**Service Restriction Policy**

**Version:** 2017 V1.2

**Effective date:** 1st June 2017

**Ratified by:** Castle Point & Rochford (CP&R) CCG
Southend CCG

**Name/Department/Sponsor/Author:** Ian Stidston – Accountable Officer, CP&R CCG and Interim Accountable Officer, Southend CCG

**Name/Title of responsible committee/individual:** NHS Castle Point and Rochford CCG Governing Body
NHS Southend CCG Governing Body

**Review date:** April 2018
Specific policy statements may be reviewed within year as part of an agreed process

**Target audience:** GPs, Optometrists, Dentists, Secondary Care consultants, Central Referral Services, community services, patients

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**Document Summary**

The policy of NHS Castle Point and Rochford CCG and NHS Southend CCG (referred to hereafter as the ‘South East Essex CCG’s’) is that treatments/interventions/procedures not currently included in commissioned established care pathways (as identified for example in the schedules to the service agreements with acute care providers) or identified for funding through the commissioning process, are not routinely funded. For a number of commissioned interventions the South East Essex CCG’s have specific policy statements setting out restrictions on access, based on evidence of effectiveness or relative priority for funding. Those related to treatments/interventions/procedures are included within this document; those relating to prescribing can be found on the Medicines Management page of each CCGs website:

- **Castle Point and Rochford CCG:**
  www.castlepointandrochfordccg.nhs.uk
- **Southend CCG:**
  www.southendccg.nhs.uk
Policy development is an on-going process and future policy on further treatments as developed or in response to NICE Guidance/Guidelines, health technology assessments etc. will be produced and published periodically, and the South East Essex CCG’s will review and update the policy as required at a minimum of annually.

This policy sets out the access/approval guidance for treatments/ interventions/ procedures where there is specific policy guidance in place. The access/approval route may vary between localities across South East Essex.

All patients being referred for non-urgent elective surgery and who are smokers should be referred to smoking cessation services at the initial referral/assessment/appointment.

There is strong clinical evidence that obese patients undergoing surgery are at significantly higher risk of getting infections and suffering heart, kidney and lung problems than people who are a healthy weight. Obese patients may have to spend more time in hospital recovering and risk of dying as a result of surgery is higher compared to patients with a healthy weight. Overweight and obese patients should be strongly encouraged to lose weight before their operation.

**Threshold Approvals**
Those that are commissioned by the South East Essex CCG’s on a routine basis where patients meet the defined criteria set out within this policy, and for which individual prior approval is **not** required. CCG notification of compliance or audit will be required according to contractual arrangements. Providers should be aware that payment will be withheld where they cannot demonstrate that patients treated meet the criteria specified in this policy.

**Individual Prior Approvals**
Those that are commissioned by South East Essex CCG’s but only for patients who meet the defined criteria set out within this policy and which require individual prior approval on a patient by patient basis, e.g. Spinal Cord Stimulators.

For these procedures, the criteria listed form guidance to both the referring and treating clinicians. If a patient is deemed to meet these criteria, prior approval must also be sought (for Prior Approval Forms, see Appendix 1).

**Not Funded**
Those which have been assessed as Low Clinical Priority by the South East Essex CCG’s and which will not be funded unless there are **exceptional clinical circumstances**. Applications for funding for these procedures can be made to the Individual Funding Request team, where the patient demonstrates true clinical exceptionality.

**Individual Funding Requests (IFR)** - The South East Essex CCG’s allow patients the opportunity to make specific funding requests via the Individual Funding Request team. Requests may include conditions for which the South East Essex CCG’s do not have an agreed policy, including patients with rare conditions and whose proposed treatment is outside agreed service agreements. In instances in which eligibility is unclear the final decision is made through an application to the Individual Funding Requests team by contacting them at: fundingrequests.south@nhs.net

The Individual Funding Request policy and application forms can be found in Appendix 1.
The responsibility for adherence to the Service Restriction Policy lies with the referring and treating clinicians. Failure to adhere to these criteria will result in non-payment of the activity.

Equality Impact Assessment (EIA) - (Appendix 2)

The Service Restriction Policy has been assessed.

What has been done to promote equality in the SRP and how will this be evaluated and how effective this has been?

Clinical engagement and Public Health have with Medicines Management been instrumental in developing the Policy document.

The evaluation of how successful this has been will be monitored by the level of clinical challenge that is received. Whilst it is recognised that individuals may challenge some of the criteria it is hoped that from the extensive engagement in developing the policy it does reflect clinical practice and current evidence. Those areas that through this process still have equality impact i.e. fertility have been prioritised as an area for further review.

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Acne Vulgaris  
Acromegaly – See Medicines Management  
Acupuncture  
Adenoidectomy – See Grommets  
Aesthetic Facial Surgery  
Allergy Disorder  
Alopecia  
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Arthroscopy  
Assisted conception using IVF/ICS/IUI for infertility  
Autologous Blood Injection for Tendinopathy – See Platelet Rich Plasma  
Autologous Cartilage Transplantation |
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Belt Lipectomy – See Liposuction  
Benign skin lesions  
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Breast Asymmetry – See Breast Procedures  
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| D | Cosmetic Surgery – General Principles  
Cosmetic Surgery Mental Health Grounds  
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Dilatation and curettage/hysteroscopy  
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| G | Endoscopic Laser Spinal Surgery  
Exogen Ultrasound bone healing |
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Gynaecomastia  
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Hair Depilation  
Hair transplantation / Alopecia  
Hernia  
Hip Arthroscopy – See Arthroscopy  
Hip Injections  
Hip replacement  
Hirsutism / hair depilation  
Hymenorrhaphy – See Vaginal Labia Refashioning  
Hyperhidrosis/Sweating  
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<tr>
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<th>Description</th>
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| I      | Infertility | – See assisted Conception  
Insulin Pump  
IUI – See infertility  
IVF – See infertility |
| K      | Knee Arthroscopy | – See arthroscopy  
Knee replacement |
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Laser treatment for Rosacea  
Laser treatment for skin lesions – See Benign skin lesions  
Laser Treatment for Soft Palate  
Laser Treatment for Tattoo removal  
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Penile implants  
Photodynamic therapy for age related macular degeneration  
Pinnaplasty/ Otoplasty  
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Vaginal/uterovaginal prolapse  
Varicose veins  
Vasectomies |
| W | Wigs and Fabric Supports  
Wisdom Teeth – See Dental Procedures |
| U | Uterine Artery Embolization – See Fibroid Embolization |
Policy statement: Abdominoplasty or Apronectomy

Status: Threshold

South East Essex CCG’s do not routinely commission abdominoplasty or apronectomy. Funding may be considered on a restricted basis for patients who meet the following criteria:

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

OR

B Those patients from the following groups who have significant abdominal aprons as a result of weight loss and have severe functional problems*:

- Patients with excessive abdominal folds who had an initial BMI >40 and have achieved a reduction in BMI < 25 and have maintained the BMI < 25 for at least 2 years.

OR

- Patient with excessive abdominal folds who have an initial BMI > 50 and have achieved a minimum drop of 20 BMI points and have maintained this BMI (reduction of a minimum of 20 points) for at least 2 years.

*Severe functional problems include, but are not limited to:

- Recurrent intertrigo beneath the skin fold that re-occurs or fails to respond despite appropriate medical therapy for at least 6 months.
- Abdominal wall prolapse with proven urinary symptoms.
- Problems associated with poorly fitting stoma bag.
- Patient is experiencing severe difficulties with daily living i.e. ambulatory restrictions.

Patient Information:

References:

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Policy statement: Acne (Mild to Moderate) Vulgaris

Status: Not Funded

The treatment of mild to moderate acne vulgaris should be provided in primary care. Severe acne, that is acne unresponsive to prolonged courses of oral antibacterials, or with scarring, or acne associated with psychological problems should be referred to a consultant dermatologist.

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.

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Acupuncture is commissioned in accordance with NICE Guidance: http://www.nice.org.uk/guidance/cg88/chapter/Key-priorities-for-implementation

**Patient Information:**

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<td>Status:</td>
<td>Threshold</td>
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For policy see Grommets.

**Patient Information:**
http://www.nhs.uk/conditions/adenoids-and-adenoidectomy/Pages/Introduction.aspx

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<tr>
<th>Policy statement:</th>
<th>Aesthetic Facial Surgery</th>
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<tr>
<td>Status:</td>
<td>Threshold</td>
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NHS funding will only be available in the following circumstances:

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

**Rhinoplasty**

Rhinoplasty is funded on a restricted basis only. Before proceeding except in instances of trauma or where patients are being treated as an emergency, referring and treating clinicians must ensure thresholds are met.

Requests for Rhinoplasty may be considered for the following indications:

- Significant post-traumatic nasal injury causing functional impairment.
  
  *OR*

- Correction of complex congenital conditions e.g. cleft lip and palate.
  
  *OR*

- Part of reconstructive head and neck surgery.
### Policy statement: Allergy disorders – Unconventional Treatment

**Status:** Not Funded

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.

### Policy statement: Alopecia

**Status:** Not Funded

**Patient Information:**
[http://www.nhs.uk/conditions/hair-loss/Pages/Introduction.aspx](http://www.nhs.uk/conditions/hair-loss/Pages/Introduction.aspx)

### Policy statement: Apnoea

**Status:** Threshold

See Sleep Studies.

**Patient Information:**

### Policy statement: Arthroscopy – hip, knee, shoulder

**Status:** Threshold

For South East Essex, referrals for Musculoskeletal (MSK) secondary care outpatient services are subject to Prior Approval, see Policy statement for Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management.

Arthroscopy is commissioned by South East Essex CCG’s on a restricted basis.

**Hip**

In diagnosis, Hip Arthroscopy (HA) was found to be more sensitive and specific than MRI and MRI arthropraphy. It is useful in patients with chronic (>6m) hip pain who have negative radiological investigations.

Therapeutic HA is indicated for the following:
- Loose bodies Labrum lesions tears, flaps) Septic arthritis – for debridement and lavage

NICE Interventional Procedure Guidance 213 suggests that arthroscopic femoro-acetabular surgery for hip impingement syndrome should only be used with “special arrangements for consent and for audit or research”. Individual Funding Request should be sought.

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**Knee**

Cases for knee arthroscopy will only be funded if they meet the criteria below:

- Arthroscopy of the knee can be undertaken where a competent clinical examination (or MRI scan if there is diagnostic reason) has demonstrated clear evidence of an internal joint derangement (meniscal tear, ligament rupture or loose body) and where conservative treatment has failed or where it is clear that conservative treatment will not be effective.

Knee arthroscopy can therefore be carried out for:

- Removal of loose body
- Meniscal repair or resection / repair of chrondral defects
- Ligament reconstruction/repair (including lateral release)
- Synovectomy/symptomatic plica
- To assist selection of appropriate patients for unicompartamental knee replacement

Knee arthroscopy should **NOT** be carried out (and will not be funded) for any of the following indications:

- Investigation of knee pain (MRI is a less invasive alternative for the investigation of knee pain)
- Treatment of osteoarthritis including arthroscopic washout and debridement.
- In line with NICE guidance CG59; this should not be offered as part of treatment for osteoarthritis unless the individual has knee osteoarthritis with a clear history of mechanical locking (not gelling, ‘giving way’)

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**Shoulder**

Shoulder arthroscopy will only be funded for patients with adhesive capsulitis (‘frozen shoulder’) if the following treatments have all been tried and failed:

(a) Activity modification
(b) Physiotherapy and exercise programme
(c) Oral analgesics including NSAIDs (unless contraindicated)
(d) Intra-articular steroid injections
(e) Manipulation under anaesthetic

Frozen shoulders or adhesive capsulitis following a fracture **WILL** be funded as undertaking manipulation under anaesthetic increases the risk of a re-fracture

In the majority of circumstances a clinical examination (history and physical examination) by a competent clinician will give a diagnosis and demonstrate if internal joint derangement is present. If there is diagnostic uncertainty despite competent examination or if there are “red flag” symptoms/signs/conditions then an MRI scan might be indicated.
Red flag symptoms or signs include recent trauma, constant progressive non-mechanical pain (particularly at night), previous history of cancer, long term oral steroid use, history of drug abuse or HIV, fever, being systematically unwell, recent unexplained weight loss, persistent severe restriction of joint movement, widespread neurological changes, and structural deformity. Red flag conditions include infection, carcinoma, nerve root impingement, bony fracture and avascular necrosis.

