreed that the features identified by a UK based consensus group might be helpful in identifying those patients who may benefit from a radiofrequency denervation. The features include:

- Increased pain unilaterally or bilaterally on lumbar para-spinal palpation
- Increased back pain on 1 or more of the following:
  - extension (more than flexion)
  - rotation
  - extension/ side flexion
  - extension/ rotation

**AND**

- No radicular symptoms

**AND**

- No sacroiliac joint pain elicited using a provocation test.

## References

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf

NICE guideline 59
https://www.nice.org.uk/guidance/ng59

NHS England Evidence-based interventions guidance
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

# 9.15 Interventional treatments for back pain – Sacroiliac joint injections (diagnostic and therapeutic)

## Criteria

- NCL CCGs do not routinely fund diagnostic sacroiliac joint injections unless the following criteria are met:
  - Patient is under the care of a specialist

    **AND**
  - Patient has persistent pain for 12 weeks or longer despite conservative management*

  The patient may have up to two diagnostic injections (if both short and long acting injections are being used) within a two-week period.

  The second diagnostic injection may only be given if the first elicits 80% improvement in pain and this is clearly documented in the notes.
- Therapeutic sacroiliac joint injections are not routinely funded by NCL CCGs

*This eligibility criterion is intended to reduce avoidable harm to patients considering that: (1) Non-specific low back pain is usually self-limiting and the majority of patients will find their symptoms resolve without treatment or with conservative management, and (2) more invasive treatments carry the risk, even if small, of harm to patients.

## Reference

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf

## 9.16 Interventional treatments for back pain – Spinal cord stimulation

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be directed to NHS England.

## 9.17 Interventional treatments for back pain – Spinal decompression

### Criteria

NCL CCGs do not routinely fund spinal decompression unless the patient fulfills all of the following criteria and prior approval has been obtained:

- The patient has spinal pain associated with radicular pain/ myotomal pain consistent with the level of spinal involvement

**AND**

- The MRI scan (unless contraindicated) shows one or more areas of spinal stenosis whereby the pathology is concordant with the clinical diagnosis.

**AND**

- The patient has shown no sign of improvement despite conventional therapy for 1 year.

### Reference

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf

## 9.18 Interventional treatments for back pain – Spinal fusion

NCL CCGs do not routinely fund spinal fusion surgery for non-radicular back pain.

### Reference

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf

## 9.19 Interventional treatments for back pain – Spinal injections (diagnostic and therapeutic)

- NCL CCGs do not routinely fund the following injections for non-specific low back pain:
  - Facet joint injections
  - Medial branch blocks (applies to therapeutic medial branch blocks only; see below for diagnostic medial branch blocks)
  - Intradiscal therapy
  - Prolotherapy
  - Trigger point injections with any agent, including botulinum toxin
  - Epidural steroid injections (see also separate section on epidurals for other indications)
  - Any other spinal injections not specifically covered above
- NCL CCGs do not routinely fund diagnostic medial branch blocks unless the following criteria are met:
  - It is being used as a diagnostic tool to establish whether the patient is likely to respond to radiofrequency denervation

  **AND**
  - Patient is under the care of a specialist

  **AND**
  - Patient has persistent pain for 12 weeks or longer despite conservative management*

Patients who experience positive responses to diagnostic medial branch blocks (as defined in the section relating to radiofrequency denervation) should be offered radiofrequency denervation rather than repeated medial branch blocks when seeking further treatment.

*This eligibility criterion is intended to reduce avoidable harm to patients considering that: (1) Non-specific low back pain is usually self-limiting and the majority of patients will find their symptoms resolve without treatment or with conservative management, and (2) more invasive treatments carry the risk, even if small, of harm to patients.

### References


NICE guideline 59
https://www.nice.org.uk/guidance/ng59

NHS England Evidence-based interventions guidance
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf

## 9.20 Knee arthroplasty

### Criteria

***Exclusions from the policy***

- Patients with joint failure from causes other than degenerative disease/ osteoarthritis
- Patients with confirmed or suspected malignancy
- Patients with acute trauma or suspected infection
- Patients with inflammatory arthropathies
- Paediatric patients

***Commissioning criteria***

NCL CCGs do not routinely fund total or partial knee replacement surgery unless patients meet **ALL** of the following criteria:

- Osteoarthritis with joint symptoms (pain, stiffness, reduced function, joint instability) that have a substantial impact on quality of life as agreed with the patient and/ or the patient's representative, referring clinicians and surgeons

**AND**

- The symptoms are refractory to non-surgical treatment (including pain relief, exercise, physiotherapy and weight loss where appropriate)

**AND**

- The patient's symptoms are consistent with degenerative disease, and prior to arthroplasty there is radiological confirmation of this

**AND**

- The patient has been engaged in shared decision making regarding treatment options.

