NHS South East Essex and NHS South West Essex

Service Restriction Policy

Policy Number:	
Version:	1.0
Ratified by:	South Essex PCT Cluster Board
Date ratified:	
Name of originator/author:	Dr Daniel Showell, Consultant in Public Health Medicine
Name of responsible committee/individual:	
Date issued:	March 2012
Review date:	1st April 2013
Target audience:	PCT staff, patients and the public, primary, secondary and tertiary care providers

Summary of changes incorporated into the South Essex Service Restriction Policy compared to the criteria in the 2011 SW Essex Service Restriction Policy and the 2011 SE Essex Care & Resource Utilisation Policy

Page in this document (Page in 2011 SW SRP & 2011 SE CRUP)	Change suggested	Why change needed
12 (18/21)	Pinnaplasty – age at time of referral to be between 5 and 14 years	To standardise referral criteria across South Essex - SW Essex had 5-18 years in their criteria
13 (21/24)	Removal of pain as a reason for removal of port wine stains.	These lesions do not normally cause pain.
14 (22/25)	Removal of specific reference to xanthelasma.	The rationale for treating xanthelasma is not different from other benign skin conditions and is specifically mentioned as a lesion not operated on for cosmetic reasons on page 24 of 2011 version. These are covered earlier.
14 (23/25)	Include criteria for revision of scars due to self-harm	To standardise referral criteria in South Essex (not in SEE Policy)
24(30/30)	Enhanced list of indications for spinal injections and spinal cord stimulator	To reflect evidence base. Detailed list not included in SEE policy
25 (29/31)	Removal of the statement under trigger finger that excision and division of fascia will not be funded.	The orthopaedic surgeon should be trusted to do the most effective operation if one is needed.
26 (70/66)	Change definition of moderately limited hip function from: 'functional capacity adequate to perform only a few or none of the normal activities and self care' to 'capable of performing some normal activities and self-care'.	Before the alteration the definition was very similar to that for severely limited hip function.
29 (34/36)	Removal of reference to IUI (intra-uterine insemination).	The current Specialist Commissioning Group policy states that IUI is only used in exceptional circumstances.
29 (not in SW policy/51)	Removal of reference to redundant prepuce as an indication for circumcision.	In a certain sense all prepuce is redundant. Redundancy does not equate to a functional problem.
32 (27/29)	Statement about pegvisomant changed from: -not being indicated if surgery has failed…..**to** -being indicated if there has been an inadequate response to surgery.	This seems to have been a simple mistake in the text of the 2011 version.

Contents

1. Introduction

This document is the policy of NHS South Essex Primary Care Trust Cluster (hereafter referred to as "the PCT"). It details the treatments which are not routinely funded by the PCT, or which are funded only if specific clinical criteria or thresholds are met.

2. Purpose

This policy is one tool to help maximise the health gain for the population within the finances available. This policy makes explicit and publicly available information on the restrictions it places upon funding specific treatments. It also explains the mechanisms for local decision-making on individual funding requests.

Service restrictions are used for interventions that:

- Have insufficient evidence to show that they are clinically effective
- Have not been shown to be cost effective

This policy ensures that the PCT meets specific rights contained within the NHS Constitution for England (2009). These include:

- The right to not be refused access to NHS services on unreasonable grounds
- Right to drugs and treatments that have been recommended by the National Institute for Health & Clinical Excellence (NICE) in their guidance known as technical appraisals for use in the NHS, if a patient's doctor says they are clinically appropriate
- The right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence and to receive an explanation if funding is denied

This policy should be read alongside the PCT's Individual Funding Requests Policy (available at http://www.southessex.nhs.uk/content/file/Document%20Library/Policies/ifr-policy.pdf) which details the mechanisms for clinicians and patients to apply under the PCT's special case review process for funding of an excluded or restricted treatment as an exceptional case.

3. Duties

Director of Public Health – is responsible for regularly reviewing the Service Restriction Policy to ensure that the restrictions and clinical thresholds remain relevant and based on the highest quality evidence available. This post holder also has Executive level responsibility for the special case review process.

The Clinical Executive Committee– is responsible for advising the Director of Public Health on any revisions or additions required to the Service Restriction Policy.

Director of Finance and Performance – is responsible for liaising with and auditing providers to ensure that they are aware of and observe the restrictions and exclusions set out in the Service Restriction policy.

Head of Governance, Risk and Customer Services– is responsible for managing all individual funding requests received by the PCT, including the management of the special case review process.

Special Case Review Panel - The Special Case Review Panel (SCRP) is responsible for considering individual funding requests (IFRs) which have been assessed through the PCT's screening process as falling outside approved policy and where no precedent can be established as a basis for approving funding.

The Special Case Review Panel does not make policy decisions for the PCT. Potential service gaps and commissioning issues that may arise through the work of the Panel will be raised with the Director of Commissioning as they arise.

East of England Specialist Commissioning Group (SCG) (now part of the Midlands and East cluster) **–** is a joint sub-committee of each of the PCT Boards in the East of England. The SCG has been established to enable the member PCTs to make collective decisions on the review, planning, procurement and performance monitoring of Specialised Services as set out in the Specialised Services National Definitions Set (2002). These services including bariatric surgery for the morbidly obese, assisted conception and gender dysphoria. A full list of all services which are commissioned by specialist commissioning groups can be found on the NHS Specialised Services website (http://www.specialisedservices.nhs.uk/info/specialised-services-national-definitions). The SCG develop policies for the services they commission which contain eligibility criteria.

National Institute for Health & Clinical Excellence (NICE) – is an independent organisation responsible, among other things, for assessing the suitability of interventions for use in the NHS.

Essex Cancer Network – is responsible for making evidence-based recommendations to the Essex PCTs around the availability of those cancer drugs which have not been approved by NICE.

4. Definitions

Individual Funding Request - An IFR is a request to a PCT to fund healthcare for an individual who falls outside the range of services and treatments that the PCT has agreed to commission (NHS Confederation 2008).