**Policy statement:** Assisted Conception Using IVF/ICS/IUI for infertility

**Status:** Individual Prior Approval - For Individual Prior Approval form, click here

**Southend CCG** commission assisted conception services in line with the embedded document below:

**Castle Point and Rochford CCG** commission assisted conception services in line with the embedded document below:

Below are the key points of the document:

- Allowing specialist fertility treatment for couples unable to achieve full sexual intercourse
- Offer one cycle of IVF to women aged 40-42 years
  
  *This means that the funding request for specialist fertility treatment must be submitted before the woman’s 43rd birthday*  
  *ie women are eligible for this treatment at 42 years and 364 days*
- Offer two full cycles of IVF for women aged 23-39 years in line with the majority of CCGs in England
  
  *This means that the funding request for specialist fertility treatment must be submitted before the woman’s 40th birthday*  
  *ie women are eligible for this treatment at 39 years and 364 days*
- Retain access to IVF treatment after three years for unexplained infertility (this does not apply where there is a diagnosed cause of infertility)

http://www.nice.org.uk/Guidance/CG156

Active forces personnel are exempt from the 12 month residency requirement (but should still meet the other registration and / or residency criteria).
Pre-implantation Genetic Diagnosis (PGD)

This policy does not include pre-implantation genetic screening as it is not considered to be within the scope of fertility treatment. This service is the commissioning responsibility of NHS England.

**Patient Information:**
Infertility Network- http://www.infertilitynetworkuk.com/
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<th>Policy statement:</th>
<th>Benign Skin Lesions/Conditions</th>
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</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Individual Prior Approval – for individual prior approval form click here</td>
</tr>
</tbody>
</table>

South East Essex CCG’s do not commission removal or treatment of clinically benign skin lesions/conditions for purely cosmetic reasons.

N.B. A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be referred to appropriate setting for assessment – this may be a 2 week wait clinic (for suspected melanoma/Squamous Cell Carcinoma).

Surgery or treatments to improve appearance alone is not provided for normal changes such as those due to ageing.

Lesions included in this policy include:
- Benign pigmented naevi (moles)
- Comedones
- Corn/callous
- Dermatofibromas (skin growths)
- Lipomas
- Milia
- Molluscum contagiosum
- Sebaceous cysts (epidermoid and pilar cysts)
- Seborrhoeic keratoses (benign skin growths, basal cell papillomas)
- Skin tags including anal tags
- Spider naevus (telangiectasia)
- Thread veins
- Warts and plantar warts
- Xanthelasma (cholesterol deposits underneath the skin),
- Neurofibromata

South East Essex CCG’s commission the removal of benign skin lesions on a restricted basis only. This applies to GPs providing Directed Enhanced Services for Minor Surgery under GMS/APMS/PMS contracts as well as secondary care consultants. Practices should not submit, and the CCG reserves the right not to fund, claims for procedures that would be classified as exclusions under this service restriction policy.

Individual prior approval must be obtained before referral to secondary care in all circumstances other than where a patient meets criteria A below.

A. Threshold Approval
If a benign skin lesion of the eye obscures vision or is causing a separate ocular problem then the patient can be referred to an appropriate service for removal.

B. Individual Prior Approval
Requests for the removal of benign skin lesions will be considered for:
- Sebaceous cysts where there has been more than one episode of infection. OR
- Lesions which cause functional impairment which prevents the individual from fulfilling work/study/carer or domestic responsibilities. OR
- Lesions on the face where the extent, location and size of the lesion can be regarded as considerable disfigurement, and which sets them apart from the cohort of people with lesions.

Evidence that previous treatment has been pursued before referral has been made will be required. For those requiring prior approval this evidence must be provided with the request for funding.
Policy statement: Beta Interferon and Glatiramer for Multiple Sclerosis
Status: Funding Responsibility of NHS England

South East Essex CCG’s do not commission Beta Interferon and Glatiramer; this is the responsibility of NHS England.

Policy statement: Biological Mesh
Status: Threshold

South East Essex CCG’s fund the use of Biological mesh in line with the East of England Prescribing Authorities Committee guidance (November 2014).

The South East Essex CCG’s will consider approval and use of biological mesh in the following indication:

Hernia:
- Primary ventral and inguinal hernia repair in non-infected fields
- Recurrent hernias, reinforced hernia repair
- Hernia prophylaxis
- Hernia repair in the contaminated or potentially contaminated fields (most widely used)
- Complex abdominal wall hernia repair

Breast reconstruction:
- Mastectomy
- Reconstructive surgery

Pelvic organ prolapse:
- Pelvic organ prolapse (POP)

Laparoscopic ventral mesh rectopexy (rectal prolapse)

Other indications (will require Individual Funding Request)
- Mucogingival surgery
- Urethroplasty
- eLAPE (Extralevator abdomino-perineal excision) reconstructive surgical technique for low rectal cancer
- Closure of laparostomy
- Diabetic foot ulcer repair
- Onlay graft during hemicraniectomy
- Sandwich bone augmentation

Biological mesh is classified by:
1. Source – usually human, porcine or bovine
2. Site – dermis, small intestine submucosa, pericardium
3. Processing method – cross-linked, non-cross linked, sterilised, non-sterilised

Treatment alternatives and uses:

The South East Essex CCG’s fund biological mesh that meet the criteria to the following financial levels:

<table>
<thead>
<tr>
<th>Biologic mesh</th>
<th>Upper cost per single dressing (£)</th>
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<tbody>
<tr>
<td>Smaller than 10X10 cm</td>
<td>500</td>
</tr>
<tr>
<td>10x10 cm</td>
<td>1200</td>
</tr>
<tr>
<td>10x15 cm</td>
<td>1600</td>
</tr>
<tr>
<td>15-20x20 cm</td>
<td>6000</td>
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<tr>
<td>&gt;20x20 cm</td>
<td>6400</td>
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</table>

**Policy statement:** Blephoraplasty

**Status:** Threshold

South East Essex CCG’s commission blepharoplasty on a restricted basis in patients who meet the following criteria:

**Upper Lid**

This procedure will be funded to correct functional impairment and **not purely for cosmetic reasons**.

**Indications:**
- Impairment of visual fields in the relaxed, non-compensated state. Evidence will be required that eyelids impinge on visual fields reducing field to 120° laterally and 40° vertically (to be confirmed by visual fields test).
  - **OR**
- Clinical observation of poor eyelid function, discomfort, e.g. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow.

**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.

See Dysthyroid eye disease.
## Policy statement: Bobath Therapy

**Status:** Not Funded

The South East Essex CCG’s do not directly commission Bobath Therapy. Funding will only be granted in exceptional circumstances and applications should be made via the IFR process.

## Policy statement: Body Contouring

**Status:** Not Funded

See Liposuction/Liposculpture.

## Policy statement: Bone Anchored Hearing Aid (BAHA)

**Status:** Funding Responsibility of NHS England

South East Essex CCG’s do not commission BAHAs; this is the responsibility of NHS England.

NHS England routinely commissions unilateral BAHAs for patient’s meeting the commissioning policy but will not normally commission bilateral Bone Anchored Hearing Aid (BAHA) implantation. Such requests for funding will only be considered through an exceptions route.

## Policy statement: Bone Morphogenic Protein (BMP)

**Status:** Threshold

South East Essex CCG’s commission BMP in line with the East of England policy for use of BMP:

**Acute tibial fractures with Grade 111B fractures (i.e. more severe cases)**

- Dibotermin alfa is recommended as an adjunct to standard care using open fracture reduction and intramedullary nail fixation in patients in whom there is a substantial risk of non-union. It is restricted to patients treated with undreamed intramedullary nails.

Non-union of long bones exceeding nine months which have been assessed for bone autograft and found to be unsuitable for such procedure:
- Eptotermin alfa combined with bovine collagen should only be considered third line
- Treatment is restricted by named consultants for use in tibial, ulnar, radial, humoral, femoral and clavicular non-union.

The CCGs do not commission BMP for:

- In skeletal immature individuals defined as those who can reasonably be expected to not have fusion of the long bone epiphyses, in other words they are still growing (variant; normally in girls below 16 years and in boys below 19 years. To be individually confirmed)
- For repeat doses or sequential use of BMPs due to the possible development of antibody production.

### Policy statement: Botox

#### Status: Threshold

The South East Essex CCG’s commission the use of Botox in line with the East of England Prescribing Advisory Committee Guidance and for those conditions covered by NICE:

- Migraine, Technology Appraisal Guidance 260, Issued June 2012
- Spasticity in children and young adults, Clinical Guideline (CG) 145, Issued July 2012
- Urinary incontinence in neurological disease, CG 148, Issued August 2012
- Lower urinary tract symptom, CG 97, Issued May 2010
- Urinary incontinence, CG 40, Issued October 2006

The South East Essex CCG’s will only fund a maximum of 4 treatments per annum.

The rationale for this decision is that initial effect of the Botox injection should be seen within three days and reaches a peak at one to two weeks post-treatment. In most cases the treatment lasts up to 12 weeks, hence 4 treatments per annum are expected. (1)

**Botox (BTA) product licensed indications (does not include cosmetic uses)** (1, 2, 3)

<table>
<thead>
<tr>
<th>Product</th>
<th>Licensed indications</th>
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<td>Blepharospasm</td>
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<td>☑</td>
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<tr>
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*Post stroke*
Overactive bladder and urinary continence
South East Essex CCG’s only fund use of Botox in the use of overactive bladder and urinary continence when all other steps in the pathway have been trialled with no success.

Detailed information for PAC July 2013 Guidance - see embedded document:

Policy statement: Breast Procedures

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<th>Threshold</th>
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**Breast Asymmetry**

Funding will only be considered if there is gross disparity of breast cup sizes i.e. asymmetry where there is at least 2 cup size difference in breast size on initial consultation with the patient’s GP.

The goal of surgery is to correct a significant deformity. Contour irregularities and moderate asymmetry (including dog-ears, nipple direction or position, breast size and shape disparity) are predictable following surgery. Any post-surgical cosmetic irregularities will not be funded by the CCGs in revision surgery.

Patients are eligible for surgery to correct breast asymmetry if all the following criteria are met and confirmed by a consultant plastic surgeon:

- There is a natural absence of breast tissue unilaterally where there is no ability to maintain a normal breast shape using non-surgical methods (e.g. padded bra).
  - and
- There is a difference of at least 2 cup sizes (e.g. C and DD cup size differential).
  - and
- Patient Aged ≥ 18 years old and has reached end of puberty (referral should be delayed if end of puberty has not been reached).
  - and
- Where relevant, treatment of the underlying cause of the problem has been undertaken.
  - and
- The patient has a BMI<25 and evidence that the patient's weight has been stable for 2 years.

The choice of surgical intervention (i.e. unilateral breast reduction or unilateral breast augmentation) should be made jointly by the person and the clinician and taking into account:

- The experience of the surgeon who will perform the operation, and
- the best available evidence on effectiveness and long term effects, and
- the facilities and equipment available, and
- Significant musculo-skeletal pain/functional problems.

Patient must be aged at least 18 years. Surgery for patients aged 16 or 17 years will only be funded if breast size has been stable for at least one year, and the referring clinician can
satisfy the Individual Funding Request panel that it is unreasonable to wait until the patient is 18 years old.

**Breast Augmentation / Breast Reconstruction**

Breast augmentation is routinely funded for the following indications:
- Reconstructive following or as part of surgery for breast malignancy or its prevention – Funding Approval **not** required.
- Congenital amastia (complete absence of breast tissue).

**Breast implants for cosmetic purposes are not funded.** In particular funding is not available for breast augmentation in the case of:
- Small but normal breasts,
- Breast changes following pregnancy or with age.

**Breast lift / Mastoplexy**

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.

**Breast Reduction**

Breast reduction surgery is regarded as a procedure of a low clinical priority. Cosmetic breast surgery (surgery undertaken exclusively to improve appearance) is **not** provided to correct natural changes such as those associated with pregnancy or ageing. This procedure is therefore **not** routinely funded by the CCGs. Breast reduction surgery is an effective intervention that should be funded if **one** of the following sets of criteria is met:

**CRITERIA SET 1:**
- The patient is suffering from neck ache or backache. Clinical evidence will need to be produced to rule out any other medical/physical problems to cause these symptoms; and the wearing of a professionally fitted brassiere has not relieved the symptoms, and
- Full evidence is provided of all conservative management options that have been attempted, and
- The patient has a BMI < 25 and evidence that the weight has been stable for 2 years, and
- The patient has persistent intertrigo for at least one year and confirmed by 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 Gynaecomastia)

**CRITERIA SET 3:**
Pubertal hyperplasia
- A reduction can be performed if it is expected that **at least 500g** will be removed from each breast.