### Advice to primary care practitioners

The following section is designed to aid decision making in primary care and does not form part of the commissioning criteria.

- It is important to note that osteoarthritis (OA) may not be progressive and many patients can be successfully managed with non-surgical measures in primary care.
- Patients should be encouraged to be involved in self-management of core (non-surgical) treatments, which includes education and lifestyle modifications, exercise and weight loss (where appropriate).
- Patients who smoke should be advised to attempt to stop smoking at least 12 weeks before surgery and should be offered support with smoking cessation services.
- Patients with raised BMI should be supported to lose weight and, where appropriate, offered access to local weight loss services (where these services are available).
- Clinical judgement should be used with regards to assessing severity of symptoms and considering referral for surgical opinion, as there are currently no classification scores validated for clinical use.
- Prior to referral, primary care practitioners should ensure that patients have meaningfully engaged with non-surgical management.

- Referrals to secondary care should be via the MSK interface services (where such pathways are in place).
- Consider earlier referral to secondary care for patients with suspected end-stage OA.

***Decision aids***

To support with informed decision making, patients should be given the opportunity in primary care to complete the Decision Aid tools on knee osteoarthritis and knee replacement surgery. These tools can be accessed online at: https://www.england.nhs.uk/rightcare/shared-decision-making/

## Reference

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-4a-Knee-Arthroplasty-Policy.pdf

# 9.21 Knee arthroscopy

## Criteria

***Exclusions from the policy***

- Patients receiving an arthroscopic procedure as part of another surgical procedure e.g. high tibial osteotomy or unicompartmental arthroplasty
- Patients with acute trauma/ injury
- Patients with ligament rupture
- Patients with a meniscal surgical target
- Patients with suspected infection
- Patients with suspected avascular necrosis
- Patients with confirmed or suspected malignancy
- Patients with inflammatory arthropathies
- Paediatric patients
- Patients requiring chondroplasty
- Patients requiring synovial biopsy and synovectomy
- Patients requiring excision synovial plica

Those few patients with osteoarthritis who also have a clear history of a truly locked knee (i.e. inability of knee extension on clinical examination, as opposed to morning joint stiffness (aka gelling), 'giving way' or X-ray evidence of loose bodies) will need therapeutic arthroscopic intervention.

***Commissioning criteria***

NCL CCGs do not routinely fund arthroscopic lavage and debridement for the treatment of knee osteoarthritis.

## Advice to primary care practitioners

The following section is designed to aid decision making in primary care and does not form part of the commissioning criteria.

- High quality evidence does not support the use of knee arthroscopic surgery in most patients with degenerative disease (with or without osteoartiritis [OA]).
- Asymptomatic meniscal tears are very common in middle and older aged patients and are often an incidental finding on MRI. There is mixed opinion regarding the clinical identification of those tears for which arthroscopic treatment is clinically effective.
- The diagnosis of OA can be made clinically without imaging if a person is 45 or over and has activity-related joint pain and has either no morning joint-related stiffness, or morning stiffness that lasts no longer than 30 minutes. (If requesting X-rays for degenerative disease, weight-bearing standing films should be requested).
- For patients who are symptomatic with degenerative disease including OA, first-line treatment should ideally be with a comprehensive programme of non-surgical measures, including education, exercise, physiotherapy, simple analgesia and steroid injection (where acceptable to the patient).
- Corticosteroid injections can be offered in primary care or community care (where acceptable to the patient); they can provide pain relief and may allow patients to better engage with physiotherapy.
- Referrals to secondary care should be triaged via the MSK interface services (where such pathways are in place).
- Patients who smoke should be offered support with smoking cessation at least 12 weeks prior to surgery.
- Patients with raised BMI should be supported to lose weight and, where appropriate, offered access to local weight loss services (where available).
- Patients should be offered the opportunity to engage with shared decision making either in primary or secondary care. There are decision tools available online for the treatment of knee OA (available at https://www.england.nhs.uk/rightcare/shared-decision-making/) and a non-validated aid for arthroscopy treatment of degenerative disease (available at https://www.bmj.com/content/357/bmj.j1982).