Cosmetic surgery – is defined as "surgical intervention undertaken with the sole purpose of enhancing an individual's appearance"

5. Main Policy

The NHS Constitution gives patients the right to any drugs and treatments that have been recommended for use in the NHS by NICE, provided that the treating clinician has deemed this treatment clinically appropriate to do so. It is only through a technology appraisal that NICE recommends a drug or treatment for use within the NHS.

The PCT will fund drugs and treatments recommended by NICE technology appraisals from a date no later than three months from the publication of the appraisal.

Whilst most of the work of plastic surgeons in the NHS concerns the restoration of appearance and function following trauma, cancer, degenerative conditions or congenital deformity, a number of referrals are made for conditions that are considered to be of lower priority or for treatments not usually available under the NHS.

Appendices A-F provide guidance on priorities for the commissioning and delivery of plastic surgery services. The service restriction policies related to plastic surgery have been developed with reference to the Modernisation Agency's Action on Plastic Surgery (2005). They advise on explicit criteria for referral and treatment for particular plastic surgery procedure patients in South Essex.

The guiding principle is that the PCT will not fund cosmetic surgery undertaken exclusively to improve appearance, in the absence of previous trauma, disease or congenital deformity.

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

A more detailed statement of the general principles underpinning the PCT's policy towards commissioning plastic surgery can be found in Appendix A.

6 Review and Revision Arrangements including Version Control

The Service Restriction Policy will be reviewed every year by the Director of Public Health, or more frequently if either the evidence-base underpinning the policies or the local commissioning priorities change.

If only minor revisions are made then the policy can be approved by the Clinical Executive Committees and the version number for the policy will be updated by ".1" e.g. from version 1.0 to 1.1.

If significant amendments need to be made then the policy will need to be approved by the PCT Board. In this case the version number would increase to the next whole number e.g. from version 1.1 to 2.

7. Process for Monitoring Compliance and Effectiveness

Responsibility for ensuring that the Service Restriction Policies remain clinically relevant with a robust evidence-base rests with the Directors of Public Health.

The Director of Commissioning is responsible for developing and implementing a rolling audit programme and other mechanisms for ensuring that all providers commissioned by the PCT are aware of and comply with the Service Restriction Policy.

8. Equality Impact Assessment

This policy has been assessed using the PCT's Equality Impact Assessment framework (revised in November 2010) and identified as having the following impact/s upon equality and diversity issues:

Age	Disability	Gender	Pregnancy	Marital status	Race	Sexuality	Religion	Human Rights	Overall Impact
3	**0**	**1**	**0**	**0**	**1**	**0**	**1**	**3**	**9 (Low Relevance)**

Points	Scoring
3 – This area has a high relevance to equalities	0 points – no relevance
2 – This area has a medium relevance to equalities	1-9 points – low relevance
1 – This area has a low relevance to equalities relevance	10-18 points – medium
0 – This area has no relevance to equalities	19-27 points – high relevance

There are clear implications for age in terms of restrictions around access to fertility services, bariatric surgery and some forms of plastic surgery. There is an impact by definition on the protected characteristics of gender associated with access to gender dysphoria services. Criteria around access to scar revision are relevant to race due to the prevalence of keloid scarring in people of Black African descent. Religion is relevant in terms of restricted access to circumcision for non-clinical reasons. Any policies that restrict access to treatments are highly relevant to Human Rights as they are open to challenge under the Human Rights Act 1998, particular the Right to Life and the Right to Family Life.

9. Appendices

The following appendices relate to specific conditions or groups of conditions.

A- Plastic Surgery

A.1 Body Contouring Procedures

Unless specifically mentioned within this Service Restriction Policy no interventions will be funded for the improvement of appearance. This includes revision of procedures not funded by the NHS. Funding in such cases can only be arranged through an IFR.

A.1.1 Abdominoplasty or Apronectomy

Only patients fulfilling category A or B below will routinely be funded for abdominoplasty or apronectomy:

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

B. Those patients from the following groups who have significant abdominal aprons as a result of weight loss **and** have at least one of the severe functional problems from the list below.

- Patients with excessive abdominal folds who have an initial BMI greater than 40 and have achieved a reduction in BMI to 25 or less and have maintained this BMI of 25 and under for at least 2 years **OR**
- Patients with excessive abdominal folds who have an initial BMI of greater than 50 and have achieved a minimum drop of 20 BMI points and have maintained this for at least 2 years.

- **Severe functional problems:**
  - recurrent intertrigo beneath the skin folds
  - abdominal wall prolapse with proven urinary symptoms
  - problems associated with poorly fitting stoma bags
  - patient is experiencing severe difficulties with daily living i.e. ambulatory restrictions.

These patients will need full assessment by appropriate professional re Occupational therapy, prior to referral.

A.1.2 Other skin excision for contour

Buttock lifts, thigh lifts and arm lifts (brachioplasty), procedures will not normally be funded.

A.1.3 Liposuction

Liposuction may be useful for contouring of localised fat atrophy or pathological hypertrophy e.g. multiple lipomatosis, lipodystrophies,

In keeping with other cosmetic procedures liposuction will not be funded simply to correct the distribution of fat.

A.2 Breast Procedures

A.2.1Breast Reduction

Breast reduction surgery will only be funded routinely when **at least 500g** needs to be removed from each breast and one of the following sets of criteria is met:

Criteria set 1

- The wearing of a professionally fitted brassiere has not relieved the symptoms **and**
- The patient has a BMI of less than 25kg/m^2
  and all of the following
    - Neck ache or back ache and appropriate investigations have ruled out any other medical/physical problems as the cause these symptoms
    - Evidence is provided that simple analgesia has not adequately improved the problem
    - The patient has persistent intertrigo for at least one year confirmed by the GP **OR** Another serious functional impairment for at least one year

Criteria set 2

- The patient is male with hormonal or drug related breast growth (please see section on gynaecomastia)

Criteria set 3

- Pubertal hyperplasia

A.2.2 Breast augmentation and reconstruction

Breast augmentation is routinely funded for the following indication:

- reconstructive following or as part of surgery for breast malignancy or its prevention
- Congenital amastia (complete absence of breast tissue)

Breast implants for cosmetic purposes are not funded. In particular funding is not available breast augmentation for:

- small but normal breasts
- breast changes following pregnancy or with age

Patients who have undergone gender reassignment and who request breast augmentation will be considered under the East of England Policy for the Commissioning & Treatment of People with Gender Dysphoria.