Patients who have predictable breast changes due to pregnancy are excluded.
Patients should have an initial assessment by the referrer prior to an appointment with a consultant plastic surgeon to ensure that these criteria are met. Assessment of the thorax should be performed, including relevant diagnostics.

**Removal and replacement of breast implants**

South East Essex CCG’s only commission the removal and replacement of breast implants in the following circumstances:

- Breast implants were provided by the NHS (e.g. as part of treatment for breast 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).

If privately funded breast implants are required to be removed for clinical reasons, patients will be offered the choice of removing both prosthesis 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.

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**Policy statement:** Brow Lift

**Status:** Threshold

**Policy statement:** Bunions

**Status:** Threshold

The surgical treatment of asymptomatic bunions is regarded as a procedure of low clinical priority. These procedures are, therefore, are not routinely funded by South East Essex CCG’s.

Removal of bunions will only be considered where:

- Conservative methods of management* have failed,

and

- The patient suffers significant functional impairment** as a result of the bunions,

and

- There is radiographic evidence of joint damage (at point of referral).

*Conservative measures include:
Avoiding high heel shoes and wearing wide fitting leather shoes
Non-surgical treatments such as bunion pads, splints, insoles or shields or exercise where appropriate
**Significant functional impairment** is defined as:
The patient complains of moderate to severe joint pain not relieved by extended non-surgical management AND has severe impact on their ability to undertake activities of daily living.

Concerns about cosmetic appearance should be managed by the patient or Primary Care and not referred into secondary care or a Community Podiatric service.
Detailed documentation against the above criteria that are fulfilled is mandatory in the referral letter to secondary care. Clinically inappropriate referrals will be returned to GPs.
Follow up will be capped at one follow up unless there are exceptional circumstances.

<table>
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<tr>
<th>Policy statement:</th>
<th>Caesarean Section (Elective)</th>
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Elective Caesarean Section procedures will only be considered when one of the following criteria is met:

- Breech presentation.
- Multiple pregnancy.
- Preterm birth
- Small for gestational age.
- Placenta praevia.
- Morbidly adherent placenta.
- For cephalopelvic disproportion in labour,
- Mother-to-child transmission of maternal infections

<table>
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<th>Policy statement:</th>
<th>Capsule Endoscopy</th>
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South East Essex CCG’s commission capsule endoscopy in line with NICE guidance. Capsular endoscopy has a useful role to play in the diagnosis and monitoring of certain gastrointestinal conditions. However judgement is needed to decide to when it is an appropriate investigation. This judgement depends on the individual patient’s condition and the results of other investigations. It is best made by the specialist caring for the patient. It is not something that can be safely restricted in by a service restriction policy.

The National Institute of Health and Care Excellence (NICE) has deemed capsule endoscopy as safe and effective enough from routine use in the NHS; Interventional Procedure Guidance 101, 2004. Both NICE pathways and Map of Medicine, an authoritative source of best practice guidance, have capsule endoscopy as one of the options for evaluating patient with small bowel conditions.
Policy statement: Carpal Tunnel

Status: Threshold

For South East Essex, referrals for Musculoskeletal (MSK) secondary care outpatient services are subject to Prior Approval, see Policy statement for Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management.

Patients with wasting of the hand muscles should be urgently referred to the acute (outside the scope of this policy).

South East Essex CCG’s commissions surgery for carpal tunnel syndrome on a restricted basis.

Nerve conduction studies (EMG) are NOT generally needed to confirm the diagnosis and are not routinely funded by the South East Essex CCG’s.

Community based conservative treatment should be initiated for ALL patients with suspected Carpal Tunnel Syndrome for a period of 6 months, excluding those noted below. Conservative treatment will include the following:

- Analgesia
- Splinting with Futuro-type cock up splint (night time only or constant)
- Steroid injection – should be administered once prior to referral for consideration of surgery

All GPs should seek access to carpal tunnel injections prior to referral to surgery.

Patients with Carpal Tunnel Syndrome should be referred if any of the following criteria apply:

- Severe symptoms (fewer than 5% of patients) uncontrolled by conservative measures, significantly interfering with daily activities.
- Neurological deficit i.e. constant sensory blunting or weakness of thenar abduction (wasting or weakness of abductor pollicis brevis).
- Unclear diagnosis or dual pathology
- Rheumatoid
- Recent trauma
- Previous surgery
Where applicable, referral letter must detail conservative methods tried and the length of time that each of these was carried out.

Uncomplicated cases who have **NOT** responded to conservative management for 6 months should be referred.

**Rationale:**
Conservative treatment offers short-term benefit (1-3 months) similar to surgery and many patients’ symptoms may resolve for at least a year after conservative treatment. After corticosteroid injection, up to 50% of patients may report minor or no symptoms at one year. The benefits of conservative therapy are seen early after treatment and then decrease while the benefits of surgery take longer to be fully realised.

Corticosteroid injections and nocturnal splinting are effective conservative therapies. Therefore patients would not normally be referred for carpal tunnel syndrome unless they have had a local steroid injection into the carpal tunnel together with the provision of night splints.

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

In the longer term (3-18 months), surgery is better than conservative therapy with up to 90% of patients reporting complete or much improvement at 18 months.

A trial of conservative therapy offers the opportunity to avoid surgery for some patients.

**Policy statement:**

<table>
<thead>
<tr>
<th>Cataracts</th>
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<td><strong>Status:</strong></td>
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Referrals should not be based simply on the presence of a cataract. **Referral of patients with cataracts to ophthalmologists should be based upon the following indications:**

**A:** The patient accepts that there are risks and benefits and wishes to undergo cataract surgery.

The referring optometrist or GP should discuss the above with the patient before referring.

Patients who are not willing to have Cataract surgery should not be referred.

**And B:** Corrected visual acuity documented of 6/12 or worse in the affected worse eye, assessed by the clinician as being due to a rectifiable lenticular opacity

**Or C:** Impairment of lifestyle (not exhaustive list) such as;
- the patient is at significant risk of falls, or
- the patient’s vision is affecting their ability to drive, or
- the patient’s vision is substantially affecting their ability to work, or

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• the patient’s vision is substantially affecting their ability to undertake leisure activities such as reading, watching television or recognising faces or
• management of other co-existing eye conditions

The reasons why the patient’s vision and lifestyle are adversely affected by cataract and the likely benefit from surgery must be documented in the clinical records.

Second eye

There are sound clinical grounds for cataract surgery in the second eye.

Patients will be offered second eye surgery provided they fulfil the referral criteria (see above).

Second eye surgery should be deemed urgent when there is resultant symptomatic anisometropia ie a large refractive difference between the two eyes resulting in poor binocular vision (this should be clearly recorded in the patient's notes).

Revisions in 'red' approved by the South Essex Ophthalmology Clinical Network July 2016.

Policy statement: Chalazia (cyst on or in eye lid) / Chalazion
Status: Threshold

Chalazia are benign, granulomatous lesions caused by blockage of the Meibomian gland duct, which will normally resolve within 6 months with conservative management in primary care.

Community excision of Chalazia (where a community service is available / commissioned) will be funded for those patients with Two or more of the following:

• Present for more than six months.
• Present on the upper eyelid.
• Source of regular infection (2 times within six month time frame) requiring medical treatment.
• Interferes with vision.
• Conservative management has been tried & failed and there is no appropriate alternative to surgical intervention.
• The site of the lesion or lashes renders the condition as requiring specialist intervention.

Only the patients meeting the following criteria should be referred to secondary care:

• All children should be referred on.
• Any recurrent chalazion should be referred.
• Any atypical features i.e. lash loss, bleeding should be referred.
• Any patient with previous history of Basal cell carcinoma (BCC) or Squamous cell carcinoma (SCC) or where malignancy is suspected should be referred on.

Back to Index
Policy statement: Cholecystectomy
Status: Threshold

See Gall Stones

Policy statement: Chronic Fatigue Syndrome (CFS)
Status: Threshold

Patients should be diagnosed and managed in a community setting. Referral for a specialist opinion may be required if there is doubt about the diagnosis, or the patient is not improving despite management in primary care. Funding for inpatient care will not be provided.

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/m2).
- 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.

CFS/ME is a debilitating disorder characterised by profound tiredness or fatigue. Patients may become exhausted with only light physical exertion. They most often function at a level of activity substantially lower than their capacity before the onset of illness. In addition to these key defining characteristics, patients generally support various non-specific symptoms, including weakness, muscle aches and pains, excessive sleep, malaise, fever, sore throat, tender lymph nodes, impaired memory and/or mental concentration, insomnia and depression.

Policy statement: Circumcision
Status: Threshold

This policy does not apply to:

Suspected penile malignancy, use the 2 week cancer referral pathway.
Traumatic foreskin injury where it cannot be salvaged.
Male circumcision is defined as the surgical removal of all or part of the foreskin of the penis.

Circumcision is considered a low priority treatment and will only be provided for therapeutic reasons if the patient meets one of the following criteria:

- Phimosis (inability to retract the foreskin due to a narrow prepuceal ring) in children with spraying, ballooning and/or recurrent infection.
- Adult phimosis.
- Recurrent balanitis, balantitis xerotica obliterans (chronic inflammation leading to a rigid fibrous foreskin).
- Paraphimosis (inability to pull forward a retracted foreskin).
- Suspicion or evidence of malignancy, dermatological disease (such as lichen planus or eczema) which is unresponsive to other treatment, where biopsy is required and occasionally for selected patients with urinary tract infections (normally referred by a paediatrician).
- Balanoposthitis (recurrent bacterial infection of the prepuce).

References:

Patient Information:
http://www.nhs.uk/conditions/Circumcision/Pages/Introduction.aspx
• Adults with Lumber or Cervical pain not warranting surgical referral.
• Adults with large joint pain as part of a care pathway that may lead to joint replacement.

**Biofeedback**, for:
• Chronic constipation (biofeedback is the primary treatment option for patients with dyssynergic defecation).
• Irritable bowel syndrome.
• Levator ani syndrome.
• Migraine and tension headaches (muscle, thermal or skin biofeedback);
• Neuromuscular rehabilitation of stroke and traumatic brain injury (TBI) (policy does not cover neuromuscular electrical stimulators).
• Raynaud's disease.
• Refractory severe subjective tinnitus – See Tinnitus.
• Temporomandibular joint (TMJ) syndrome – See TMJ.
• Urinary incontinence.

**Electrical stimulation**
As an adjunct or as an alternative to the use of drugs either in the treatment of acute postoperative pain in the first 30 days after surgery, or for certain types of chronic, intractable pain not adequately responsive to other methods of treatment including, as appropriate, physical therapy and pharmacotherapy. A physician evaluated trial lasting between 1 and 2 months should determine if treatment is to continue.

**Selected use in palliative care**
• Mistletoe in cervical cancer.
• Meditation and Tai Chi in selected elderly patients with optimally treated heart failure – evidence of reduction in sympathetic activity (SIGN 95).

**Hypnotherapy**
• Severe chronic insomnia.
• IBS.

**Manipulation and Stretching**
• Selected cases of osteoarthritis of the hip as an adjunct to core treatment.
• Sub-acute and chronic low back pain of more than six weeks duration.
• Acute low back pain of less than six weeks.
• Mobilisation of the neck.