## Reference

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-5a-Knee-Arthroscopy-Policy.pdf

## 9.22 Subacromial decompression in the treatment of subacromial shoulder pain

### Criteria

***Exclusions from the policy***

- Emergency referral (same day):
  - Acutely painful red warm joint – e.g. suspected infected joint
  - Trauma leading to loss of rotation and abnormal shape – unreduced shoulder dislocation
- Urgent referral (<2 weeks) to secondary care:
  - Shoulder mass or swelling – suspected malignancy
  - Sudden onset of acute pain and/ or loss of ability to actively raise the arm (with or without trauma) – acute rotator cuff tear
  - New symptoms of inflammation in several joints – systemic inflammatory joint disease (refer to rheumatology)
- Paediatric patients are excluded from the policy.

***Commissioning criteria***

NCL CCGs do not routinely fund subacromial decompression surgery unless patients meet **ALL** of the following criteria:

- The patient has had symptoms for at least 3 months from the start of treatment

**AND**

- Symptoms are intrusive and debilitating (for example waking several times a night, pain when putting on a coat)

**AND**

- The patient has been compliant with conservative management (education, rest, nonsteroidal anti-inflammatory drugs [NSAIDs], simple analgesia, appropriate physiotherapy) for at least 6 weeks

**AND**

- A bursal injection has been considered* (if acceptable to the patient)

**AND**

- Following bursal injection (where given) above symptoms have returned**

* This may be done in primary, community or secondary care as appropriate.

** Where symptoms recur following bursal injection, this will usually be apparent by 8 weeks after injection.

### Advice to primary care practitioners

- Subacromial pain and impingement syndrome are most typically seen in relatively active patients between 35-60 years of age.

- Shoulder impingement syndrome is an uncommon diagnosis in patients under 30 years or over 80 years and consideration should be given to alternative causes of symptoms.
- Assessment and diagnosis of subacromial shoulder pain should be clinically guided and imaging is not usually an essential component of assessment in primary care. However, where patients present with traumatic or sudden change to subacromial pain, referral and imaging are advisable.
- First-line management of most patients should be with conservative measures, including rest, education, simple analgesia, physiotherapy and a bursal injection (where locally available and acceptable to the patient).
- The majority of patients will not require a surgical procedure and can be successfully managed with conservative treatment in primary care.
- Many patients with subacromial shoulder pain will have pathology amenable to improvements with appropriate structured physiotherapy which should start to show benefits over a course of six weeks e.g. through postural correction and strengthening of the rotator cuff and scapula muscles.
- If patients have improved following six weeks of appropriate physiotherapy, it is reasonable to consider a second six week (or longer) course of physiotherapy.
- A bursal injection of steroid or local anaesthetic may provide pain relief for up to three months and allow patients to better engage with physiotherapy and rehabilitation (a maximum of two bursal injections can be offered).
- Prior to referral to secondary care, the primary care practitioner should ensure that patient wishes to discuss surgical treatment options.
- When making a referral for patients with subacromial pain, it is expected that this should be via the MSK interface services (where such pathways are in place).
- Evidence regarding the effectiveness of surgical management of subacromial pain is conflicting, however the procedure can be effective in certain circumstances and patient selection is key.
- Patients undergoing surgery for subacromial pain and shoulder impingement can expect a period of recovery and rehabilitation of up to six months. As neither conservative nor operative pathways seem to offer a faster restoration of function, patient involvement in decision making is crucial.
- The risk profile of subacromial decompression is low and similar to other shoulder arthroscopy procedures; the commonest adverse events are:
- Pain and stiffness: around 5 to 20 people in 100 will have some degree of ongoing pain and/ or stiffness (including frozen shoulder),
- Infection: most commonly a superficial infection and occurs in <1 in 100 people; deep infection is rare (c. 0.02%)
- Primary care practitioners should encourage smoking cessation and weight reduction (where appropriate), offering referral to appropriate services where required. These lifestyle changes have the potential to improve general health and wellbeing, as well as intervention success rates and enhance recovery times from surgery.
- Consider earlier referral to secondary care services in certain situations (for example patients who are wheelchair bound and/ or patients with lower limb amputations).
- Patients must have the opportunity to engage with a shared decision making process prior to surgical intervention.

