NORTH CENTRAL LONDON

PROCEDURES OF LIMITED CLINICAL EFFECTIVENESS (PoLCE)

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.

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Background

The NCL PoLCE 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.

Procedures of Limited Clinical Effectiveness (PoLCE) 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 PoLCE 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 on annual basis, revised, updated and reissued using the most up to date and validated evidence base.
4. Effectively and consistently communicated to health care professionals within the footprint.
5. An open and transparent process, adhering to governances policies.

All five NCL CCGs have a clinically led review of PoLCE 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 PoLCE.

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 the formal process 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 patients that is clinically appropriate and based on robust evidence or with a sharp focus on patient outcome.

This policy will be reviewed 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 PoLCE application.
- Emergency or urgent care.

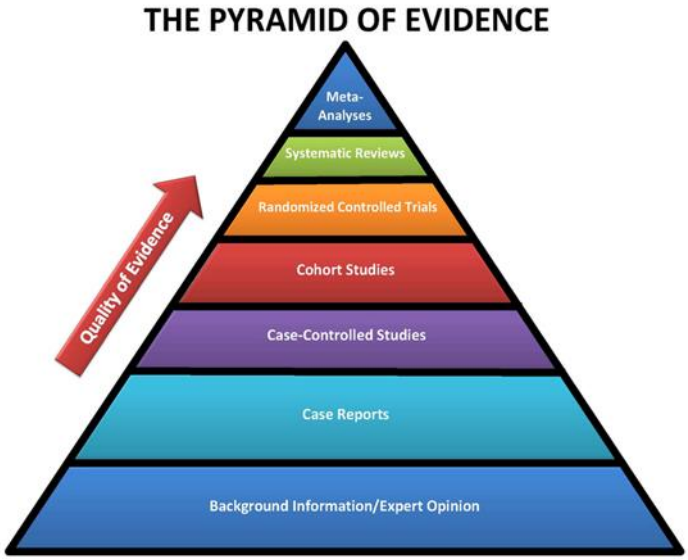
In relation to the above exclusions, the provider should be able to demonstrate the clinical need as part of the payment verification process.

Hierarchy of evidence

The NCL PoLCE 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 PoLCE 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 PoLCE 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 PoLCE 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.

Performance monitoring arrangements

Performance measures and audits will be introduced to monitor PoLCE 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 PoLCE 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 (ERS)
	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)
	Local Medical Committee (LMC)
	Local Dental Committee (LDC)
	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;
- Partial TMJ joint reconstruction;

• Known allergic reaction to any materials used in the components; • Patients with mental or neurological conditions who are unwilling or unable to follow post-operative care instructions; • Skeletally immature patients; • Patients with severe hyper-functional habits (e.g. clenching, grinding etc.)
Reference
NICE Guidance 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: Minor 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 30 kg/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 recurs or 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 or other 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 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 least 18 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 or fails to respond despite appropriate medical therapy for at least six months.

2.4 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.

2.5 Breast procedures – Breast asymmetry

Criteria

Procedures to correct breast asymmetry will not be routinely funded.

Reduction of the larger breast should be regarded as the first line treatment for patients seeking to correct breast asymmetry.

Procedures to correct breast asymmetry will only be considered for funding in the following circumstances:

- 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

2.6 Breast procedures – Gynaecomastia (male breast reduction for gynaecomastia)

(Liposuction may form part of the treatment plan for this condition)

Criteria

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

NCL CCGs will consider funding this procedure if all the criteria are met as outlined below.

The patient should meet the following criteria:

1. The patient should be 25 or over at the time of application

AND

2. Have Grade III gynaecomastia where resection would be >100gm (avoids purely minor cosmetic requests)

AND

3. BMI must be <25 (avoids pseudo-gynaecomastia requests)

AND

4. Have been screened for endocrinological causes

AND

5. Have been screened for drug related causes

AND

6. Other non-surgical treatments have been considered, tried or have been unsuccessfully

OR

7. For specific un-correctable aetiological factor identified such as androgen therapy, or caused by a side effect of treatment of another condition such as a side effect of treatment for prostate cancer. BMI should be <30 in these cases.

Documented additional information should be provided where circumstances include:

- Pain
- Gross asymmetry
- The gynaecomastia is iatrogenic.