**Complementary and Alternative Therapies**

The South East Essex CCG's will **NOT** fund the following therapies because of lack of sufficient evidence of effectiveness*:

• Homeopathy
• Aromatherapy
• Herbal remedies
• Clinical ecology
• Active release technique
• Acupressure
• Alexander technique
• AMMA therapy
• Antineoplastons -- see CPB 240 - Antineoplaston Therapy and Sodium
- Phenylbutyrate
- Antineoplastons -- see CPB 240 - Antineoplastic Therapy and Sodium Phenylbutyrate
- Apitherapy
- Applied kinesiology
- Art therapy
- Autogenous lymphocytic factor
- Auto urine therapy
- Bioenergetic therapy
- Biofield Cancell (Entelev) cancer therapy
- Bioidentical hormones
- Brain integration therapy
- Carbon dioxide therapy
- Cellular therapy
- Chelation therapy for Atherosclerosis -- see CPB 234 - Chelation Therapy
- Chiropractic services
- Chung Moo Doe therapy
- Coley's toxin
- Colonic irrigation
- Clinical ecology
- Active release technique
- Acupressure
- Alexander technique
- AMMA therapy
- Conceptual mind-body techniques
- Craniosacral therapy
- Cupping
- Dance/Movement therapy
- Digital myography
- Ear Candling
- Egoscue method
- Electrodiagnosis according to Voll (EAV)
- Equestrian therapy -- see CPB 151 - Hippotherapy
- Essential Metabolics Analysis (EMA)
- Essiac
- Feldenkrais method of exercise therapy (also known as awareness through movement)
- Flower essence
- Fresh cell therapy
- Functional intracellular analysis (also known as essential metabolic analysis, intracellular micronutrient analysis, leukocyte nutrient analysis, as well as micronutrient testing).
- Gemstone therapy
- Gerson therapy
- Glyconutrients
- Graston technique
- Greek cancer cure
- Guided imagery
- Hair analysis - see CPB 300 - Hair Analysis
- Hako-Med machine (electromedical horizontal therapy)
- Hellerwork
- Hoxsey method
- Human placental tissue
- Hydrolysate injections
- Humor therapy
- Hydrazine sulfate
- Hypnosis
- Hyperoxygen therapy
- Immunoaugmentive therapy
- Infratronic Qi-Gong machine
- Insulin potentiation therapy
- Inversion therapy
- Iridology
- Iscador
- Juvent platform for dynamic motion therapy
- Kelley/Gonzales therapy
- Laetrile
- Live blood cell analysis
- Macrobiotic diet
- Magnet therapy
- MEDEK therapy
- Meditation/transcendental meditation
- Megavitamin therapy (also known as orthomolecular medicine)
- Meridian therapy
- Mesotherapy
- Moxibustion (except for fetal breech presentation) - see CPB 135 - Acupuncture
- MTH-68 vaccine
- Music therapy
- Myotherapy
- Neural therapy
- Ozone therapy
- Pfrimmer deep muscle therapy
- Polarity therapy
- (Poon's) Chinese blood cleaning
- Primal therapy
- Psychodrama
- Purging
- Qigong longevity exercises
- Ream's testing
- Reflexology (zone therapy)
- Reflex Therapy
- Reiki
- Remedial massage
• Revici’s guided chemotherapy
• Rife therapy/Rife machine
• Rolfing (structural integration)
• Rubenfeld synergy method (RSM)
• 714-X (for cancer)
• Sarapin injections
• Shark cartilage products
• Telomere testing
• Therapeutic Eurythmy-movement therapy
• Therapeutic touch
• Thought field therapy (TFT) (Callahan Techniques Training)
• Trager approach
• Visceral manipulation therapy
• Whitcomb technique
• Wurn technique/clear passage therapy
• Yoga

*Adapted from the AETNA Complementary and Alternative Medicine Policy.

Complimentary therapies are seen by an increasing number of people (with increasing requests for treatment) as a more holistic and ‘natural’ approach to dealing with a variety of complaints. Attractions include the comparably longer interaction time with the practitioner and the belief that such therapies will work, affecting a complex mix of factors impacting on health. However there is much uncertainty about benefit/effectiveness, evidence of complications for some therapies and considerable grounds to suspect other adverse effects may occur. Since conventional medicine also aspires to a holistic approach, this means that some alternative therapies should be considered where evidence exists.

The types of complimentary therapies covered under this policy include Homoeopathy, Acupuncture, Osteopathy, Biofeedback, Hypnotherapy, Chiropractic Therapy, Massage, Reflexology, Clinical Ecology, Aromatherapy, Herbal Remedies, Chinese medicines, Psychotherapy and Meditation. This list is not exhaustive and other treatments not listed here but that are considered ‘alternative’ or ‘complimentary’ therapies will be considered in the same way. Some procedures may be available through services in hospices and hospitals as part of a palliative care package; these are usually through charitable services and not part of commissioned services.

Some patients may also be treated as part of an integrated conventional and complimentary service for a specific condition where these are commissioned, although exceptionality would need to be demonstrated.

**Evidence Base**
The House of Commons Science and Technology Committee enquiry into the provision of homeopathic services within the NHS in 2009 recommended that homeopathic treatments should not be routinely available within the NHS.\(^1\) The committee report included a robust review of the evidence base for a variety of homeopathic treatments but found no evidence of effectiveness for any condition from published RCTs and systematic reviews. A previous report commissioned by the Association of Directors of Public Health in 2007\(^2\) and more recent reviews by AETNA\(^3\) are all consistent in confirming the lack of sufficient evidence of effectiveness of homeopathic treatments despite many years of research and hundreds of studies.
There is some evidence of clinical benefit for some complimentary therapies such as acupuncture, osteopathy, biofeedback and hypnotherapy for certain conditions. For example, NICE recommends Acupuncture for up to ten sessions for the treatment of sub-acute and chronic low back pain of more than six weeks duration. NICE also suggests that manipulation and stretching should be considered as an adjunct to core treatment for osteoarthritis of the hip, sub-acute and chronic low back pain of more than six weeks duration, acute low back pain of less than six weeks duration and mobilisation of the neck.4,5,6,7

**Patient information:**
http://www.nhs.uk/Search/Pages/Results.aspx?q=alternative+therapy

**References:**
4. NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE (2009), Clinical Guideline 88, Early management of persistent non-specific low back pain, Shekelle et al., (1992), Spinal Manipulation for Low Back Pain, Annals of internal Medicine, 117 (7), pp 590-598

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**Policy statement:** Correction of Privately Funded Treatments

**Status:** Not Funded

Correction of privately funded treatments which are causing clinical problems for the patient will be considered on a case by case basis by the CCGs Individual Funding Request panel.

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**Policy statement:** Cosmetic Surgery – General Principles

**Status:** Not Funded

Referrals for plastic surgery from both primary and tertiary sources will be assessed in line with the relevant section of the Service Restriction Policy and the clinical evidence provided.

For an authorised first appointment, the Plastic Surgery Specialist to whom the referral is subsequently passed should decide whether the patient would benefit from plastic surgical intervention, and if so, establish that the patient fully understands the risks and benefits of surgery.

All referrals should be assessed for both first Outpatients Department appointments and subsequent procedure appointments, in line with this policy and clinical evidence.
The Mental Health Transformational Delivery Board has recently decided that it does not support commissioning cosmetic surgery to treat mental health symptoms. It concluded that this would be considered a low priority mental health intervention and that there was insufficient evidence to support the effectiveness of the intervention in terms of treating mental health conditions.

Assessment of patients being considered for referral who have an underlying conditions e.g. genetic or endocrine should have had this fully investigated by a relevant specialist prior to the referral to plastic surgery being made.

Surgery should be supported where a patient has been accepted onto an NHS waiting list prior to taking up residence in South East Essex, providing the existing clinical evidence has remained the same. Referrals within the NHS for the revision of treatments originally performed outside the NHS will not usually be permitted unless the patient meets the local criteria for the original treatment. Referrers should be encouraged to re-refer to the practitioner who carried out the original treatment for resolution first where not endangering the health of the individual.

Where a patient has previously had NHS funded treatment, procedures necessary for dealing with complications or an outcome that, because of complications or technical difficulties, has resulted in cosmetic or physical problems that, from a professional point of view, are severe enough to oblige the NHS to fund corrective treatment, should be supported.

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 this should be taken into consideration prior to referral.

Referrals will only be reviewed by the Individual Funding Request panel on an exceptional case basis.

The Mental Health Transformational Delivery Board has recently decided that it does not support commissioning cosmetic surgery to treat mental health symptoms. It concluded that this would be considered a low priority mental health intervention and that there was insufficient evidence to support the effectiveness of the intervention in terms of treating mental health conditions.

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Policy statement: Cyberknife
Status: Funding Responsibility of NHS England

This service is now the commissioning responsibility of NHS England.

Policy statement: Dental Procedures
Status: Funding Responsibility of NHS England

This service is the commissioning responsibility of NHS England.

Policy statement: Dilatation and Curettage (D&C) / Hysteroscopy
Status: Threshold

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

- As an investigation for structural and histological abnormalities where ultrasound has been used as a first line diagnostic tool and where the outcomes are inconclusive, for example to determine the exact location of a fibroid or the exact nature of the abnormality.
  
or
- Where dilatation is required for non-hysteroscopic ablative procedures.
  
or
- Hysteroscopy should be considered immediately prior to the ablative procedure to ensure correct placement of the device (unless pre-operative ultrasound assessment has already been undertaken).
  
or
- Postmenopausal women who have had a pelvic scan and endometrial biopsy and who present with further bleeding 6 months later should be offered hysteroscopy to be sure no small cancer has been missed without a mandatory preliminary scan.

Dilation and Curettage will not be funded in the following circumstances:
- As a diagnostic tool for heavy menstrual bleeding.
  
or
- As a therapeutic treatment for heavy menstrual bleeding.

Rationale: D&C and hysteroscopy will only be used in line with NICE guidance (CG44, 2007).

Patient Information:
### Policy statement: Dupuytren’s Contracture

**Status:** Threshold

For South East Essex, referrals for Musculoskeletal (MSK) secondary care outpatient services are subject to Prior Approval, see Policy statement for Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management.

See Minor Hand Conditions

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### Policy statement: Dysthyroid eye disease / Proptosis

**Status:** Threshold

Surgery for proptosis is commissioned on a restricted basis.

Funding will be provided to treat proptosis, arising from thyroid disease, as a result of enlargement of muscles in the socket and increased fatty tissue or abnormality of position of eyelid which causes extra exposure to the eye surface.

Surgery will only be offered for abnormality of the eyelid position after artificial tears have been tried for at least 6 months and failed.

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### Policy statement: Ear Lobes

**Status:** Not Funded

See Repair of ear lobes.

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### Policy statement: Ear Wax Removal

**Status:** Threshold

See Microsuction

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### Policy statement: Endoscopic laser spinal surgery

**Status:** Not Funded

The only indications for this spinal surgery to be considered are those from NICE guidance (IPG027, IPG031, IPG061, IPG088, IPG081) and must conform to this guidance i.e. should not be used without special arrangements for audit consent and research.
• IPG027 Laser lumbar disectomy considered when there is nerve compression or persistent symptoms that are unresponsive to conservative treatment. Laser disectomy can be performed when the prolapse is contained. It is one of several minimally invasive surgical techniques which are alternatives to open repair procedures such as open lumbar disectomy or laminectomy.

• IPG031 Endoscopic laser surgery for aminoplasty for chronic back and leg pain from a variety of causes.

• IPG061 Percutaneous endoscopic laser thoracic disectomy is used to treat symptomatic thoracic disc hemiation.

• IPG088 Endoscopic division of epidural adhesions for lower back pain, particularly when radiculopathy (a disorder of the spinal nerve roots) is present.

• IPG081 Percutaneous intradiscal electrothermal therapy for discogenic back pain.

Patients should have a BMI of between 20kg/m² and 27kg/m². Evidence will be required that the patient’s weight has been stable for a period of not less than two years.

Rationale: Endoscopic laser spinal surgery for chronic back pain is of unproven benefit. Referral and treatment should only be considered under exceptional circumstances, in settings which meet the requirements of NICE guidance (IPG027, IPG031, IPG061 and IPG088).

Policy statement: Exogen ultrasound bone healing system for long bone fracture with non-union or delayed healing

Status: Individual Prior Approval – click here for individual Prior Approval Form

South East Essex CCG’s fund the use of Exogen ultrasound bone healing system in line with the East of England Prescribing Authorities Committee guidance.

On this basis South East Essex CCG’s only funds Exogen ultrasound heating system in the following circumstances:
- Patient has a non-union fractures in long bones which have failed to heal after 9 months in patients over 18 years or older

South East Essex CCG’s do not recommend use of Exogen ultrasound bone healing system in the following patient groups:
- Use of Exogen in patients with delayed healing fractures that have no radiological evidence of healing after 3 months
- Use of Exogen ultrasound bone healing system for any other indications.
Policy statement: Face Lift / Rhytidectomy
Status: Threshold

See Aesthetic Facial Surgery.

Policy statement: Facet Joint Injections / Spinal Injections (acute, chronic, facet)
Status: Threshold

For South East Essex, referrals for Musculoskeletal (MSK) secondary care outpatient services are subject to Prior Approval, see Policy statement for Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management.

Referral to a hospital consultant for Facet Joint Injections for lower back pain are considered low priority, and will only be provided under the NHS in line with the guidance below.

Policy statement: Facial Surgery
Status: Threshold

These procedures will be considered for the treatment of:
- 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

They will not be available to treat the natural processes of ageing.

Policy statement: Fibroid embolisation/uterine artery embolisation
Status: Not Funded

The South East Essex CCG’s do not fund this.
Policy statement: **Functional Electrical Stimulation (FES) Status**

**Status:** **Not Funded**

South East Essex CCG's will fund functional electrical stimulation (FES) for **drop foot of central neurological origin only**.

Patients should have been assessed by a multidisciplinary team specialising in rehabilitation prior to referral.