## References

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-8a-Subacromial-Shoulder-Pain-Policy.pdf

# 9.23 Trigger finger release in adults

## Criteria

- Mild cases of trigger finger which cause no loss of function require no treatment or avoidance of activities which precipitate triggering and may resolve spontaneously.
- Cases interfering with activities or causing pain should first be treated with:
  - one or two steroid injections*

  **OR**

  - splinting of the affected finger for 3-12 weeks**
- NCL CCGs do not routinely fund surgery for trigger finger unless:
  - the triggering persists or recurs after one of the above measures

  **OR**

  - the finger is permanently locked in the palm

  **OR**

  - the patient has previously had 2 other trigger digits unsuccessfully treated with appropriate nonoperative methods

  **OR**

  - the patient has diabetes.
- Surgery is usually effective and requires a small skin incision in the palm, but can be done with a needle through a puncture wound (percutaneous release).

*There is strong evidence to indicate one or two steroid injections are likely to be successful, however trigger finger may recur, especially in people with diabetes.

**There is weak evidence to support the use of splinting.

## Reference

NHS England Evidence-based interventions guidance
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

# 10 Other therapies

## 10.1 Complementary and alternative medicines

NCL agrees ONLY to fund applications for complementary treatments where there are current NICE recommendations. The specific reference and supporting section of the NICE Guidance must be included in the application.

Applications must include the patient's diagnosis, the treatment for which is being applied for, the duration of treatment, the expected outcomes and total cost of the treatment.

### Acupuncture (applies age 2+)

NCL agrees ONLY to fund applications for complementary treatments where there are current NICE recommendations. The specific reference and supporting section of the NICE Guidance must be included in the application.

### Bio-Feedback (applies age 2+)

NCL agrees ONLY to fund applications for complementary treatments where there are current NICE recommendations. The specific reference and supporting section of the NICE Guidance must be included in the application.

### Electrical stimulation (applies age 2+)

NCL agrees ONLY to fund applications for complementary treatments where there are current NICE recommendations. The specific reference and supporting section of the NICE Guidance must be included in the application.

### Hypnotherapy (applies age 2+)

NCL agrees ONLY to fund applications for complementary treatments where there are current NICE recommendations. The specific reference and supporting section of the NICE Guidance must be included in the application.

### Osteopathy/ osteopathic intervention (applies age 2+)

NCL agrees ONLY to fund applications for complementary treatments where there are current NICE recommendations. The specific reference and supporting section of the NICE Guidance must be included in the application.

### Selected use in palliative care (applies age 2+)

NCL agrees ONLY to fund applications for complementary treatments where there are current NICE recommendations. The specific reference and supporting section of the NICE Guidance must be included in the application.

| List of interventions not funded | |
|---|---|
| NHS NCL will NOT routinely fund complementary therapies including (but not limited to) the following because of the lack of sufficient evidence of effectiveness. This list is not exhaustive. | |
| Active release technique | Hypnosis |
| Acupuncture (applies to age 2+) | Hypnotherapy (applies to age 2+) |
| Acupressure | Hyperoxygen therapy |
| Airrosti (Applied Integration for the Rapid Recovery of Soft Tissue Injuries) technique | Immunoaugmentive therapy |
| Alexander technique | Infratronic Qi-Gong machine |
| Amma therapy | Insulin potentiation therapy |
| Antineoplastons/ Antineoplaston therapy and sodium phenylbutyrate | Inversion therapy |
| Apitherapy | Iridology |
| Applied kinesiology | Iscador |
| Aromatherapy | Juvent platform for dynamic motion therapy |
| Art therapy | Kelley/ Gonzales therapy |
| Aura healing | Laetrile |
| Autogenous lymphocytic factor | Live blood cell analysis |
| Auto urine therapy | Macrobiotic diet |
| Bioenergetic therapy | Magnet therapy |
| Biofeedback (applies to age 2+) | Mistletoe therapy |
| Biofield Cancell (Entelev) cancer therapy | Metodo Dinamico de Estimulacion Kinesica (MEDEK) therapy or Dynamic Method for Kinetic Stimulation therapy |
| Bioidentical hormones | Meditation/transcendental meditation or other relaxation or talking therapies other than the IAPT services routinely commissioned from local Mental Health trusts. |
| Brain integration therapy | Megavitamin therapy (also known as orthomolecular medicine) |
| Carbon dioxide therapy | Meridian therapy |
| Cellular therapy | Mesotherapy |
| Chakra healing | Moxibustion |
| Chelation therapy | MTH-68 vaccine |
| Chung Moo Doe therapy | Music therapy |
| Coley's toxin | Myotherapy |
| Colonic irrigation | Neural therapy |