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 – Reduction mammoplasty (female breast reduction)

Criteria

This cosmetic procedure is not routinely funded by the NCL CCGs. All patients should meet the following criteria:

1. BMI equal to or below 27 for at least two years (documented) and for at least two years post bariatric surgery
2. The patient should be 18 or over at the time of application.
3. The patient's breast size is cup H or larger.

AND

4. Evidence to be submitted to demonstrate patient is symptomatic – with at least TWO of the following for at least one year (documented evidence of GP visits for these problems):

- 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.

AND

5. Evidence to be submitted to demonstrate pain symptoms persist as documented by the physician 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.

AND

6. Chronic intertrigo, eczema or dermatitis alone will not be considered as grounds for this procedure unless the entire above are met and the patient has failed to respond to six months of conservative treatment.

OR

7. Patients with virginal hyperplasia/hypertrophy.

2.9 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 PoLCE policy.

2.10 Breast procedures – Surgical correction of nipple inversion

This cosmetic procedure is not routinely by the NCL CCGs.

2.11 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 child psychologist.
- Requests for patients over 19 years old will be considered as an IFR application

2.12 Ear procedures – Repair of external ear lobes

This procedure is not routinely funded by NCL CCGs.

2.13 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.

2.14 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

2.15 Facial procedures – Rhytidectomy (face lift)

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

2.16 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.

2.17 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.

2.18 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 through the Choosing Wisely process.

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 following criteria 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 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

2.19 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 to wear 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 least six 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

2.20 Liposuction

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

2.21 Minor skin lesions (treatment of) (applies to age 2+)

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.

Minor skin lesions include pigmented moles, comedones, corn/callous, lipoma, milia, molluscum contagiosum, sebaceous cysts (epidermoid or pilar cysts), seborrheic keratoses (basal cell papillomata), skin tags including anal tags, spider naevus (telangiectasia), warts, xanthelasma and neurofibromata.

A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be referred to an appropriate specialist for urgent assessment.

For all other benign skin lesions the NCL CCGs will only routinely fund surgery in patients meeting the following criteria:

- The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this.

AND

- This results in infections such that the patient requires 2 or more courses of oral or intravenous antibiotics per year

OR

- The lesion is obstructing an orifice or impairing field vision

OR

- The lesion significantly impacts on function e.g. restricts joint movement

OR

- Greater than 1cm facial lesions that cause significant disfigurement

OR

- Congenital deformity (this does not include normal variation).

Applications should clearly evidence the size and site of the lesion, and the impact on the patient. For example:

- a lesion of 1.5cm diameter, on the chin, which bleeds every time the patient shaves.
- a lipoma measuring 20cm x 25cm raised by 2cm lying across the left shoulder which restricts full joint movement.
- a sebaceous cyst measuring 1cm x 1cm on the right ear which regularly becomes infected and has twice required antibiotic treatment in the previous 12 months

References

NICE Guidance
http://www.nice.org.uk/guidance/csgstim/evidence/skin-tumours-including-melanomaevidence-update2

http://www.nice.org.uk/guidance/cg27/resources/guidance-referral-guidelines-forsuspected-cancer-pdf

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 (Adenoidectomy) Tonsillectomy (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 tonsillectomies with or without adenoidectomies. Adenoidectomies 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:

- FIVE or more episodes in the last year

OR

- FOUR or more episodes in each of the last two successive years

OR

- THREE or more episodes in each of the last three years

AND

- With significant impact on quality of life indicated by absence from school, work or playgroup or failure to thrive.

B. Tonsillectomy for obstructive sleep apnoea 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. Tonsillitis exacerbating existing disease such as febrile convulsions, guttate psoriasis, glomerulonephritis or rheumatic fever.

Reference

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

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

This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if 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.

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

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 gallbladder carcinoma.
- Patient is diabetic, has 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 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

5.4 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/

5.5 Varicose veins

Criteria

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

This guidance applies to each leg individually. The techniques that are normally approved are open surgery (ligation and stripping) and the endovenous techniques endovenous laser ablation (EVLA) and radiofrequency ablation (RFA) using VNUS Closure system. Sclerotherapy will not normally be funded. Factors to be taken into account when selecting the most appropriate treatment include local equipment, clinical assessment (including vein tortuosity and anatomy) and patient preference.

Criteria for eligibility

NCL will normally fund surgical or endovenous intervention for varicose veins if they are accompanied by one or more of the following complications:

- Intractable ulceration secondary to venous stasis.

OR

- Healed venous ulcerations in patients that cannot tolerate compression stockings for clinical reasons.