Funding is **not** available for:

- Upper limbs or foot-drop due to lower motor neurone diseases (such as motor neurone disease, polio, Guillain–Barre syndrome, peripheral neuropathy, traumatic injury etc.).
- There is a lack of evidence for FES for shoulder pain, shoulder subluxation or reaching or grasping and so FES will not be funded for these indications.
- Patients who are already receiving treatment will only be considered for on-going funding if the following criteria apply:
  - Documented history of tripping, falling, or gait problems;
  - Patient has a full range of ankle dorsal flexion/good calf tone/absence of severe spasticity and lower limb oedema.

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Policy statement: **Gall Stones/Cholecystectomy**

**Status:** **Threshold**

Cholecystectomy is routinely approved for symptomatic gallstones.

**Treatment is not routinely approved for asymptomatic gallstones** because the risks of prophylactic cholecystectomy outweigh the benefits.

Asymptomatic gallstones are defined as the presence of gallstones detected incidentally in patients who do not have any abdominal symptoms, or have symptoms that are not thought to be due to gallstones.

The following tables indicate appropriateness of indication versus risk due to patient co-morbidity.

**Indications for cholecystectomy:**

<table>
<thead>
<tr>
<th>Indication</th>
<th>Investigative Findings</th>
<th>Comorbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vague Symptoms</td>
<td>Stone in CBD</td>
<td>No+low</td>
</tr>
<tr>
<td>Single attack of biliary colic</td>
<td>Stone(s) in GB or CBD or non-functioning GB</td>
<td>No+low</td>
</tr>
<tr>
<td>Multiple attacks of biliary colic</td>
<td>Stone(s) in GB or CBD or non-functioning GB</td>
<td>No+low</td>
</tr>
<tr>
<td>Confirmed acute cholecystitis</td>
<td>Stone(s) in GB or CBD or non-functioning GB</td>
<td>No+low</td>
</tr>
<tr>
<td>Suspected acute</td>
<td>Stone(s) in GB or CBD</td>
<td>No+low</td>
</tr>
<tr>
<td>Indication</td>
<td>Investigative Findings</td>
<td>Comorbidity</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Asymptomatic</td>
<td>Single stone in GB</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Multiple stones in GB, chronic acalculus cholecystitis, or stone in GB</td>
<td>Med/high</td>
</tr>
<tr>
<td>Vague Symptoms</td>
<td>Stone in GB or chronic cholecystitis Any</td>
<td>Med+high</td>
</tr>
<tr>
<td>Single attack of biliary colic</td>
<td>Stone(s) in GB or non-functioning GB</td>
<td>High</td>
</tr>
<tr>
<td>Suspected acute cholecystitis</td>
<td>No Stones</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Stones but no complications</td>
<td>High</td>
</tr>
<tr>
<td>Porcelain gall bladder</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Silent onset of jaundice</td>
<td>No Stones</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Stones in GB only</td>
<td>Low+med</td>
</tr>
<tr>
<td></td>
<td>Stone in CBD only</td>
<td>High</td>
</tr>
<tr>
<td>Acute pancreatitis with and without appreciable alcohol intake</td>
<td>No Stones</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Stones in GB only</td>
<td>Low+med</td>
</tr>
<tr>
<td></td>
<td>Stones in CBD only</td>
<td>High</td>
</tr>
<tr>
<td>Acute recurrent pancreatitis – no significant alcohol intake</td>
<td>No Stones</td>
<td>Med+high</td>
</tr>
<tr>
<td></td>
<td>Stones in GB only</td>
<td></td>
</tr>
<tr>
<td>Incidental cholecystectomy + compatible symptoms</td>
<td>Stone in CBD</td>
<td>No + low</td>
</tr>
<tr>
<td>Porcelain gall bladder</td>
<td>Stone(s) in GB or CBD</td>
<td>No, low+med</td>
</tr>
<tr>
<td>Silent onset of jaundice</td>
<td>No Stones</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Stones in GB only</td>
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<tr>
<td>Acute recurrent pancreatitis – appreciable alcohol intake</td>
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</tr>
<tr>
<td></td>
<td>Stones in GB only</td>
<td>High</td>
</tr>
<tr>
<td>Acute recurrent pancreatitis – appreciable alcohol intake</td>
<td>No Stones</td>
<td>Med+high</td>
</tr>
<tr>
<td>Acute recurrent pancreatitis – appreciable alcohol intake</td>
<td>Stones in GB only</td>
<td></td>
</tr>
<tr>
<td>Incidental cholecystectomy + compatible symptoms</td>
<td>Stone in GB only</td>
<td>Med + high</td>
</tr>
<tr>
<td>Long term TPN</td>
<td>Symptoms only</td>
<td>Med + high</td>
</tr>
<tr>
<td></td>
<td>Stones only</td>
<td>Med + high</td>
</tr>
<tr>
<td></td>
<td>Symptoms + stones</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Incidental findings</td>
<td>Med + high</td>
</tr>
<tr>
<td>Asymptomatic cholecystenteric fistula</td>
<td></td>
<td>Med+high</td>
</tr>
</tbody>
</table>

**Exceptions** to this policy could include patients with asymptomatic gallstones and
- Sickle cell disease.
- Calcified 'porcelain' gallbladder or a family history of gallbladder carcinoma immunosuppression, as they would be at higher risk if they develop an infective complication i.e. cholecystitis or cholangitis.

**Policy statement:** Ganglion

**Status:** Threshold

For policy see Minor Hand Conditions.

**Patient Information:**
http://www.nhs.uk/conditions/excisionofganglion/Pages/Introduction.aspx

**Policy statement:** Gastroelectrical Stimulation for Gastroparesis

**Status:** Not Funded

Gastric stimulation / gastroelectrical stimulation is not routinely funded for use in intractable nausea and vomiting from idiopathic or diabetic gastroparesis in accordance with NICE guidance IPG103 which can be found at http://www.nice.org.uk/Guidance/IPG103

**Policy statement:** Gender Dysphoria

**Status:** Funding Responsibility of NHS England

This service is now the commissioning responsibility of NHS England, please refer to their specialist service policies held within the attached link:


**Policy statement:** Grommets

**Status:** Threshold

South East Essex CCG's commissions grommet insertion on a restricted basis. Patients will be funded for grommet (ventilation tube) insertion if they meet the following criteria:

- Children with persistent bilateral OME documented over a period of 3 months with a hearing level in the better ear of 25–30 dBHL or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available).

**OR**
- Children who have had at least 5 occurrences of acute otitis media in the last year with additional complications such as perforations, persistent discharge, febrile convulsions, sensor neural deafness or cochlear implantation.

The persistence of bilateral OME and hearing loss needs to be confirmed over a period of 3 months before surgical intervention will be considered. The child’s hearing should be re-tested at the end of this time. During this active observation period of 3 months, advice on educational and behavioural strategies to minimise the effects of the hearing loss should be offered.

Patients will be considered for funding if they meet one of the following criteria:

- A child with persistent bilateral OME with a hearing loss less than 25–30 dBHL where the impact of the hearing loss on a child’s developmental, social or educational status is judged to be significant.
- Adjuvant adenoidectomy will not be considered in the absence of persistent and/or frequent upper respiratory tract symptoms in the child.
- Children with Down’s Syndrome or cleft palate, as an alternative to hearing aids for treating persistent bilateral OME with hearing loss (and/or significant impact on child’s developmental, social or educational status).

For children with Down’s Syndrome, the following factors need to be considered before the intervention is offered:
- The severity of hearing loss.
- The age of the child.
- The practicality of ventilation tube insertion.
- The risks associated with ventilation tubes.
- The likelihood of early extrusion of ventilation tubes.

**Patient Information Leaflet:**
http://www.nhs.uk/conditions/glue-ear/pages/treatment.aspx

**References:**
2. NICE Clinical Guidance 60, Surgical Management Of OME, by the Collaborating Centre for Women’s and Children’s Health

Policy statement: Gynaecomastia

| Status:     | Threshold       |

All men have breast tissue and a breast bud. This policy intends to provide treatment for extreme/severe breast contour resulting from true breast development. This policy excludes treatment for excess skin folds in the breast following weight loss.

True gynaecomastia is benign enlargement of male breast tissue. It can be defined as the presence of >2cm palpable, firm, subareolar gland and ductal tissue (not fat) which should be confirmed by ultrasound.
True gynaecomastia will be funded (i.e. true breast tissue is present not just adipose tissue – pseudogynaecomastia). The clinician should ensure that the following are confirmed:

- Breast cancer has been ruled out.
- Testicular cancer has been ruled out.
- Underlying endocrine or liver abnormality has been ruled out.
- The condition is not due to the abuse of drugs with bodybuilding.
- The condition is not a side effect of medication or drugs e.g. spironolactone, cimedtidine, digoxin or cannabis.

Surgery to correct unilateral or bilateral gynaecomastia should be funded if the patient:

- Is post pubertal (stable height for past 6 months).
- Has BMI < 25 kg/m2 with evidence that the patient’s weight has been stable for 2 years.
- Has breast enlargement on at least one side which is Grade III or above using Cordova’s classification system **OR** has unilateral breast enlargement with a difference of at least 2 grades (e.g. normal and Grade II differential).

Scarring, contour irregularities and moderate asymmetry (including dog-ears, nipple direction or position, breast size and shape disparity) are predictable following surgery. Any postsurgical revision for cosmetic irregularities will **not** be funded by the CCG.

Applications must include at least 2 colour photographs of the chest. Photographs should go from the top of the chest down to the umbilicus. One should be taken from directly in front of the patient and another at an angle of 45 degrees (e.g. Grades II – IV).

**Patient Information:**

**References:**
Haemorrhoidectomy will be funded for patients with third or fourth-degree haemorrhoids that are either too large for other measures or have not responded to them.

**Policy statement:** Hair Depilation  
**Status:** Not Funded

Hirsutism/hair depilation is not routinely funded including hair depilation procedures or medication. Hair depilation will only be considered via IFR route.

**Policy statement:** Hair Transplantation  
**Status:** Not Funded

Hair transplantation will only be considered for reconstruction via IFR route in exceptional cases, such as reconstruction of the eyebrow following cancer or trauma.

**Patient Information:**  
http://www.nhs.uk/conditions/hair-loss/Pages/Introduction.aspx

**Policy statement:** Hernia  
**Status:** Threshold

If emergency treatment is required e.g. strangulation is suspected then the referring clinician should refer the patient.

South East Essex CCG’s commissions surgical treatment of hernias on a restrictive basis for patients meeting the defined criteria below. This Service Restriction Policy covers the management of:
- Inguinal
- Femoral
- Umbilical
- Ventral
- Incisional hernias

Criteria for referrals/treatment as below:

**Inguinal:**  
For asymptomatic or minimally symptomatic hernias, a watchful waiting approach is advocated with informed consent.  
Surgical treatment should only be offered when one of the following criteria is met:
- Symptomatic i.e. symptoms are such that they interfere with work or activities of daily living  
or  
- The hernia is difficult or impossible to reduce
or

- Inguino-scrotal hernia

or

- The hernia increases in size month on month

or

- The patient is currently asymptomatic but works in a heavy manual occupation (for e.g. in removal firms lifting heavy weights) and there is an increased risk of strangulation and future complications.

Femoral:
All suspected femoral hernias should be referred to secondary care due to the increased risk of incarceration/strangulation

Umbilical:
Surgical treatment should only be offered when one of the following criteria is met:

- pain/discomfort interfering with activities of daily living

or

- increase in size month on month

or

- to avoid incarceration or strangulation of bowel

or

- The patient is currently asymptomatic but works in a heavy manual occupation (for e.g. in removal firms lifting heavy weights) and there is an increased risk of strangulation and future complications

Incisional:
Surgical treatment should only be offered when BOTH of the following criteria are met:

- Pain/discomfort interfering with activities of daily living

And

Appropriate conservative management has been tried first e.g. weight reduction where appropriate

or

- The patient is currently asymptomatic but works in a heavy manual occupation (for e.g. in removal firms lifting heavy weights) and there is a risk of strangulation and future complications.

Patient Information:
http://www.nhs.uk/conditions/hernia/pages/introduction.aspx

References:

**Policy statement:** Hip Arthroscopy

**Status:** Threshold

For South East Essex, referrals for Musculoskeletal (MSK) secondary care outpatient services are subject to Prior Approval, see Policy statement for Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management.

**See Arthroscopy**

**Policy statement:** Hip Injections

**Status:** Threshold

For South East Essex, referrals for Musculoskeletal (MSK) secondary care outpatient services are subject to Prior Approval, see Policy statement for Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management.