| | |
|---|---|
| Colour therapy | National Upper Cervical Chiropractic Ass (NUCCA) procedures |
| Conceptual mind-body techniques | Osteopathy/ osteopathic intervention (applies to age 2+) |
| Craniosacral therapy | Ozone therapy |
| Crystal healing | Pfrimmer deep muscle therapy |
| Cupping | Polarity therapy |
| Dance/Movement therapy | (Poon's) Chinese blood cleaning |
| Digital myography | Primal therapy |
| Ear candling | Psychodrama |
| Egoscue method | Purging |
| Electrical stimulation (applies to age 2+) | Qigong longevity exercises |
| Electrodermal stress analysis | Ream's testing |
| Electrodiagnosis according to Voll (EAV) | Reflexology (zone therapy) |
| Equestrian therapy (e.g. hippotherapy) | Reflex therapy |
| Essential Metabolics Analysis (EMA) | Reiki |
| Essiac | Remedial massage |
| Feldenkrais method of exercise therapy (also known as awareness through movement) | Revici's guided chemotherapy |
| Flower essence | Rife therapy/Rife machine |
| Fresh cell therapy | Rolfing (structural integration) |
| Functional intracellular analysis | Rubenfeld synergy method (RSM) |
| Gemstone therapy | 714-X (for cancer) |
| Gerson therapy | Sarapin injections |
| Glyconutrients | Shark cartilage products |
| Graston technique | Telomere testing |
| Greek cancer cure | Therapeutic Eurythmy-movement therapy |
| Guided imagery | Therapeutic touch |
| Hair analysis | Thought field therapy (TFT) (Callahan techniques training) |
| Hako-Med machine (electromedical horizontal therapy) | Tai Chi |
| Hellerwork | Trager approach |
| Homeopathy | Traumeel preparation |
| Hoxsey method | Vascular endothelial cells (VECs) therapy |
| Human placental tissue | Vibrational essences |
| Hydrolysate injections | Visceral manipulation therapy |
| Humor therapy | Whitcomb technique |
| Hydrazine sulfate | Wurn technique/clear passage therapy |

| | |
|---|---|
| Hydrogen peroxide therapy | Yoga |

## 10.2 Massage – Manual lymphatic drainage (MLD)

### Criteria

NCL CCGs will not routinely fund Manual lymphatic drainage (MLD) as part of the Decongestive Lymphoedema Treatment (DLT) or on its own.

In all applications please include the patient's full diagnosis, the duration of treatment, the expected outcomes and cost of the treatment.

Applications must come from the secondary care vascular team after a full and appropriate assessment and be part of a wider programme to address the patients' symptoms.

## 10.3 Open MRI/ bariatric MRI

See individual CCGs referral criteria.

# Appendix 1: Age ranges for specific procedures

| Condition | Age relevant to policy |
|---|---|
| Acupuncture | Age 2+ |
| Bio-Feedback | Age 2+ |
| Chalazia removal | Age 13+ |
| Circumcision | Age 14+ |
| Electrical stimulation | Age 2+ |
| Hypnotherapy | Age 2+ |
| Keloidectomy | Age 2+ |
| Osteopathy/ osteopathic intervention | Age 2+ |
| Removal of benign skin lesion | Age 2+ |
| Selected use in palliative care | Age 2+ |
| Tonsillectomy | Age 2+ |

# Appendix 2: Individual Funding Request (IFR) Application Process

The clinical applicant (primary, secondary, tertiary or other) completing this form is responsible for collating all information and relevant evidence, which may involve working with other clinicians, outside of your organisation, involved in this patient's care. All forms must be typed, acronyms / abbreviations must be written out in full and all fields must be completed (or N/A stated where a field is not applicable). Incomplete mandatory fields and hand-written forms will result in the form being returned and may cause delays to consideration for funding. Please refer to your Clinical Commissioning Group's (CCGs) Individual Funding Request (IFR) policy or team (details at bottom form if any further support is required