OR

- Significant haemorrhage from a ruptured superficial varicosity (serious enough to warrant transfusion or admission)

Alternatively

After an unsuccessful **six month trial** of conservative management (compression stockings **AND** exercise **AND** daily elevation several times a day) when varicosities result in either:

- recurrent documented thrombophlebitis (two or more episodes)

OR

- persistent skin changes (eczema, pigmentation or lipodermatosclerosis)

OR

- persistent aching, heaviness, itching or swelling severely affecting the patient's quality of life (for example the patient is unable to stand throughout the day for their job or they are woken regularly at night by severe discomfort)

5.6 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)

This procedure is not routinely funded by the NCL CCGs.

Reference

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

7.3 Hysterectomy for heavy menstrual bleeding (HMB)

Criteria

This guidance applies to patients with no identified pathology, fibroids <3cm and excludes patients if in whom there is suspected or diagnosed adenomyosis or fibroids larger than 3cm.

When agreeing treatment options for heavy menstrual bleeding with women, take into account the woman's preferences, any comorbidity and the presence or absence of fibroids (including size, number and location), polyps, endometrial pathology or adenomyosis and other symptoms such as pressure and pain. Discussions with women should cover the

benefits and risks of the various options, suitable treatments if she is trying to conceive and whether she wants to retain her fertility and/or her uterus.

If there is no identified pathology, fibroids less than 3 cm or suspected or diagnosed adenomyosis:

- Consider an LNG-IUS as the first treatment

If a woman declines or it is unsuitable, consider the following treatments:

- non-hormonal:
  - tranexamic acid
  - 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 heavy menstrual bleeding.

If treatment is unsuccessful, the woman declines pharmacological treatment, or symptoms are severe, consider referral to specialist care for further investigations and alternative treatments including surgical options of second-generation endometrial ablation or hysterectomy. For women with submucosal fibroids, consider hysteroscopic removal.

Reference

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

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 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 Chalazion (internal stye or meibomian cyst) (applies to age 13+)

Criteria

NCL CCGs will not routinely fund excision of chalazia except when the patient presents with the following:

- The cyst is present for >6 months despite conservative treatment (e.g. applying a warm compress/heat and massage at least twice daily)

AND/OR

- The site or size of the cyst interferes with the vision and documentary evidence is provided.

Consider management of co-existing risk factors:

- Chronic blepharitis

- Seborrhoeic dermatitis
- Acne rosacea

References

BMJ eyelid lumps and lesion [2014]
https://www.bmj.com/content/348/bmj.g3029

The college of Optometrists Clinical Management Guidelines of Chalazion [2015] –
https://www.college-optometrists.org/guidance/clinical-management-guidelines/chalazion-meibomian-cyst-.html

BMJ review article on Chalazion 2010
https://www.bmj.com/content/341/bmj.c4044

CKS Meibomian cyst (chalazion) November 2015
https://cks.nice.org.uk/meibomian-cyst-chalazion

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 (surgical treatment of)

Criteria

NCL CCGs will fund carpal tunnel surgery where:

1. Conservative therapy with either local corticosteroid injection and/or nocturnal splinting has been trailed for minimum of 6 weeks

AND

2. Patient has moderate to severe symptoms interfering with daily activities. This is classified as nocturnal pain or paraesthesia in the median nerve distribution and daytime symptoms with prolonged positions or repetitive hand movements, e.g. complaints of weakness or clumsiness when using the hands, difficulty holding objects, turning keys or doorknobs, button clothing, or opening jar lids.

References

Royal College of Surgeons of England (RCSEng)

British Society for Surgery of the Hand (BSSH)

British Orthopaedic Association (BOA),
https://www.boa.ac.uk/wp-content/uploads/2016/08/CTS-Guide-Final.pdf

Preston DC, Shapiro BE. Median neuropathy at the wrist. In: Electromyography and Neuromuscular Disorders: Cinica-Electrophysiologic Correlations, 3rd ed, Elsevier, 2013. p.267
https://www.elsevier.com/books/electromyography-and-neuromuscular-disorders/9781455726721

9.4 Dupuytren's contracture (fasciotomy/ fasciectomy [surgical treatment])

Criteria

NCL CCGs will fund surgical treatment for patients with Dupuytren's contracture who meet the following criteria:

1. Patient has loss of extension in the metacarpophalangeal joint by 30 degrees and cannot be straightened

OR

2. Patient has at least 10 degrees loss of extension in the proximal interphalangeal joint

OR

3. Rapid progressing over a few months.

Conservative and 'non-operative' treatment includes collagenase clostridium histolycum as per NICE guidelines. This is for patients who have a palpable cord along with MCP or PIP contracture.