Current evidence on safety and efficacy does not appear adequate to routinely recommend hip injections. On this basis South East Essex CCG’s only fund Hip injections in the following circumstances:

- Diagnostic aid.
- To introduce contrast medium to the joint as part of hip arthrogram.
- Babies for hip arthrogram.
- Children and adults with inflammatory arthropathy.
- Investigation of infection in biological and replaced hips.

**Policy statement:** Hip Replacement

**Status:** Threshold

For South East Essex, referrals for Musculoskeletal (MSK) secondary care outpatient services are subject to Prior Approval, see Policy statement for Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management.

South East Essex CCG's commission surgery for hip replacement on a restricted basis.

Referral should be when other pre-existing medical conditions have been optimised AND conservative measures have been exhausted and failed. South East Essex CCG's will only fund hip joint replacement surgery if:
- The patient complains of severe joint pain AND has radiological features of severe disease AND has severe functional limitation irrespective of whether conservative management has been trialled, OR

- The patient complains of severe joint pain AND has radiological features of severe disease AND has minor to moderate functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.

- The patient complains of mild to moderate joint pain AND has radiological features of severe disease AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies AND is assessed to be at low surgical risk.

- The patient has completed a self-assessment score, e.g. the Oxford Hip Score as part of their pre-assessment provided by secondary care prior to surgery.

http://www.orthopaedicsscore.com/scorepages/oxford_hip_score.html

- Has supporting clinical diagnostics and other assessments to support the decision to operate

Please refer to the classification of pain levels and functional limitations in the table below.

**Evidence suggests that the following patients would be INAPPROPRIATE candidates for hip joint replacement surgery:**

- Where the patient complains of mild joint pain AND has minor or moderate functional limitation
- Where the patient complains of moderate to severe joint pain AND has minor functional limitation AND has not previously had an adequate trial of conservative management as described above

**Hip replacement: Classification of Pain Levels and Functional Limitations**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pain Level</strong></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>Pain interferes minimally on an intermittent basis with usual daily activities. Not related to rest or sleep. Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin/paracetamol at regular doses.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Pain occurs daily with movement and interferes with usual daily activities. Vigorous activities cannot be performed. Not related to rest or sleep. Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin/paracetamol at regular doses</td>
</tr>
</tbody>
</table>
Severe
- 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.

### Previous non-surgical treatments

| Correctly Done | NSAIDs, paracetamol, aspirin or narcotic analgesics at regular doses during 6 months with no pain relief; weight control treatment if overweight, physical therapies done. |
| Incorrectly Done | NSAIDs, paracetamol, aspirin or narcotic analgesics at inadequate doses or less than 6 months with no pain relief; or no weight control treatment if overweight or no physical therapies done. |

### Functional Limitations

| Minor | Functional capacity adequate to conduct normal activities and self-care. Walking capacity of more than one hour. No aids needed. |
| Moderate | Functional capacity adequate to perform only a few or none of the normal activities and self-care. Walking capacity of about one half hour. Aids such as a cane are needed. |
| Severe | 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 required. |

Relevant OPCS(s):
- W38 – Total replacement of hip joint not using cement.
- W39 – Other total replacement of hip joint.
Hymenorrhaphy, 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 East of England Gender Dysphoria Policy.

See vaginal labia refashioning.

### Policy statement: Hyperhidrosis / Sweating

<table>
<thead>
<tr>
<th>Status:</th>
<th>Threshold</th>
</tr>
</thead>
</table>

The South East Essex CCG’s commission management of hyperhidrosis in line with East of England Priorities Advisory Committee guidance.

### Patient information:

Hysterectomy for non-cancerous heavy menstrual bleeding will **only** be funded by south east Essex CCGs within NICE guidance and when:

- There has been an unsuccessful trial and appropriate clinical assessment, with a levonorgestrel-releasing intrauterine system LNG-IUS, e.g. Mirena®, unless contraindicated, for at least 12 months which has not successfully relieved symptoms or has produced unacceptable side effects.

and

- At least one alternative treatment has failed, is not appropriate or is contra-indicated in line with NICE guidelines.

**Alternative hormonal treatment**

Other hormone methods (e.g. combined oral contraceptives, injected progesterons, Gn-RH analogue).

- In line with NICE guidance.
- NSAIDs and Tranexamic Acid.
The following are not clinically appropriate:
1. Endometrial ablation if normal uterus or if LNG-IUS contraindicated or if ablation is contraindicated e.g. previous multiple caesarean section
2. Uterine Artery Embolisation (for fibroids under 3cm)
3. Myomectomy (for fibroids over 3cms)

Contraindications to the levonorgestrel intrauterine system are:
- Distorted or small uterine cavity (with proven ultrasound measurements; Uterocervical canal length < 5cm).
- Genital malignancy.
- Active trophoblastic disease.
- Active pelvic inflammatory disease.
- Large cavity over 10cm length.

References:

Policy statement: Hysteroscopy
Status: Threshold

See Dilatation and Curettage

Policy statement: Insulin Pump
Status: Threshold

The South East Essex CCG’s will fund initiation of continuous subcutaneous insulin infusion or ‘insulin pump’ therapy is recommended as a possible treatment for adults and children 12 years and over with type 1 diabetes mellitus if:
- attempts to reach target haemoglobin A1c (HbA1c) levels with multiple daily injections result in the person having 'disabling hypoglycaemia', or
HbA1c levels have remained high (8.5% or above) with multiple daily injections (including using long-acting insulin analogues if appropriate) despite the person and/or their carer carefully trying to manage their diabetes.

The person has attended a CCG approved diabetes educational course for example DAFNE.

Insulin pump therapy should only be started by a trained specialist team. This team should include a doctor who specialises in insulin pump therapy, a diabetes nurse and a dietitian (someone who can give specialist advice on diet). This team should provide structured education programmes and advice on diet, lifestyle and exercise that is suitable for people using insulin pumps.

Insulin pump therapy is not recommended for people with type 2 diabetes mellitus.


Policy statement: Knee Arthroscopy
Status: Threshold
For South East Essex, referrals for Musculoskeletal (MSK) secondary care outpatient services are subject to Prior Approval, see Policy statement for Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management.

See Arthroscopy

Policy statement: Knee Replacement
Status: Threshold
For South East Essex, referrals for Musculoskeletal (MSK) secondary care outpatient services are subject to Prior Approval, see Policy statement for Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management.

Referral should be when other pre-existing medical conditions have been optimised AND conservative measures have been exhausted and failed. This will include weight reduction, NSAIDs and analgesics, changing activity, and introducing a walking aid.

South East Essex CCG’s will only fund knee replacements (total knee replacement: patello-femoral (PFJ) and unicompartmental) if:

- The patient complains of intense or severe symptomatology AND has radiological features of severe disease AND has demonstrated disease within all three
compartments of the knee (tri-compartmental) or localised to one compartment plus patello-femoral disease (bi-compartmental). OR

- The patient complains of intense or severe symptomatology AND has radiological features of moderate disease AND is troubled by limited mobility or stability of the knee joint.
- The patient has completed a self-assessment score, e.g. the Oxford Hip Score as part of their pre-assessment provided by secondary care prior to surgery.

http://www.orthopaedicscore.com/scorepages/oxford_hip_score.html

- Has supporting clinical diagnostics and other assessments to support the decision to operate

Knee replacement: classification of pain levels and functional limitations

<table>
<thead>
<tr>
<th>Variable</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>Mild</td>
<td>Pain interferes minimally on an intermittent basis with usual daily activities. Not related to rest or sleep. Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin/paracetamol at regular doses</td>
</tr>
<tr>
<td>Moderate</td>
<td>Pain occurs daily with movement and interferes with usual daily activities. Vigorous activities cannot be performed. Not related to rest or sleep. Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin/paracetamol at regular doses</td>
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<td>Severe</td>
<td>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.</td>
</tr>
</tbody>
</table>

Previous non-surgical treatments

| Correctly Done    | NSAIDs, paracetamol, aspirin or narcotic analgesics at regular doses during 6 months with no pain relief; weight control treatment if overweight, physical therapies done. |
| Incorrectly Done  | NSAIDs, paracetamol, aspirin or narcotic analgesics at inadequate doses or less than 6 months with no pain relief; or no weight control treatment if overweight or no physical therapies done. |

Functional Limitations

| Minor             | Functional capacity adequate to conduct normal activities and self-care. Walking capacity of more than one hour. No aids needed. |
| Moderate          | Functional capacity adequate to perform only a few or none of the normal activities and self-care. Walking capacity of about one half hour. Aids such as a cane are needed. |
| Severe            | 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 required. |
Policy statement: Labia Reduction / Refashioning
Status: Not Funded

See Vaginal Labia Refashioning.

Policy statement: Laser treatment for Hirsutism
Status: Not Funded

See Hirsutism.

Policy statement: Laser treatment for Rosacea
Status: Threshold

Rosacea is a syndrome of the facial skin consisting of a combination of cutaneous signs including flushing, erythema, papules (small solid elevation of the skin), pustules (a small collection of pus), telangiectasia’s, oedema (abnormal accumulation of fluid beneath the skin), ocular lesions and rhinophyma. These signs typically involve the convexities of the central face (cheeks, chin, nose and central forehead).

Eligibility Criteria:

Laser treatment for moderate to severe rosacea on the face and neck area which is erythemato-telangiectatic in nature will be considered for patients with the following:

- Frequent severe and troublesome flushing, moderate to pronounced persistent erythema, many prominent telangiectasia’s, possible burning, stinging or scaling of the skin. and
- All other treatments have been attempted and have failed. These include trigger identification, lifestyle management, and drug therapies such as topical metronidazole or oral tetracycline for papules and pustules.

Surgery is a more effective treatment for rhinophyma, therefore, laser therapy should not be offered. See policy for Rhinophyma for more information.
Policy statement: Laser treatment for skin lesions
Status: Individual Prior Approval – click here for individual prior approval form

See Benign skin lesions.

Policy Statement: Laser treatment for soft palate
Status: Not Funded

This procedure is considered a low priority treatment and is not normally provided under the NHS. Laser treatment for snoring is considered a low priority treatment and will only be provided on exceptional cases. In contrast, specialist assessment and appropriate treatment for OSA sufferers will normally be provided.

Definition:
Palatal flutter is thought to be the main contributor to snoring. This may be corrected by the procedure called “laser uvulopalatoplasty” which aims to cause fibrosis and stiffen the palate by removing a central strip of palatal mucosa with a laser. There is still a lack of good long-term trial based evidence about this procedure.

Note: Obstructive Sleep Apnoea (OSA) is a different and more serious condition. This involves the periodic reduction or cessation of breathing due to the narrowing of the upper airways during sleep. OSA sufferers have an irregular snoring pattern with short and shorter sounds leading to a period of silence. This is usually followed by an episode of struggling for air associated with sudden awakening. As a result, these patients experience daytime somnolence. (This policy does not apply to patients suffering from OSA)

Risks:
Although laser treatment is possible associated with less risk side effects such as post-nasal regurgitation and pain than more conventional surgery it remains a painful procedure and carries the same dangers associated with normal surgery.

IFR applications for funding will be reviewed in line with NICE Guidance: http://guidance.nice.org.uk/IPG476

The submission would need to outline how many procedures and how often the clinician was intending to repeat the course.

Policy statement: Laser treatment for Tattoo Removal
Status: Threshold

The funding for removal of tattoos will be considered in the following circumstances:
• Funding may be considered for tattoos inflicted under duress during adolescence. In such instances, tattoo removal will only be considered where the tattoo is on the face or visible parts of the body.

OR

• In unusual circumstances where the tattoo causes marked limitations of psychosocial function

Psychiatric/psychological reports will need to be provided with the initial referral.

OPCS Codes:
SO9 Laser therapy
SO91 Laser destruction of lesion of skin of head or neck.
SO92 Laser destruction of lesion of skin NEC.
SO93 Photodestruction of lesion of skin of head or neck NEC
SO94 Infrared photocoagulation of lesion of skin of head or neck.
SO95 Infrared photocoagulation of lesion of skin NEC
SO98 Other specified photodestruction of lesion of skin
SO99 Unspecified photodestruction of lesion of skin

Patient Information:

Policy statement: Liposuction / Liposculpture / Body Contouring

Status: Not Funded

Liposuction will not be funded simply to correct the distribution of fat. Liposuction is sometimes an adjunct to other surgical procedures and may be useful for contouring of localised fat atrophy or pathological hypertrophy e.g. multiple lipomatosis, lipodystrophies.