Anonymity – please ensure that in order to protect patient identity, apart from section A, the patient is not referred to by name or initials within the application form.
* Mandatory fields for all requests ** Mandatory fields for drug requests *** Mandatory fields for non-drug requests

| **Before completing this form, please answer the following questions** | |
|---|---|
| **Is this drug or non-drug request for a treatment currently commissioned by NHS England? ***<br>*If **Yes**, then **STOP HERE** and refer to NHS England.* | **Yes** ☐ **No** ☐ |
| **Drug requests** | |
| **Is the requested intervention part of a clinical trial? ****<br>*If **Yes**, **then STOP HERE.** This funding route is not appropriate. Please speak to your trust chief pharmacist regarding drug trials.* | **Yes** ☐ **No** ☐ |
| **Is the drug listed on the National Tariff excluded drug list and is for use in accordance with a NICE Technology Appraisal Guidance / locally commissioned pathway? ****<br>*If **Yes**, **then STOP HERE.** This funding route is not appropriate. Please redirect to the appropriate High Cost Drug (HCD) team.* | **Yes** ☐ **No** ☐ |
| **Governance - Has the treatment been approved through the provider's clinical governance arrangements for the requested intervention for use? ****<br>*If **No, then STOP HERE.** The application requires trust governance approval. Evidence **MUST** be supplied e.g. drug and therapeutic committee (DTC) minutes, a letter from the DTC Chairman, if Chairman's action has been taken.* | **Yes** ☐ **No** ☐ |
| **Non drug requests** | |
| **Does the intervention requested fall under an existing policy (Treatment Access Policy (TAP), Effective Commissioning Initiative (ECI), Policy of Limited Clinical Value / Effectiveness (POLCV/E), prior approval)? *****<br>*If **Yes,** and this application is being submitted by a GP, please check whether your CCG provides a referral management, clinical assessment or prior approval service.* | **Yes** ☐ **No** ☐ |
| **Has this request already been declined by a referral management/clinical assessment centre or Prior Approval Service? *****<br>*If **Yes**, and the patient does not meet local policy criteria then your application needs to explicitly explain why your patient is clinically exceptional or rare in section G.* | **Yes** ☐ **No** ☐ |
| **Governance - Has the medical device/ intervention been approved in accordance with Provider's clinical governance arrangements *****<br>*If **No, then STOP HERE.** The application requires approval. Evidence **MUST** be supplied e.g. minutes of the governance meeting where approval was given.* | **Yes** ☐ **No** ☐ |

| Section A: Contact Information * | | |
|---|---|---|
| **1. Applicant details**<br>*The applicant should have clinical responsibility for this intervention for this patient for this specific clinical indication.*<br>*Please ensure the declaration is signed and dated (section I)* | **Name** * | |
| | **Designation/Job title** * | |
| | **Telephone** * | |
| | **nhs.net address**<br>*(no other emails accepted)* * | |
| **2. Patient details** | **Initials** * | |
| | **NHS number** * | |
| | **Date of Birth (DoB)** * | |
| | **Registered consultant** * | |
| | **Registered GP name** * | |
| | **GP practice code** * | |
| | **CCG** * | |
| | **Date of referral** * | |

| Section B: Diagnosis *<br>*(Diagnosis refers to condition that the requested intervention will treat)* | |
|---|---|
| **3. Patient diagnosis or condition** *(for which the intervention is requested)* * | |
| **4. Date of diagnosis and summary of any other relevant medical history** * | |
| **5. Does your patient have any other relevant diagnoses or co-morbidities?** *If yes, please list* * | |
| ***6.*** **What is the patient's current quality of life (QoL)?** *Please summarise the current status of the patient in terms of their QoL for example performing activities of daily living (please note the IFR panel cannot take social factors into consideration)* * | |
| ***7.*** **What is the severity of the current clinical condition, in relation to this diagnosis?** *Please use standard scoring systems e.g. World Health Organisation (WHO), Disease Activity Score (DAS28), cardiac index or those applicable to the patient's clinical diagnosis. Please include interpretation of the score where applicable* * | |