A.2.3 Removal and replacement of breast implants

Funding for the removal of breast implants is limited to the following circumstances:

- Breast implants provided by the NHS (e.g. as part of treatment for cancer **OR**
- The implant needs to be removed for clinical reasons such as implant rupture (whether the implantation was funded privately or under the NHS).

For the removal of privately funded breast implants for clinical reasons, patients will be offered the choice of removing both prostheses in the event that only one has ruptured with the intention of preserving symmetry.

The *replacement* of privately funded breast implants where removal is clinically required is not routinely commissioned.

A.2.4 Asymmetry

NHS funding will only be routinely available in the following conditions:

- Patients aged 18 years or over and who have reached the end of puberty.
- The patient has a BMI of 25 or under with evidence this has been stable for 2 years
- There is gross disparity of breast cup sizes, defined as two or more cup size difference between breasts

Either unilateral breast reduction or unilateral breast augmentation may be considered.

A.2.5 Mastopexy (Breast Lift)

This is included as part of the treatment of breast asymmetry and reduction but not for purely cosmetic/aesthetic purposes such as post-lactational ptosis.

A.2.6 Nipple Inversion

Newly developed nipple inversion requires urgent referral and assessment to exclude malignancy. Surgical correction of nipple inversion should only be available for functional reasons in a post-pubertal woman and if the inversion has not been corrected by correct use of a non-invasive suction device.

A.2.7 Gynaecomastia

Surgical correction of gynaecomastia will be funded by the NHS only if the patient is:

- Post pubertal
- Has a stable body mass index (BMI) <25

Prior to making a referral for surgical correction of gynaecomastia, the following conditions must be investigated and ruled out:

- Breast cancer
- Testicular cancer
- Underlying endocrine or liver abnormality
- Abuse of drugs with bodybuilding
- Side effect of medication or drugs, e.g., spironolactone, digoxin or cannabis

Funding will not be available for surgical correction of pseudo-gynaecomastia where the enlargement of the male breast is due to an excess of adipose tissue and the BMI outside the normal range.

A.3 Plastic procedures of the head and face.

A.3.1 Face lifts and brow lifts (Rhytidectomy)

NHS funding will only be available for face/brow lifts in the following circumstances:

- Congenital face abnormalities
- Facial palsy (congenital or acquired paralysis)
- As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis
- To correct the consequences of trauma
- To correct deformity following surgery

A.3.2 Blepharoplasty (upper and lower lid)

- **Upper Lid**

This procedure will be funded by the NHS only when there is evidence that the visual field is restricted to 120 degrees or less laterally or 40 degrees or less vertically

- **Lower Lid**

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

A.3.3 Rhinoplasty

NHS funding for rhinoplasty is limited to the following condition:

- Problems caused by obstruction of the nasal airway
- Significant nasal deformity caused by trauma
- Part of reconstructive head and neck surgery
- Correction of complex congenital conditions e.g.cleft lip and palate

A.3.4 Pinnaplasty/Otoplasty

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

- The patient must be between the ages of 5 and 14 years at the time of referral
- Patients seeking pinnaplasty should be seen by ENTbuand following assessment, if there is any concern, assessed by a psychologist

Repair of external ear lobes

- This procedure will be routinely funded for primary suture post trauma, e.g. the patient is automatically eligible for emergency treatment when he/she presents for

repair at A&E at the time of trauma. Post emergency applications will only be considered on an exceptional basis.

A.3.5 Aesthetic Facial Surgery

NHS funding is only available in the following circumstances:

- Anatomical abnormalities in children <19 years, likely to cause impairment of normal emotional development
- Pathological abnormalities
- Correction of post traumatic bony and soft tissue deformity of the face

A.3.6 Hair transplantation

Hair transplantation, as treatment for alopecia or andronic pattern baldness will not be funded, regardless of gender, other than in exceptional cases, such as reconstruction of the eyebrow following cancer or trauma.

A.3.7 Hair depilation

For idiopathic hirsutism, eflornithine cream 11.5% will be funded for up to 4 months treatment. Funding will not continue in the absence of response to treatment.

Hair depilation will be funded by the NHS for patients who:

- Have undergone reconstructive surgery leading to abnormally located hair-bearing skin
- Are undergoing treatment for pilonidal sinuses to reduce recurrence

A.3.8 Acne Vulgaris

The treatment of active acne vulgaris should be provided in primary care or through a dermatology service.

Resurfacing procedures can be undertaken under the NHS for severe facial post-acne by the plastic surgery service once the active disease is controlled. All resurfacing techniques, including laser, dermabrasion and chemical peels may be considered for post-traumatic scarring, including post-surgical and severe acne scarring once the active disease is controlled.

A.3.9 Facial trauma

Resurfacing procedures can be undertaken under the NHS for severe post-traumatic scarring.

A.3.10 Vascular skin lesions on the face

Port wine stains on the face will be funded for removal under the NHS as will port wine stains resulting in tissue hypertrophy. The threshold for agreed funding will be lower for patients under the age of 19 years. NHS funded treatment will be available for other haemangiomatous or vascular lesions if:

- There are physical problems such as bleeding or ulceration
- The lesion is on the face and is unusually prominent or is getting bigger.

Funding will not be allowed for small benign, acquired vascular lesions such as thread veins and spider naevi.

A.3.11 Rhinophyma

The first-line treatment of the nasal skin condition is medical. Severe cases or those that do not respond to medical treatment may be considered for surgery or laser treatment on the NHS.

A.3.12 Scar revision

Scars that are resulting in physical disability due to contraction, tethering or recurrent breakdown will be funded under the NHS.