Those considered an exception will have to provide evidence to (at a minimum) demonstrate the following:

• Patients with excessive 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 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:
  o recurrent intertrigo beneath the skin folds
  o abdominal wall prolapse with proven urinary symptoms
  o problems associated with poorly fitting stoma bags
  o patient is experiencing severe difficulties with daily living i.e. ambulatory restrictions.
These patients will need full assessment by appropriate professional prior to referral.

This procedure will not be funded for cosmetic purposes. Buttock lifts, thigh lifts and arm lifts (brachioplasty), procedures will not normally be funded.

<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Lycra Dynamic Splinting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Not Funded</td>
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Requests for funding will only be considered on an individual patient basis by exceptional treatment panels. The referral needs to come from a local lead specialist physiotherapist or occupational therapist. The expected benefits for that patient over other treatments must be clearly quantified.

Expert opinion suggests that younger children with athetoid disorders (involuntary movements), those with quadriplegic palsy and those with neuromuscular disorders benefit the most. Lycra dynamic splinting is not suitable for clients who have fixed deformities of a bony nature which are not amenable to change.

Compliance has a significant role to play in determining outcome, as it does for all therapy and medical interventions. The client and family or carers, who may be assisting them to apply the splints, must be made fully aware of the commitment required to ensure success.

Provision of subsequent garments will depend on clear, quantifiable demonstration of benefit for the individual patient which has been set up front.

<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Lymphedema</th>
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Treatment of patients with Lymphedema should be carried out through South East Essex Lymphedema services. Treatment of Lymphedema by specialist units in the private sector will only be funded in exceptional circumstances following involvement of appropriate local services and completion of the Individual Funding Request process.

**Definition:**
Lymphedema is swelling due to excess accumulation of fluid in the tissues caused by inadequate lymphatic drainage. It can affect any part of the body, but most commonly affects the arms and legs. There is no agreement on the quantitative definition of Lymphedema. Lymphedema can be classified as primary or secondary. Primary lymphedema is due to abnormality intrinsic to the lymphatic system. Secondary Lymphedema is due to damage/obstruction of the lymphatic system. This can be caused by cancer or cancer treatment, but there are a variety of other, non-cancer causes. Historically, Lymphedema services have often developed in relation to cancer services and have extended their scope to treat other types of Lymphedema.

Lymphedema is essentially incurable as it represents end-stage failure of lymph drainage and will invariably progress unless controlled. Skin infections occur which can necessitate hospital admissions and there is increasing lack of mobility if patients are untreated.
Symptoms include the weight and discomfort of the affected limb, recurrent inflammation and infection, and the psychological distress caused by the appearance on the limb.

**Criteria:**
As Lymphedema is only one cause of oedema the GP should ensure:

- the correct diagnosis (remembering that most causes of peripheral oedema are cardiac, renal, hepatic or venous in origin, rather than lymphedema)
- The oedema is persistent or greater than 3 months duration; or
- Patient is at known risk of lymphedema.
- Patient must have tried and failed all available conservative management options before referral to a community based lymphedema service.

Once correct diagnosis has been established, the patient should be referred on to a local Lymphedema service.

Where children or younger adults present with limb swelling, the GP may wish to refer to the appropriate specialist to exclude diagnosis such as malignant or vascular causes, dependant on the exact clinical picture. If Lymphedema is diagnosed following investigation, these patients should be regarded as high priority by local Lymphedema services, to prevent avoidable deterioration.

GPs must include evidence of meeting these requirements and confirm before referral to a community based lymphedema service.

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**Policy statement:** Magnetic Resonance Ultrasound for Uterine Fibroids

**Status:** Not Funded

South East Essex CCG’s will **not** fund magnetic resonance guided ultrasound (MRgFUS) treatment for uterine fibroids for the purposes of fertility preservation due to lack of evidence of effectiveness.

South East Essex CCG’s will **not** routinely fund MRgFUS treatment for symptomatic relief except in exceptional circumstances via the individual funding request (IFR) route.

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**Policy statement:** Mastopexy

**Status:** Threshold

**See Breast Procedures**

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**Policy statement:** Mears Irlen Syndrome

**Status:** Not Funded
See Scotopic Sensitivity Syndrome.

<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Medicines Management</th>
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<td>Status:</td>
<td>Threshold</td>
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</table>

**Rationale:**
- To advise on the managed entry of new drugs, indications, formulations and devices which will have a significant impact on the local health economy.
- To develop a work plan for the improvement of prescribing practice ensuring that prescribing takes place in the setting which is most appropriate for patient care.
- To ensure that prescribing is underpinned through robust governance guidelines e.g. shared care documents and antimicrobial guidance

For further information on the following criteria for funding, please see the Medicines Management section of each CCG website at:
- Castle Point and Rochford CCG: [https://www.castlepointandrochfordccg.nhs.uk/](https://www.castlepointandrochfordccg.nhs.uk/)
- Southend CCG: [http://www.southendccg.nhs.uk/](http://www.southendccg.nhs.uk/)

**Criteria for funding:**

- **New Drugs/devices/ formulations/indications** – these drugs/devices are highlighted through the horizon scanning process and evaluated through the Medicines Management Committee in a planned programme of review.

- **Guidelines** – these indicate the preferred drugs options at various points in the treatment pathway as a guide to prescribers for different conditions e.g. diabetes, stable angina, generic or antibiotic prescribing

- **NICE TA’s** – funding agreed within the NICE criteria as detailed in the Technical Appraisal (TA) document in conjunction with the local decision tree/policy which has been agreed through the Medicines Management Committee processes. The outcome including the date agreed is added to the “NICE Technology Appraisals About Medicines: Formulary Adherence Checklist” and the updated document published on the website in compliance with Innovation, Health & Wellbeing.

- **Governance guidelines** – These documents ensure that prescribers are supported to ensure that the risk to patients are minimised through a defined protocol for prescribing and where relevant monitoring the patient

- **Shared care guidelines**
- **Antimicrobial prescribing guidance**
- **High cost drugs**

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<tr>
<th>Policy statement:</th>
<th>Medicines Management – PbR excluded Drugs and Devices</th>
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<td>Threshold</td>
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</table>

**Rationale:**
• To advise on the managed entry of new drugs and devices that will have a significant impact on the local health economy.
• To develop a work plan for the improvement of prescribing practice ensuring that prescribing takes place in the setting which is most appropriate for patient care.
• To ensure that treatment meeting the criteria is funded by the appropriate body i.e. CCG, provider or NHSE
• To ensure that prescribing is underpinned through robust governance guidelines/pathways e.g. Rheumatoid Arthritis treatment algorithm, WetAMD Initiation, Continuation and Discontinuation policy

For further information on the following criteria for funding, please see the Medicines Management section of each CCG website at:

• Castle Point and Rochford CCG : https://www.castlepointandrochfordccg.nhs.uk/
• Southend CCG: http://www.southendccg.nhs.uk/

Criteria for funding:
• New Drugs/ devices/ formulations/indications – these drugs/devices are highlighted through the horizon scanning process and evaluated through the Medicines Management Committee in a planned programme of review.

• NICE TA’s – funding agreed within the NICE criteria as detailed in the Technical Appraisal (TA’s) document in conjunction with the local decision tree/policy which has been agreed through the Medicines Management Committee processes.

The agreed commissioning criteria are defined in a specific funding request proforma for each drug and indication for initiation and continuation of treatment. Funding is agreed for a specified period of time for those individuals that meet the criteria, with continuation of funding being dependant on achieving and maintaining a suitable response to the treatment.

• PbR excluded drugs and devices - The criteria for the majority of these drugs and devices are defined through a NICE TA which is commissioned as detailed above. The responsible commissioner for funding is defined in the documents which are integral as part of the contract with providers.

• Guidelines/pathways – these define the agreed drug/device options at various points in the treatment pathway, and specifies to clinicians, the commissioning criteria for funding for various conditions e.g. Rheumatoid arthritis, WetAMD, botulinum.

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<th>Policy statement:</th>
<th>Microsuction/Ear Wax Removal</th>
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</table>

Removal of ear wax in secondary care will not be funded unless a patient has one of the following contraindications to ear irrigation:
• The patient has previously experienced complications following this procedure in the past.
• There is a history of a middle ear infection in the last six weeks.
• The patient has undergone ANY form of ear surgery (apart from grommets that have extruded at least 18 months previously and the patient has been discharged from the ENT Department).
• The patient has a perforation or there is a history of a mucous discharge in the last year.
• The patient has a cleft palate (repaired or not).
• In the presence of acute otitis externa with pain and tenderness of the pinna.

**Policy statement:**

<table>
<thead>
<tr>
<th>Minor Hand Conditions</th>
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<td><strong>Status:</strong> Threshold</td>
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For South East Essex, referrals for Musculoskeletal (MSK) secondary care outpatient services are subject to Prior Approval, see Policy statement for Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management.

Referral to a hospital consultant for minor hand conditions such as those mentioned below are considered low priority, and will only be provided under the NHS in line with the guidance below.

**Ganglia**

Ganglia are caused by cystic degeneration of a joint capsule or tendon sheath. Lesions at the base of the digits are often small but very tender (seed ganglion). Mucoid cysts arise at the distal interphalangeal joint and may disturb nail growth. Ganglia arising at the level of the wrist are rarely painful and most will resolve spontaneously within 5 years. The recurrence rate after excision of wrist ganglia is between 10-45%.

Surgery for ganglion of the wrist will only be funded for patients who have fulfilled the criteria as follows:

• there are symptoms associated with the ganglia such as pain, loss of sensation in certain parts of the hand, neurological loss or weakness of the wrist with the ganglion, and restriction of work or hobbies because of the ganglia
• patients are aware that most ganglia resolve spontaneously over time
• patients are aware of the complications of excision such as scar tenderness, stiffness or numbness, and likelihood of recurrence.

**Rationale:**

Many hand conditions occur commonly, cause few serious symptoms and will generally resolve spontaneously. Given the potential complications of surgical procedures and the duty of the CCGs to use its limited resources to provide the greatest benefit to the population of South East Essex, the below criteria for referral have been developed. These criteria are aimed at offering treatment to those who need it most and who are most likely to benefit from surgical treatment.

Ganglia arising at the level of the wrist are rarely functionally impairing and about 50% will resolve spontaneously within 5 years. In the longer term approximately 60% of ganglia
remain resolved following aspiration and about 70% following surgery. When other complications of surgery such as scar sensitivity, joint stiffness or distal numbness are taken into account operating is usually an unattractive option. Appropriately counselled patients will often not request surgical referral. Patients with asymptomatic ganglia should not be referred to secondary care. They can be reassured in primary care and asked to seek assistance if the ganglion becomes symptomatic.

**Trigger Finger**
A tender nodule in the flexor tendon at base of a finger or thumb causing a snapping of the finger/thumb as it is extended from a flexed position.

Referrals for surgery for trigger finger will only be funded for patients who have fulfilled one or more of the criteria as follows:

- Failure to respond to conservative measures [e.g. up to 2 hydrocortisone injections]
- When the patient has a fixed deformity that cannot be corrected
- Patients for whom corticosteroid treatment is not suitable such as multiple digits affected.

**Rationale:**
Many hand conditions occur commonly, cause few serious symptoms and will generally resolve spontaneously. Given the potential complications of surgical procedures and the duty of the CCGs to use its limited resources to provide the greatest benefit to the population of South East Essex, the below criteria for referral have been developed. These criteria are aimed at offering treatment to those who need it most and who are most likely to benefit from surgical treatment.

Trigger finger and thumb in adults is caused by thickening of the A1 pulley. It is most common in middle aged women, is more frequent in diabetics but is usually idiopathic. Patients complain of the finger becoming stuck bent. When the digit is straightened there is a palpable clunk which is painful. Examination reveals a tender thickening over the A1 pulley which is at the level of the distal palmar crease in the fingers and at the base of the thumb.

Conservative treatment includes rest and avoiding precipitating activities. Non-steroidal anti-inflammatory drugs will often settle early cases. Injection of hydrocortisone is safe and can provide lasting relief in up to 70% of cases.

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

**Dupuytren’s Contracture**
Nodular or cord-like thickening of the palmar fascia causing a tethering of the digits and a loss of range of extension.

Surgery for Dupuytren’s contracture will only be funded for patients who have a flexion contracture exceeding 30 degrees at the metacarpophalangeal joint and/or a contracture
exceeding 10 degrees at the proximal interphalangeal joint. Needle apronectomy will not be funded (this may be reviewed in light of any published NICE guidance for the treatment) Simple nodules in the palm are not an indication for referral.

**Rationale:**
Many hand conditions occur commonly, cause few serious symptoms and will generally resolve spontaneously. Given the potential complications of surgical procedures and the duty of the CCGs to use its limited resources to provide the greatest benefit to the population of South East Essex, the below criteria for referral have been developed. These criteria are aimed at offering treatment to those who need it most and who are most likely to benefit from surgical treatment.