| Section C: Intervention Requested<br>*(Intervention refers to requested treatment, investigation, etc)* | | |
|---|---|---|
| ***8.*** **Details of intervention** *(for which funding is requested)* | **Name of intervention** *If the intervention forms part of a drug regimen, please document the full regimen (e.g. Drug X as part of regimen Y (consisting of drug V, drug W, drug X and drug Z)* * | |
| | **Type of Intervention** * | Drug ☐ Procedure ☐ Device ☐ Other ☐ |
| | **Planned duration of intervention** * | |
| | **Dose and frequency of drug** ** | |
| | **Route of administration of drug** ** | |
| **9. Anticipated time frames** | **Your request will be acknowledged within 5 working days of receipt.** | |
| | **Is the case more urgent than this?** *If the clinical decision needs to be made immediately on the basis of clinical urgency, the trust should proceed at its own financial risk and submit an IFR application retrospectively. The decision to treat in the event of immediate or life-threatening circumstances must be made in accordance with NHS approved provider (Trust) governance mechanisms* *<br>**Yes** ☐ **No** ☐ | |
| | **If 'Yes' please state why this case is clinically urgent** | |
| **10. Provider name*** | | **Is this provider NHS commissioned?** *<br>**Yes** ☐ **No** ☐<br>*If no, please explain why an NHS commissioned service is not appropriate* |
| **11. Provider address** * | | |

| Section D: Comparison with Standard Commissioned Intervention | |
|---|---|
| **12. What would be the standard intervention / management for this patient at this stage of their disease / condition?** * | |
| **13. What would be the expected outcome from the standard intervention for this patient?** * | |
| **14. What are the specific reasons that make the standard intervention inappropriate for this patient?** * | |

| Section E: Previous and Current Treatment/ Interventions | | | | |
|---|---|---|---|---|
| **15.Summary of all previous intervention(s) this patient has received for the condition** * *Reasons for stopping may include:* ▪ *Course completed* ▪ *No or poor response* ▪ *Disease progression* ▪ *Adverse effects/ poorly tolerated (please detail nature of adverse effect/intolerance)* *Please add more lines if required* | **Start date** | **Stop date** | **Name of Intervention** *for drugs include name, dose and frequency of use* | **Response** *reason for stopping or indicate if still continuing* |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Section F: Evidence for Effectiveness of Intervention Requested | |
|---|---|
| **16. Is the requested intervention licensed for the requested indication in the UK?** * | **Yes** ☐ **No** ☐ |

**17. Evidence***

*It is the applicant's responsibility to provide robust relevant and valid evidence to support the use of the intervention in this patient.*

*All relevant evidence should be provided. Give details of national or local guidelines/ recommendations [e.g. National Institute of Clinical Excellent (NICE), Scottish Medicines Consortium (SMC), London (Cancer) New Drugs Group etc.] and/ or full published papers (rather than abstracts) supporting the use of the requested intervention for this condition, unless the application relates to the use of an intervention in a rare disease. Please include any available data on the use of this treatment by your unit including clinical audit data for rare diseases. Copies of key references **MUST** be provided.*

| | |
|---|---|
| **(a) What is the evidence that this intervention is likely to be effective in this type of patient?** * | |
| **(b) Details of National, Regional or Local Guidelines/ Recommendations** * | |
| **(c) What are the anticipated benefits?*** | |

**18. Outcomes** *

| | |
|---|---|
| **(a) What would you consider to be a successful outcome for this intervention in this patient?** * *Include details of the parameters you intend to measure* | |
| **(b) How and when will you monitor this?** * | |
| **(c) What is the minimum timeframe/ course of treatment at which a clinical response can be assessed?** * | |

| | |
|---|---|
| **(d) What criteria will be used to decide when the intervention is no longer effective? *** *Include details of the parameters you intend to measure* | |
| **19. What are most frequent anticipated adverse effects and what would their estimated frequency be? *** | |
| **20.Do the benefits outweigh the risks? If so in what way? *** | |
| **21. What are the likely consequences for this patient if funding is not approved? *** | |
| **22. What are the other treatment options for this patient if funding is not approved? *** | |