NHS Funding will also be available for scars on the face that are ragged and over 2cm in length or can otherwise be regarded as particularly disfiguring. Any such scar revision will only be offered after two years to allow the natural healing process to complete.

Funding will be available for significant keloid scarring on the face but will not be available for keloid scars on other parts of the body. Scars as a result of self-harm will only be funded when there has been no self- harm for a minimum of three years and there is a supporting assessment report from a psychiatrist indicating that such behaviour would be unlikely to recur.

B Skin and Subcutaneous Lesions

Restrictions do not apply for skin or subcutaneous lesions that have features suspicious of malignancy or where there is significant uncertainty that the diagnosis is benign.

B.1 Lipomata

The NHS should consider lipomata of any size for treatment in the following circumstances:

- There is a functional impairment
- The lipoma is/are symptomatic
- The lipoma is rapidly growing or abnormally located e.g. sub-fascial, sub-muscular
- The lipoma has an unusual feature raising serious doubts about its origins

B.2 Viral Warts

Most viral warts will clear spontaneously or following application of topical treatments. Treatment for non-genital warts, including cryotherapy, should not be funded by the NHS.

Painful, persistent or extensive warts in the immuno-suppressed patient may need specialist assessment from a dermatologist. Appropriate treatment recommended by such a specialist will be received NHS funding.

B.3 Other Benign Skin Lesions

Clinically benign skin lesions should not be removed on purely cosmetic grounds. This will include, amongst other conditions, skin tags including anal tags, seborrhoeic keratosis (basel cell papillomata), benign pigmented moles, comedones, milia and molluscum contagiosum, spider naevus, sebaceous cysts, xanthelasma, neuorfibromata, corn/callous, benign pigmented moles, pipoma.

Where a benign skin lesion of the eye obscures vision or is causing a separate ocular problem then the patient can be referred to an ophthalmologist for removal. NHS funded removal of benign skin lesions will only be available if one of the following apply:

- The size or location interferes with physical function or routine daily activity and prevents the individual from fulfilling work/study/carer or domestic responsibilities
- Lesions on the face where the extent, location and size cause considerable disfigurement.
- For treatment of multiple neurofibromatosis.
- Removal of lesion for other clinical indications including changes to the lesion over time including pain, bleeding, recurrent infection or recurrent trauma will be considered on an individual patient basis.

B.4 Tattoo Removal

NHS funding for removal of tattoos will be only be available where there is evidence of allergy to pigments.

C Bariatric Surgery for Morbid Obesity

Bariatric surgery is commissioned on behalf of NHS South Essex by the East of England Specialist Commissioning Group (EOESCG) this policy can be found on the EOESCTG website www.eoescg.nhs.uk. For ease of reference, the key aspects of the policy are outlined below though the website should be consulted for updates.

Eligibility criteria for referral of morbidly obese patients for surgical assessment

Patients referred for primary bariatric surgical assessment

- Body mass index above 40 kg/m^2
- Has type 2 diabetes and/or severe sleep apnoea **and**
- Who are in the 18-60 years age group **and**
- Have received intensive obesity management for at least 6 months and have tried all appropriate and available non-surgical measures adequately but have not been able to maintain weight loss.

Patients who have undergone primary bariatric surgery in a non-NHS facility and who are seeking NHS follow up

- The patient currently has a BMI >40, has type 2 diabetes and/or severe sleep apnoea.

Or

- At the time of primary surgery they met the criteria for assessment for bariatric surgery (above).

Or

- The patient is experiencing complications from the surgery i.e. malabsorption, that are not a predictable consequence of the primary surgery i.e. band filling.

Approved centres are: Homerton University Hospital NHS Foundation Trust or Luton and Dunstable Hospital NHS Foundation Trust.

D General surgery

D.1 Gallstones

Surgery for asymptomatic gallstones will not be funded.

D.2 Hernia repair (Inguinal) - Applies to adults only

The simple excision of inguinal hernia sac, primary repair or recurrent repair of inguinal hernia will not routinely be funded. Patients will be followed up in primary care with referral or re-referral should symptoms develop or progress.

Patients who have a history of incarceration of, or real difficulty reducing the hernia or significant pain or discomfort leading to the need for time off work or reduced duties while at work, can be referred.

D.3 Primary lymphoedema – intensive inpatient therapy

This is a low priority treatment due to the lack of evidence of effectiveness. Intensive inpatient or extensive outpatient therapy will not be funded. Intensive short-term outpatient decongestive lymphatic therapy will be funded, followed by long-term self-management.

E Surgery for Varicose Veins

Surgical treatment will not normally be funded for those veins that present a largely cosmetic problem or that cause simple aching that could be adequately controlled by properly measured surgical support stockings.

Surgery for patients with varicose veins with the complications outlined below will continue to be funded on the NHS:

- Venous ulceration
- Venous eczema refractory to short term steroid creams
- Recurrent superficial thrombophlebitis (at least two minor episodes)
- Bleeding associated with varicose veins (two minor episodes or one major episode)
- Post phlebitic syndrome

F Ear, nose and throat surgery

Service restrictions related to plastic surgery on the ear and nose can be found in section A.3 above.

F.1 Grommets for otitis media with effusion

Grommets for the treatment of otitis media with effusion (OME) will be funded under the NHS where eligibility criteria 1A, 1B, or 2 apply.

1. Has otitis media with effusion (OME) which has persisted for at least 3 months of watchful waiting from the date of the first appointment with an audiologist or GP. The child can only be placed on a waiting list for the procedure at the end of this period.

   AND

   A. The child is aged three years and over and suffers from at one or more of the following:
      - at least 5 recurrences of acute otitis media in a year
      - evidenced delay in speech development
      - educational or behavioural problems attributable to persistent hearing impairment, with a hearing loss of at least 25dB particularly in the lower tones (low frequency loss)
      - a second disability predisposing to OME such as Down's syndrome or cleft palate

   OR

   B. for children aged 2 years, the child has:
      - OME with prolonged effusion (6 months or longer);
      - AND measured hearing losses for 6 months or more;
      - AND disability attributable to hearing loss (delay in speech development or other problems).