Radiation therapy will not be funded due to lack of evidence of clinical effectiveness.

References

https://cks.nice.org.uk/dupuytrens-disease#!scenario

https://www.bmj.com/content/332/7538/397

NICE (2004) *Needle fasciotomy for Dupuytren's contracture.* Interventional procedure guidance 43 *National Institute for Clinical Excellence*.
https://www.nice.org.uk/guidance/ipg43

Townley, W.A., Baker, R., Sheppard, N. and Grobbelaar, A.O. (2006) Dupuytren's contracture unfolded.*British Medical Journal***332**(7538), 397-400
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1370973/

Shaw, R.B., J.r, Chong, A.K., Zhang, A. et al. (2007) Dupuytren's disease: history, diagnosis, and treatment.*Plastic and Reconstructive Surgery***120**(3), 44e-54e.
https://www.ncbi.nlm.nih.gov/pubmed/17700106

Becker, G., Davis, T. (2010) The outcome of surgical treatments for primary Dupuytren's disease--a systematic review. *Journal of Hand Surgery***35** (8), 623-626.
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https://www.medicines.org.uk/EMC/medicine/28953

Chen, N., Srinivasan, R., Shauver, M., Chung, K. (2011) A systematic review of outcomes of fasciotomy, aponeurotomy, and collagenase treatments for Dupuytren's contracture. *Hand* **6**(3), 250-255.
https://www.ncbi.nlm.nih.gov/pubmed/22942847

BSSH (2012) *Dupuytren's disease. British Society for Surgery of the Hand*. www.bssh.ac.uk

Mafi, R., Hindocha, S., Khan, W. (2012) Recent Surgical and Medical Advances in the Treatment of Dupuytren's Disease - A Systematic Review of the Literature. *Open Orthopaedics Journal* **6**, 77-82.
https://www.ncbi.nlm.nih.gov/pubmed/22431952/

Van Dijk, D., Finigan, P., Gerber, R., Szczypa, P., Werker, P. (2013) Recognition, diagnosis and referral of patients with Dupuytren's disease. *Current Medical Research and Opinion* 29(3), 269-277.
https://www.ncbi.nlm.nih.gov/pubmed/23320611

Industrial Injuries Advisory Council (2014) Dupuytren's contracture due to hand-transmitted vibration: IIAC report. Independent report Department of Work and Pensions.

https://www.gov.uk/government/publications/dupuytrens-contracture-due-to-hand-transmitted-vibration-iiac-report

Collagenase clostridium histolyticum for the treatment of Dupuytren's contracture: systematic review and economic evaluation. Health Technol Assess. 2015;19:1-202. https://www.ncbi.nlm.nih.gov/pubmed/26524616

9.5 Ganglion (excision of ganglia)

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.

Patients should be made aware that many ganglia resolve spontaneously over time, and be aware of the complications of ganglion excision.

Aspiration or injection should be considered first line where this is clinically appropriate and safe.

If aspiration/ injection has been tried or is clinically inappropriate then NCL CCGs will fund the surgical removal of the ganglia in the following cases:

1. The ganglion is painful and causing functional impairment or where there is diagnostic uncertainty.

OR

2. Mucous cysts in patients with significant skin breakdown, nail deformity, or episodes of spontaneous discharge

To enable the CCG to assess individual requests, the following information and examples of significant functional impairment should be provided with the request:

- Precise location of ganglion e.g. flexor tendon
- Size in cm/inches (length and width)
- How functioning of the area is impaired? I.e. what is the patient unable to do?
- Impact on work/studies/care i.e. is the patient unable to fulfil any essential activities such as cooking, washing etc.
- Degree of pain
- How long it has existed and treatments tried to date.

9.6 Interventional treatments for back pain – Overview

Criteria

The following exclusions apply:

- 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.

If the clinician considers the need for treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.

This policy relates to adults over 16 years.