| **Section G: Statement of Exceptionality or Rarity** | | |
|---|---|---|
| **23. On which basis are you making this request? *** | ☐ Exceptional clinical circumstances (please continue to question 24)<br>☐ Rarity of condition or presentation (please continue to question 25) | |
| **24. If exceptionality, please describe why this patient's clinical circumstances are exceptional *** *Give specific information in each section opposite to indicate how this patient is significantly different from the cohort of other patients with the same clinical condition* | (a) Please describe in detail how the clinical presentation of this patient differs from other patients with this condition | |
| | (b) Please describe why and how this patient might be expected to gain greater health benefit from this intervention compared to other patients with this condition | |
| **25. If rarity, please describe why this patient's condition or clinical presentation is so rare or unusual that there is no relevant commissioning arrangement in place *** | (a) Please state the UK prevalence and quote the source/reference | UK prevalence: Ref: |
| | (b) Please describe how the clinical presentation of this patient makes them rare * | |
| | (c) Please state, how many patients with the same condition or presentation as this patient does your trust / practice expect to see in the next 12 months? * | |

| **Section H: Costs and Review for Drug or Non Drug Interventions** *(to be completed by approved NHS provider Chief Pharmacist or Service Manager)* * | |
|---|---|
| **26. Total acquisition cost (inc VAT) for duration of treatment being applied for** *and associated costs such as administering a drug, phlebotomy, activity etc* * | |
| **27. State the value of any offset costs** * | |
| **28. Please benchmark these costs against London procurement contract prices** * | |
| **29. Application reviewed by chief pharmacist / service manager or nominated authorised deputy** * | **Name:** |
| | **Signature and email confirmation *:** |

| **SECTION I: APPLICANT'S DECLARATION** * | | |
|---|---|---|
| **30. Declaration** *<br>I declare that this application is complete and accurate and that all necessary supporting information and evidence has been provided on this form (and attachments) | | **Yes** ☐ **No** ☐ |
| **31. Patient consent** *<br>I confirm that the patient has given their explicit consent for their patient identifiable data to be shared with the following organisations in order to facilitate their funding request; the patient's host CCG, CSU staff, GP surgery and other clinicians and their organisation named in this form, along with any sub-contractors (who are directly involved in providing or planning my care). The sharing of this information is necessary in order to enable full consideration of this request. In the case of a minor or vulnerable adult, I confirm I have complied with the relevant legislation guidance and for people who are approving on the patient's behalf, the consent has been lawfully obtained in accordance with the Children Act 2004 and / or Mental Capacity Act 2005. | | **Yes** ☐ **No** ☐ |
| | | **Clinical applicants name and job title**: |
| **Responsible clinician name:** * | **Signature or email confirmation:** * | **Date:** *<br>**DD/MM/YY** |

Forward application to the IFR team (via Trust Service Agreements Department or equivalent, if applicable).

**For NC London CCGs: Barnet, Camden, Enfield, Haringey and Islington**
**Forms should be submitted to: ncl.ifr@nhs.net Tel. enquiries: 020 3688 1290**

**For WELC CCGs: City and Hackney, Newham, Tower Hamlets and Waltham Forest,**
**Forms should be submitted to: nelcsuwelc-ifr@nhs.net Tel. enquiries: 020 3688 1290**

**For BHR CCGs: Barking and Dagenham, Havering and Redbridge**
**Forms should be submitted to: nelcsubhr-ifr@nhs.net Tel. enquiries: 020 3688 1290**

# Appendix 3: Prior  Approval

Please refer to your local CCG for the agreed Prior  Approval process.

# Appendix 4: Evidence Based Interventions and Clinical Standards Feedback Form

| | NCL Evidence Based Interventions and Clinical Standards Policy Feedback Form |
|---|---|
| 1 | **In what capacity are you responding?** |
| | **Are you responding on behalf of an organisation or as an individual clinician?** |
| 2 | **Please confirm the issue date and version of the North Central London Evidence Based Interventions and Clinical Standards Policy?** |
| 3 | **Which of the Policy Areas relates to your feedback?** |
| 4 | **Are you proposing an amendment to the wording for the policy?** |
| | **If yes, please insert proposed rewording** |
| | **If No, are you providing a general comment?** |
| 5 | **Please state the rationale for any suggested amendments or comments?** |
| 6 | **Are you providing additional evidence to substantiate your amendments or comments?** |
| 7 | **Please provide contact details if you are happy to be contacted in relation to your submission** |
| 8 | **Date of submission** |
| | **Please submit your comments using this feedback form to**<br>**nelcsu.hpsu@nhs.net**<br>**It is suggested than individual feedback forms are submitted for individual policy areas.** |