2. NHS funding will also be agreed if:

   - OME is overlaying sensorineural deafness or is delaying diagnosis or treatment with aids or cochlear implants - this would be an indication for immediate grommets;

F.2 Tonsillectomy

Referrals for tonsillectomy will be funded if the criteria in the Surgical Threshold Checklist overleaf are met. These criteria are as follows:

If the patient is aged 12 or under, tonsillectomy will be funded if:

- One criteria in group A below apply,
  OR
- All criteria from group C below **AND** at least one criteria from group D below apply.

If the patient is aged 13 or over, tonsillectomy will be funded if:

- One criteria from group A below apply,
  OR
- One criteria from group B below apply,
  OR
- All criteria from group C below AND at least one criteria from group D below apply.

Group A

- Two or more quinsies (or 1 quinsy with a history of recurrent tonsillitis)
- Obstruction
- Suspected malignancy

Group B

- Intractable cough with a high level of streptococcal antibody
- Severe halitosis which has been demonstrated to be due to tonsil crypt debris

Group C

- Sore throats due to tonsillitis
- Symptoms for at least a year
- Episodes of sore throat are disabling and prevent normal functioning

Group D

- Five or more episodes of tonsillitis per year
- Three or more episodes per year requiring at least a week off school/work on each occasion

F.3 Cochlear implants

For cochlear implants only referrals from a consultant ENT surgeon or Audiologist will be funded by the NHS. Cochlear implantation will be funded by the NHS for any children needing them. The level of funding allocated for cochlear implantation in adults is agreed by commissioners each year and depends on other financial commitments.

F.4 Bone Anchored Hearing Aids

Bone anchored hearing aids are commissioned on behalf of NHS South Essex by the East of England Specialist Commissioning Group (EOESCG).

The PCT will therefore apply the relevant EOESCG policy, the current version of which is accessible from www.eoescg.nhs.uk. As the policy changes, the PCT will automatically adopt the amended policy in its entirety.

Providers and other stakeholders should refer to the EOESCG policy in full to ensure full understanding of the eligibility criteria and other provisions in place. However for ease of reference, the key provisions contained in the policy are reproduced below.

Selection criteria BAHAs will be considered only for patients who meet the following criteria:

- *Congenital malformation of the middle/external ear or microtia*
- *Chronically draining ear that does not allow use of an air conduction hearing aid (e.g. external otitis, draining mastoid cavity)*
- *Patients with bilateral conductive hearing loss due to ossicular disease (and not appropriate for surgical correction) or unable to be aided by conventional air conducting hearing devices*
- *A maximum speech discrimination score better than 60 per cent when using a PB word list. The audiologist must determine whether the candidate has sufficiently good speech discrimination ability based on that particular patient's need*
- *Patients (either by themselves or with the aid of parents, guardians, or others) must be able to maintain and clean the skin around the abutment. Therefore careful consideration must be given as to the patient's psychological, physical, emotional and developmental capabilities to maintain hygiene*
- *Biologically, titanium fixtures can be placed in most patients*

Sufficient bone volume and bone quality must be present for successful fixture placement. Alternative treatments should be considered for patients having a disease state that might jeopardise osseointegration.

Exclusions

A BAHA would not be suitable for patients with:

- *Soft bone, e.g. following gamma knife treatment*
- *Purely sensory neural hearing loss (outside that recommended by the manufacturers)*

Trials before fitting:

A BAHA should be regarded as a last resort. Before proceeding to surgery patients will have had:

- *An unsuccessful trial of a conventional hearing aid*
- *A successful trial with a test headband creating an effect similar to a BAHA*
- *Assessment by an audiologist*

F.4 Ear Wax Removal

Removal of ear wax in secondary care will not be funded unless a patient's condition warrants micro suction.

G Oral and maxilla-facial surgery

G.1 Non-third molar extraction in secondary care

The appropriated place for “routine” tooth extractions in healthy patients is primary dental care. In the following scenarios referral to hospital Oral Surgery Departments is appropriate:

- Retained roots following dental extraction in primary care
- Associated pathology that needs to be submitted for histological examination (e.g. cysts).
- Extractions from abnormal or diseased bone (e.g. patients who have received therapeutic doses of irradiation to the jaws).
- Surgical complexity such that a general anaesthetic may be indicated.
- Difficult access due to opening restrictions.
- Patients with comorbidities that require extraction in hospital (but it is rare for a patient’s history to mandate extraction in hospital).

For patients that are referred because they request treatment under general anaesthesia, the GDC guidelines with regard to risk counselling must have been followed and evidence of this must be provided in the IFR.

If a referral is made outside these guidelines, reasons must be given why treatment cannot be undertaken in primary dental care. Referrals will not be accepted if extraction in primary care is appropriate. All referrals must be accompanied by the relevant radiographs. These radiographs will be returned once treatment has been completed.

G.2 Apical surgery

The success rate of apical surgery on molar teeth is low and will not be routinely be funded by the NHS. Repeat apicectomy has a low success rate and will also not be routinely undertaken.

Referral for NHS treatment will be considered in the following situations:

- Peri-radicular disease in root filled teeth while orthograde endodontic therapy cannot be re-performed or has failed,
- Suspected root perforation, root fracture or where biopsy of peri-radicular tissue is required (e.g. cystic change suspected).

In order to prevent recontamination and failure of apical surgery, all patients should also have a satisfactory coronal seal.

All relevant radiographs must accompany all IFRs in order to avoid unnecessary radiation exposure to patients. These radiographs will be returned once treatment has been completed.

G.3 Third molars

The prophylactic removal of pathology-free impacted third molars is not funded by the NHS.

Surgical removal of impacted third molars funded by the NHS is limited to patients with evidence of pathology. Such pathology includes unrestorable caries, non-treatable pulpal and/or periapical pathology, cellulitis, abcess and osteomyelitis, internal/external resorption of the tooth or adjacent teeth, fracture of tooth, disease of follicle including cyst/tumour, tooth/teeth impeding surgery or reconstructive jaw surgery, and when a tooth is involved in or within the field of tumour resection.