References

NICE Guidelines
https://www.nice.org.uk/guidance/ng59
https://www.nice.org.uk/guidance/ng59/resources/low-back-pain-and-sciatica-in-over-16s-assessment-and-management-pdf-1837521693637

Lancet
https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30489-6/fulltext

NHSE
http://www.noebackpainprogramme.nhs.uk/wp-content/uploads/2015/05/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf

Manchikanti L et al. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. Pain Physician 2013;16(2):1533-3159
https://www.ncbi.nlm.nih.gov/pubmed/23615883

Simopoulos TT et al. A systematic evaluation of prevalence and diagnostic accuracy of sacroiliac joint interventions. Pain Physician 2012;15(3):1533-3159
https://www.ncbi.nlm.nih.gov/pubmed/22622915

9.7 Interventional treatments for back pain – Acupuncture

Acupuncture for back pain is not routinely funded.

9.8 Interventional treatments for back pain – Diagnostic spinal injections

(including facet joint injections, medial branch blocks and sacroiliac joint injections)

Criteria

- Patient is under the care of a specialist

AND

- Patient has persistent pain for 12 weeks or longer

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

The second diagnostic spinal injection may only be given if the first elicits 80% improvement in pain and this is clearly documented in the notes.

9.9 Interventional treatments for back pain – Discectomy

Criteria

NCL CCGs will only commission the following procedure with prior approval if:

- 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).

9.10 Interventional treatments for back pain – Epidurals

Criteria

NCL CCGs will only commission the following procedure with prior approval if:

- 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.

9.11 Interventional treatments for back pain – Lumbar disc replacement

Lumbar disc replacement surgery is not routinely funded.

9.12 Interventional treatments for back pain – Ozone discectomy

Ozone discectomy is not routinely funded.

9.13 Interventional treatments for back pain – Radiofrequency denervation

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

Criteria

NCL CCGs will only commission the following procedure with prior approval if:

- Patient has persistent pain

AND

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

AND

- MRI or SPECT (unless contraindicated) findings are concordant with the patient's symptoms and other structural lesions are excluded

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.

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.

9.14 Interventional treatments for back pain – Spinal cord stimulation

Spinal cord stimulation is not routinely funded.

9.15 Interventional treatments for back pain – Spinal decompression

Criteria

NCL CCGs will only commission the following procedure with prior approval if:

- 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.

9.16 Interventional treatments for back pain – Spinal fusion

Spinal fusion surgery is not routinely funded for non-radicular back pain.

9.17 Interventional treatments for back pain – Therapeutic spinal injections

(including facet joint injections, medial branch blocks, intradiscal therapy, prolotherapy, trigger point injections, sacroiliac joint injections)

Therapeutic spinal injections are not routinely funded.

9.18 Knee washout (in patients with knee osteoarthritis)

This procedure is not routinely funded by the NCL CCGs

References

https://www.nice.org.uk/guidance/ipg230

http://northwestcsu.nhs.uk/BrickwallResource/GetResource/60889d15-30dc-43bb-a94c-13a6fe5e8f71

9.19 Trigger finger

Criteria

Surgical treatment for trigger finger will be funded if the following apply:

1. Patient has failed to respond to a single hydrocortisone injection after 2 months

OR

2. Patient has fixed deformity that cannot be corrected.

OR

3. Where corticosteroid injection is contraindicated

Reference

British Society for Surgery of the Hand Evidence for Surgical Treatment (BEST) – Published October 2016; Review Date October 2021
http://www.bssh.ac.uk/_userfiles/pages/files/professionals/BEST%20Guidelines/BEST%20trigger%20finger%20PUBLISHED(1).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+
Chalazion	Age 13+
Circumcision	Age 14+
Electrical stimulation	Age 2+
Hypnotherapy	Age 2+
Keloidectomy	Age 2+
Minor skin lesion	Age 2+
Osteopathy/ osteopathic intervention	Age 2+
Selected use in palliative care	Age 2+
Tonsillectomy	Age 2+

Appendix 2: PoLCE Approval and IFR Application Process

Please refer to your local CCG for the agreed PoLCE Approval and IFR Application process.

Appendix 3 – PoLCE Feedback Form

	NCL PoLCE Policy Feedback Form
1	**In what capacity are you responding?**
	Are you responding on behalf of an organisation or as an individual clinician?
2	**Have you read the document: North Central London Procedures for Limited Clinical Effectiveness Policy, Updated September 2018?**
3	**Which of the 35 Policy Areas under review 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**
	Please submit your comments using this feedback form to **nelcsu.hpsu@nhs.net** **It is suggested than individual feedback forms are submitted for individual policy areas.**