All relevant radiographs must accompany all IFRs in order to avoid unnecessary radiation exposure to patients. These radiographs will be returned once treatment has been completed.

For patients that are referred because they request treatment under general anaesthesia, the GDC guidelines with regard to risk counselling must have been followed and evidence of this must be provided in the IFR.

H Ophthalmic Surgery

Plastic surgery procedures of the skin around the eyes are covered under section A.3 and B.3.

H.1 Clinical Threshold for Elective Cataract Surgery

These eligibility criteria have been developed in consultation with local clinicians. Patients who meet the following criteria may have NHS funded cataract surgery.

Eligibility criteria for cataract surgery on the First ('worst') eye

1. Corrected visual acuity documented of 6/12 or worse in the affected worst eye, assessed by the clinician as being due to a rectifiable lenticular opacity

   AND:

2. Impairment of lifestyle such as the patient is at significant risk of falls or
   - vision is affecting their ability to drive or experience significant glare which affects driving or
   - substantially affecting their ability to work or
   - patients with glaucoma who require cataract surgery to control ocular pressure
   - patients with diabetes who require clear views of their retina to screen for, and monitor any, retinopathy

   AND

3. The patient understands the risks and benefits of the surgery and is willing to have it.

Eligibility criteria for cataract surgery on the Second eye (i.e. following surgery on the 'worst' affected eye)

1. Visual acuity:
   - Cataract surgery on the first (worst) eye has not achieved a corrected visual acuity of at least 6/9 or the corrected visual acuity in the second eye is 6/12 or worse.
   - There are sound clinical grounds for cataract surgery in the second eye, despite good acuities, e.g. a large refractive difference between the two eyes resulting in poor binocular vision.

   AND

   Criteria 2 from the eligibility criteria for the first ('worse') eye apply (see above).

   AND

   Criteria 3 from the eligibility criteria for the first ('worse') eye apply (see above).

I Orthopaedic surgery

I.1 Spinal injections for backache

Following review of evidence in support of spinal Interventions for back pain the below listed procedures will be considered;

1. Facet joint nerve injection for diagnosis
2. Discography for diagnosis
3. Transforaminal epidural injections in pre-op evaluation for patients with negative or inconclusive imagining results
4. Selective nerve root block in pre-op evaluation for patients with negative inconclusive imagining results
5. Therapeutic lumbar intraarticular facet joint injection
6. Lumbar branch block
7. Cervical Branch Block
8. Medial Branch neurotomy
9. Caudal epidural steroid for chronic low back and radicular pain
10. Interlaminar epidural steroid injection for lumbar radiculopathy & cervical radiculopathy
11. Transforaminal epidural steroid injection for lumbar root pain & cervical root pain
12. Percutaneous epidural adhesiolysis
13. Spinal endoscopic adhesiolysis
14. Intradiscal electrothermal therapy for chronic discogenic low back pain
15. Automated percutaneous lumbar discectomy for disc decompression
16. Vertebroplasty & Kyphoplasty for vertebral augmentation

In addition to:

1. Lumbar caudal or interlaminar epidural steroid injections for low back pain <u>with</u> sciatica or radiculopathy.
2. Lumbar caudal or interlaminar epidural steroid injections for sciatica or radiculopathy.
3. Lumbar caudal or interlaminar epidural steroid injections for disc prolapse.
4. Lumbar intradiscal injections with neurolytic agent for low back pain <u>without</u> radiculopathy.
5. Lumbar transforaminal epidural steroid injections for low back pain with sciatica or radiculopathy.
6. Cervical epidural steroid injections for neck pain with disc compression and radiculities radiculopathy.

All patients should have documented evidence of pain for over 3 months and a discharge summary from a physiotherapist confirming that the patient has had minimal improvement after complying with 6 sessions of physiotherapy.

Other forms of spinal injection, and other indications, will not be funded due to the lack of convincing evidence of clinical effectiveness or cost effectiveness.

I.2 Spinal cord stimulators

In line with the NICE Tag 159 NHS South Essex will consider funding for Spinal Cord Stimulators (SCS) for the following groups of patients;

1. Adults with chronic pain of neuropathic origin who continue to experience chronic pain measuring at least 50mm on a 0-100mm visual analogue scale) for at least 6 months despite appropriate conventional medical management **and**

    - Who have been assessed by an inter-disciplinary team **and**
    - Who have had a successful trial of stimulation as part of the assessment process.

Requests will only be funded on a prior approved basis on receipt of documented evidence to show that all other treatment paths have been exhausted.

Requests for replacement batteries for previously inserted Spinal Cord Stimulators (SCS) will only be considered on review of clinical information relating to a patient's progress following insertion of the SCS, to include number of hospital admissions in the last 12 months.

I.3 Surgery for Carpal Tunnel Syndrome

The PCT will fund carpal tunnel surgery where:

- Symptoms persist after conservative therapy with either local corticosteroid injections and/or nocturnal splinting **OR**
- There is neurological deficit, for example sensory blunting, muscle wasting or weakness or thenar abduction **OR**
- Severe symptoms significantly interfering with daily activities.

I.4 Palmar fasciectomy for Dupuytren's disease

Surgical treatment on the NHS will only be available if the patient either has a fixed flexion deformity of 25 degrees or more, or is under 45 and has at least 10 degrees loss of extension in two or more joints

I.5 Trigger Finger Corrective Surgery

Funding for trigger finger surgery on the NHS will only be considered in cases where there is evidence that the trigger finger cannot be corrected after splinting or treatment with steroid injection.

I.6 Elective primary total hip joint replacement

Elective total hip joint replacement will be funded on the NHS only when either conditions A or B below apply. (The numbers in superscript refer to the definitions at the end of section I.6).

A. the patient has severe[3] joint pain **AND**

    - has severe functional limitation[7] irrespective of whether conservative management has been tried **OR**
    - minor[5] to moderate functional limitation [6], despite the use of non-surgical treatments[4]

B. the patient has mild[1] to moderate[2] pain **AND**

- has severe[7] functional limitation, despite the use of non-surgical treatments [4] **AND**
- is assessed to be at low surgical risk.

Definition of terms used in the elective total hip replacement threshold:

Joint Pain
[1]Mild: Pain interferes minimally with usual daily activities. Pain controlled by non-steroidal anti-inflammatory drugs, aspirin or paracetamol individually or in combination.

[2]Moderate pain: Pain occurs daily with movement and interferes with usual daily activities. Vigorous activities cannot be performed.
Pain controlled by non-steroidal anti-inflammatory drugs, aspirin or paracetamol individually or in combination.

[3]Severe pain: Pain is constant and interferes with most activities of daily living. Pain at rest or interferes with sleep. Pain not controlled, even by narcotic analgesics.

[4]Non-surgical treatments:
NSAIDs, paracetamol, aspirin or narcotic analgesics at regular doses during 6 months with no pain relief; weight control treatments if overweight and physical therapies.

Functional limitations:
[5]Minor: capable of conducting normal activities and self-care. Able to walk for more than one hour without walking aids.

[6]Moderate functional limitation: capable of performing some normal activities and self-care. Able to walk for between 30 and 60 minutes with the aid of a simple walking aid such as a cane.

[7]Severe functional limitation: Largely or wholly incapacitated. Walking capacity of less than half hour or unable to walk or bedridden. Aids such as a cane, a walker or a wheelchair are always required.

I.7 Elective primary knee replacement

Patients will qualify for NHS funded elective primary knee joint replacement only when criterion A, B or C, detailed below, are met AND conservative measures have been exhausted. Conservative measures are weight reduction, changing activity, NSAIDs and other analgesics, and introducing a walking aid. (The numbers in superscript refer to the definitions at the end of section I.7).

A. Intense[3] or severe[4] symptomatology
AND
- has radiological features of severe[8] disease

AND
- has demonstrated tri-compartmental[11] or bi-compartmental[10] disease.

B. Intense[3] or severe[4] symptomatology

AND

- has radiologic features of moderate[7] disease

AND

- is troubled by limited mobility or stability[5] of the knee joint.

C. Severe[4] symptomatology

AND

- has radiological features of slight[6] disease

AND

- is troubled by limited mobility or stability[5] of the knee joint.

Definition of terms used in the elective total knee joint replacement threshold

Symptomatology:

[1]Slight: Sporadic pain for example when climbing/descending stairs. Usual daily activities can be carried out; though those requiring great physical activity may be limited. Pain is adequately controlled by aspirin, paracetamol or non-steroidal anti-inflammatory drugs singly or in combination.

[2]Moderate: occasional pain for example when walking on level surfaces for half an hour, or prolonged standing. Some limitation of daily activities. Pain is adequately controlled by aspirin, paracetamol or non-steroidal anti-inflammatory drugs singly or in combination.

[3]Intense: pain of almost continuous nature. Pain when walking short distances on level surfaces or standing for less than half an hour. Daily activities significantly limited. Continuous use of NSAIDs for treatment to take effect. Requires the sporadic use of walking aids such as a stick or crutches.

[4]Severe: continuous pain including when resting. Daily activities significantly limited constantly. Continuous use of analgesics - narcotics/NSAIDs with adverse effects or no response. Requires constant use of walking aids such as a stick or crutches.

Mobility and stability:

[5]Limited mobility and/or stable joint: limited mobility is equivalent to a range of movement less than 0^{o} to 90^{o} unstable or lax is equivalent to the presence of slackness of more than 5mm in the extended joint.

Radiological changes:

[6]Slight: Ahlback grade I.

[7]Moderate: Ahlback grade II and III.

[8]Severe: Ahlback grade IV and V.

Localisation

[9]Unicompartmental: excluded patello-femoral isolated.

[10]Bicompartmental: unicompartmental plus patello-femoral.

[11]Tricompartmental: disease affecting all three compartments of the knee.

I.8 Knee arthroscopy

NHS funding for knee arthroscopy is only available for diagnostic and/or therapeutic indications which have a strong evidence base of effectiveness. Each case must be explicitly approved as the most appropriate management for the patient by a Consultant Orthopaedic Surgeon.

In particular there is inadequate evidence on the efficacy to support arthroscopic knee washout with debridement for the treatment of osteoarthritis.

I.9 Ganglion

Ganglia of the hand, wrist, knee of foot will not be surgically removed unless there is neurovascular compromise.

J Urology

J.1 Circumcision

Circumcision should only be funded for medical reasons. The medical indicators for circumcision are

- Phimosis (inability to retract the foreskin due to a narrow prepucial ring) and paraphimosis (inability to pull forward a retracted foreskin)
- Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin)
- Balanoposthitis (recurrent bacterial infection of the prepuce)

J.2 Penile Implants

Requests for funding will be individually reviewed. Prostheses should only be considered when all other appropriate treatment options for erectile dysfunction have failed. The surgeon must consider that the patient will benefit and the patient should be fully informed of the risks.

K Gynaecology

K.1 Dilatation and curettage (D&C) and hysteroscopy for heavy menstrual bleeding

Hysteroscopy for the investigation and management of heavy menstrual bleeding will be funded on the NHS only when it is carried out:

- Where ultrasound has been inconclusive.
- Where dilatation is required for non-hysteroscopic ablative procedures to ensure correct placement of the device;
- Pre-procedure when undertaking endometrial ablation.

Patients will not receive D&C:

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

K.2 Hysterectomy

Hysterectomy for non-cancerous heavy menstrual bleeding will only be funded within NICE Guidance and when:

- There has been an unsuccessful trial with levonorgestrel intra-uterine device (LNG-IUS, Mirena, unless contra-indicted)
- At least one of another treatment has failed,: alternative hormonal treatment ; NSAIDS and Tranexamic Acid; endometrial ablation
- Patients with ethical reasons cannot accept the use of mirena, they should have tried at least two of the alternative treatments.

K.3 Labiaplasty, vaginoplasty and hymenorrhaphy

Labiaplasty for cosmetic reasons is not funded on the NHS. Labiaplasty will be funded on the NHS for the following indications:

- Where the labia are directly contributing to recurrent disease or infection
- Where repair of the labia is required after trauma

Vaginoplasty will be available on the NHS only for the following indications:

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

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

This policy does not apply to genital reconstruction for gender dysphoria which is covered by the EOESCG Gender Dysphoria Policy.

L Fertility procedures

L.1 Infertility and assisted conception (including reversal of sterilisation)

Fertility services are commissioned on behalf of NHS South Essex by the East of England Specialist Commissioning Group (EOESCG). This policy can be found on the EOESCTG website www.eoescg.nhs.uk. For ease of reference, the key aspects of the policy are outlined below though the website should be consulted for updates.
Following assessment in primary care patients experiencing infertility can be referred for specialist assessment or treatment. Referral to the tertiary care fertility service commissioned by the EOESCG is via a consultant gynaecologist or GP with a special interest in fertility. The eligibility criteria for accessing fertility services are:

Eligibility criteria

- At the start of any treatment cycle:
  - The women must be no younger than 23 years of age and younger than 40 years old.
  - Any treatment cycle must be commenced before the male is 55 years of age.

- The woman must have a body mass index of between 19 kg/m^2 and up to and including 30 kg/m^2

- There are no children from the couple's relationship. This includes adopted children

- Where couples smoke they must take part in a supportive programme of smoking cessation and be non-smoking at the time of treatment

- Couples must have an identified cause for their fertility problems or have had infertility of at least three years duration.

- Neither partner can have had a previous sterilisation, even if it has been reversed.

Amount of treatment to be funded

- For couples requiring In-Vitro Fertilisation or Intra-Cytoplasmic Sperm Injection, this policy supports a maximum of 6 embryo transfers with a maximum of three fresh cycles

L.2 Reversal of Sterilisation

Reversal of sterilisation (either gender) will not be funded.

M Treatment of people with gender dysphoria

Specialist services for people with gender dysphoria are commissioned on behalf of NHS South Essex by the East of England Specialist Commissioning Group (EOESCG). This policy can be found on the EOESCTG website www.eoescg.nhs.uk. For ease of reference, the key aspects of the policy are outlined below though the website should be consulted for updates.

A GP wishing to refer a patient for specialist management of gender dysphoria must refer them to an approved local consultant psychiatrist. The consultant psychiatrist will assess the need for a referral to the Gender Identity Clinic at West London Mental Health NHS Trust. On receipt of a copy of communication from the consultant psychiatrist making a clear recommendation for referral to the PCT's Individual Funding Requests (IFR) Service will confirm in writing that the patient may enter the pathway. This is a formality and will not need a special case review panel. The PCT's approval letter will be sent to the psychiatrist (copied to the GP and EOESCG), requesting that the psychiatrist makes the necessary referral.

In the event that the PCT does not receive a clear recommendation from a local psychiatrist, approval to enter the pathway will be declined by the IFR Service.

If the Gender Identity Clinic assesses a patient as needing gender reassignment surgery this surgery will be funded on the NHS. Such an assessment requires a successful 2 year trial living in the desired gender.

Only the reassignment surgery will receive NHS funding. In particular breast augmentation in male to female gender reassignment will be considered in the same way as for born females with no breast growth.

Operations such as larynx reshaping, crico-thyroid approximation surgery (to raise vocal pitch) and waist liposuction are considered cosmetic and not funded on the NHS. Hair removal will only be funded where it is situated on donor sites to be used in surgery.

N Bobath Therapy

This policy specifically outlines the criteria for referral of children with cerebral palsy to the Bobath Centre in London. Referrals are to be considered by the multidisciplinary team caring for the child, led by the Consultant Community Paediatrician.

Children with cerebral palsy, requiring multidisciplinary therapeutic input, can be assessed for referral for Bobath therapy:

- Severe complex cerebral palsy
- Ataxic cerebral palsy
- Atheroid cerebral palsy
- Children with severe feeding difficulties
- Dystonic and hypertonic cerebral palsy

.

The Consultant Community Paediatrician leading the child's care will be responsible for the referral and informing the PCT of the decision.

O Chronic Fatigue Syndrome / Myalgic Encephalomyelitis (CFS/ME)

All specialist treatment for chronic fatigue syndrome / myalgic encephalomyelitis (CFS/MS) is accessed through a referral from the patient's clinician to the Essex CFS/ME Service. Patients can be referred for unexplained fatigue lasting at least 4 months once the following alternative diagnosis have been considered and excluded:

- Obesity (BMI ≥40kg/m^2)
- Organ failure
- Chronic infections
- Chronic inflammatory diseases
- Major neurological diseases
- Systemic treatment for neoplasms
- Untreated endocrine diseases
- Primary sleep disorders
- Alcohol/Substance abuse
- Reversible causes of fatigue (medications, infections or recent major surgery)
- Psychiatric conditions

P Acromegaly

Pegvisomant for acromegaly will only be funded by the NHS when initiated by a physician experienced in the treatment of acromegaly and the following apply:

- The patient has had an inadequate response to surgery and / or radiotherapy **AND**
- The patient has had an inadequate response to somatostatin analogues

Q Allergy Disorders

Only standard treatments with evidence of clinical effectiveness will be funded under the NHS. These include allergen avoidance, drugs and immunotherapy. Unconventional approaches to the management of allergy disorders should not be funded. These include clinical ecology, acupuncture, homeopathy, hypnosis, ionisation and herbal medicine.

R Complementary Therapies

Treatments or diagnostic procedures outside the mainstream of medical practice will not be funded on the NHS. Providers of services of unknown effectiveness will be asked to present evidence that would support funding.

Specific examples of services that would be funded only if approved by PCT's special case review process are:

- Homeopathy
- Acupuncture – except for the relief of pain or nausea, as an adjunct to other treatments provided under the NHS
- Osteopathy and chiropractic services
- Other complementary therapies such as aromatherapy and massage