- Most patients with Dupuytren’s disease do not need treatment, but regular follow-up is needed to detect early joint contracture. Intervention is almost exclusively surgical and should be considered when the patient is having functional difficulties.

Recurrence is very common after surgery (up to 50%) but some patients with a ‘Dupuytren’s diathesis’ are particularly at risk. A recent review regarding this found that with a family history, bilateral disease, Garrod’s pads, male sex and onset less than 50 years the risk of recurrent disease was 71%. With none of these risk factors the rate was 23%.

**Policy statement:**
Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management

**Status:**
Prior Approval

All referrals for secondary care outpatient services that meet the criteria below are subject to Prior Approval. For South East Essex referrals, the CCGs commission an MSK Service (CATS) who provide the Prior Approval Service on behalf of the commissioners.

Inclusion criteria for the MSK Service (CATS):
- Patient must be registered with a GP in Castle Point and Rochford and Southend CCGs
- Patient will be aged 16 years or over
- Patient will have a MSK or suspected MSK condition

**Policy statement:**
Myopia

**Status:**
Not Funded

South East Essex CCG’s will not fund laser eye surgery for the correction of Myopia, only in exceptional circumstances.
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<tr>
<th>Policy statement:</th>
<th>Nipple Inversion</th>
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<td>Status:</td>
<td>Threshold</td>
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</table>

South East Essex CCG’s commissions surgery to correct nipple inversions on a restricted basis. Nipple inversion may occur as a result of underlying breast malignancy. If the inversion is newly developed, it requires urgent referral and assessment.

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. GPs who refer must ensure that patients comply with this criteria.

<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Open MRIs</th>
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<tbody>
<tr>
<td>Status:</td>
<td>Individual Prior Approval – for individual prior approval form click here</td>
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</table>

Referral for open MRIs in secondary care is commissioned by South East Essex CCG’s on a restricted basis.

Cases will only be funded if they meet the criteria below:

- Morbidly obese patients unable to access local MRI services because of their size i.e. obesity

Patients with claustrophobia are not eligible for open MRI scans unless an oral, prescription sedative has not been effective (GPs are expected to support Extended Scope Practitioners (ESPs) in prescription of sedatives in this situation).

<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Orthodontics</th>
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<tr>
<td>Status:</td>
<td>Funding Responsibility of NHS England</td>
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<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Orthopaedic Outpatient Services</th>
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<tbody>
<tr>
<td>Status:</td>
<td>Prior Approval</td>
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</tbody>
</table>

See Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management.
### Otoplasty

**Policy statement:** Otoplasty  
**Status:** Threshold

See Pinnaplasty.

### Pain Management Outpatient Services

**Policy statement:** Pain Management Outpatient Services  
**Status:** Prior Approval

See Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management

### Penile Implants

**Policy statement:** Penile Implants  
**Status:** Not Funded

This procedure will not be funded other than post cancer reconstruction.

### Photodynamic Therapy for Age Related Macular Degeneration

**Policy statement:** Photodynamic Therapy for Age Related Macular Degeneration  
**Status:** Not funded

South East Essex CCG’s commission Photodynamic therapy (PDT) for Age-Related Macular Degeneration on a restricted basis, requests will be considered on a case by case basis by the CCGs Individual Funding Request panel.

### Pinnaplasty/Otoplasty

**Policy statement:** Pinnaplasty/Otoplasty  
**Status:** Threshold

South East Essex CCG’s commissions Pinnaplasty/Otoplasty surgery on a restricted basis. Pinnaplasty/Otoplasty will not be considered unless there is evidence of significant impact upon ability to lead a normal life, and the child expresses concern, rather than the parents alone.

Surgery will **only be funded if BOTH of the criteria below are met:**
- Patient is aged between 10 and 16 years old and has expressed concern about their appearance **AND**
- the prominence is of a severity that it presents as disfigurement which is having a significant detrimental impact upon the child’s ability to lead a normal life.
All applications for funding should be accompanied by photographs.

**Patient Information:**

<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Plagiocephaly</th>
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<tr>
<td><strong>Status:</strong></td>
<td>Not Funded</td>
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</table>

South East Essex CCG’s commission treatment for Plagiocephaly on a restricted basis, requests will be considered on a case by case basis by the CCGs Individual Funding Request panel.

Plagiocephaly may be divided into craniosynostosis, which results from premature closure of one or more of the cranial sutures, and nonsynostotic or positional plagiocephaly (also referred to as deformational plagiocephaly, non-synostotic plagiocephaly, positional plagiocephaly, flat-head syndrome and occipital plagiocephaly).

This distinction is highly important as craniosynostosis carries a significant risk of raised intracranial pressure, therefore requiring interventional surgery. Interventions for craniosynostosis are covered by NHS England specialist commissioning arrangements.

Positional plagiocephaly, however, has not been shown to be associated with any long term developmental problems and its treatment has been described as entirely cosmetic and is therefore not funded.

<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Platelet Rich Plasma Injections for Tendinopathy</th>
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<tr>
<td><strong>Status:</strong></td>
<td>Threshold</td>
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</table>

South East Essex CCG’s commission Autologous Blood Injections for Tendinopathy on a restricted basis in accordance with NICE Guidance 438 guidance.nice.org.uk/ipg438.

Requests for this procedure will only be considered where:
- conservative methods of management* have failed,
- the patient suffers significant functional impairment** as a result of the Tendinopathy,

*Conservative measures include:
Rest, analgesics, anti-inflammatory medication, use of orthotic devises eccentric exercise and physiotherapy.

**Significant functional impairment is defined as:
The patient complains of moderate to severe joint pain not relieved by extended non-surgical management AND has severe impact on their ability to undertake activities of daily living.
Policy statement: Repair of Ear Lobes – Post Trauma

Status: Not Funded

Funded for primary suture post trauma at the time of trauma e.g. the patient is automatically eligible for emergency treatment when he/she presents for repair at Emergency Department at the time of trauma.

Post trauma applications will only be considered where there are clinically exceptional circumstances.

Policy statement: Reversal of Sterilisation

Status: Not Funded

Reversal of sterilisation (both male and female) is considered a low priority treatment and will not normally be provided under the NHS.

Sterilisation is provided under the NHS on the understanding that it is an irreversible procedure. Patients are informed and written consent is sought before the operation is carried out. Provider clinical governance systems should continue to embrace good practice guidelines from the Royal Colleges regarding the giving of information and informed consent prior to sterilisation.

Definition:
Sterilisation is a procedure by which a person is rendered permanently unable to produce children. This is called a vasectomy in men and operative occlusion of the fallopian tubes in women. Reversal of sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes in women and vas deferens in men.

Policy statement: Rheumatology Outpatient Services

Status: Prior Approval

See Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management

Policy statement: Rhinophyma

Status: Not Funded

South East Essex CCG’s will not fund cosmetic correction of 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 a case by case basis via the individual funding request route.
Policy statement: Rhinoplasty/Rhytidectomy
Status: Threshold

See Aesthetic Facial Surgery

Policy statement: Scar Revision - Keloid
Status: Threshold

The South East Essex CCG’s will only fund keloid scar revision in the following circumstances. In all cases Scar Revision will only be funded after 2 years to allow the natural healing process to complete.

- Scars on the face (excluding ears) secondary to trauma/accident that are ragged, or can otherwise be regarded as particularly disfiguring.
- Scars (excluding those on the ears) as a result of self-harm
  These are very difficult to treat and usually the only achievable outcome is to make the scars resemble trauma or burns rather than be obviously due to self-harm. Treatment will only be funded when there has been a minimum period of three years where there has been no self-harm and where there is a supporting report from a psychiatrist indicating that the behaviour would be unlikely to recur.
- Scars (excluding those on the ears) that are resulting in physical disability due to contraction, tethering or recurrent breakdown

Funding may be available via Individual Funding Request for the following criteria:

[In all cases, medical photography will be required as part of the Individual Funding Request]

- Significant Keloid scarring on the face (excluding those on the ears)
- Keloid scars (excluding those on the ears) that result in physical distress due to significant pain or pruritis.
- Scars secondary to trauma/accident (other than those on the face) for cosmetic purposes will not be funded unless the disfigurement can be regarded as particularly grave.

In all cases Scar Revision will only be funded after 2 years to allow the natural healing process to complete.

**Funding will not be available for:**

- Keloid scars (with exception of criteria above and excluding those on the ears)
- Keloid scars secondary to body piercing procedures (including those on the ears) or other cosmetic procedures.
Policy statement: Scar Revision – Other
Status: Not Funded

Funding may be available via Individual Funding Request panel for the following criteria:

[In all cases, medical photography will be required for the individual funding request]

- Scars as a result of self-harm
  These are very difficult to treat and usually the only achievable outcome is to make the scars resemble trauma or burns rather than be obviously due to self-harm. Treatment will only be funded when there has been a minimum period of three years where there has been no self-harm and where there is a supporting report from a psychiatrist indicating that the behaviour would be unlikely to recur.

- Scars secondary to trauma/accidents
  - Scars on the face that are ragged, or can otherwise be regarded as particularly disfiguring will be funded.
  - Scars on the rest of the body. Scar revision for cosmetic purposes will not be funded unless the disfigurement can be regarded as particularly grave. Cases will be judged on an individual basis.

- Other
  - Keloid scars (refer to section on keloid scarring above).
  - Scars that are resulting in physical disability due to contraction, tethering or recurrent breakdown will be funded.

Scar revision will only be offered after 2 years to allow the natural healing process to complete.

Policy statement: Scotopic Sensitivity Syndrome / Mears Irlen Syndrome / Coloured Filtered Lenses
Status: Not Funded

Provision of coloured filters/tinted lenses for specific reading difficulty (SRD) is not funded.

Policy statement: Septoplasty/Septorhinoplasty
Status: Threshold

South East Essex CCG’s will not fund Septorhinoplasty procedures for cosmetic reasons.

Criteria for Septoplasty include:
- Problems caused by obstruction of the nasal airway amenable to the procedure
- Deviated nasal septum

Criteria for Septorhinoplasty for functional reasons include:

- Patient has a deviated septum causing significant and persistent nasal blockage
- A septoplasty alone will not improve functional impairment
- Septorhinoplasty is not being performed for cosmetic reasons

Policy statement: Shoulder Arthroscopy
Status: Threshold

For South East Essex, referrals for Musculoskeletal (MSK) secondary care outpatient services are subject to Prior Approval, see Policy statement for Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management.

See Arthroscopy

Policy statement: Skin Lesions
Status: Individual Prior Approval

See Benign Skin Lesions

Policy statement: Sleep Studies
Status: Threshold

South East Essex CCG’s commission sleep studies for patients with suspected sleep apnoea, complex sleep disorders or where necessary to confirm a diagnosis of narcolepsy.

Snoring (defined as)
- loud and chronic (ongoing)
- Pauses may occur in the snoring.
- Choking or gasping may follow the pauses.

Sleep apnoea (defined as)
- fighting sleepiness during the day, at work, or while driving
- witnessed breathing pauses whilst asleep

If sleep apnoea is suspected patients should be referred if they have red flag symptoms or relevant comorbid conditions (see below). Those without red flag symptoms or relevant comorbid condition must meet the following criteria prior to referral to the sleep unit.
  o Daytime sleepiness (rather than tiredness) assessed by Epworth score of 10 or above AND
o symptoms and / or signs indicating significant sleep apnoea.

Red flag symptoms:
- cor pulmonale
- respiratory failure/severe pulmonary disease
- vigilance critical occupations (pilots, professional drivers, operators of heavy machinery)
- extreme sleepiness leading to risk of danger to self or others
- planned general anaesthetic

Relevant comorbid conditions:
- respiratory failure/severe pulmonary disease
- significant neurological or neuromuscular disease
- uncontrolled hypertension
- unstable angina/ischaemic heart disease
- pregnancy
- recent cerebrovascular disease
- congestive heart failure

Where nasal obstruction is an issue, patients should be referred for nasoendoscopic assessment of their upper airways prior to referral for sleep studies to exclude any structural cause for obstruction.

South East Essex CCG’s do not commission sleep studies for parasomnia, periodic limb movement disorder, chronic insomnia or snoring.

Policy statement: Snoring ENT Referrals

| Status:    | Threshold |

In circumstances where a cancer is suspected, the 2 week wait referral process should be used.

A referral for an assessment to exclude sinister pathology will be funded when all conservative measures have been tried prior to referral. These are:
- Weight reduction if BMI is over 35.
- Use of therapies such as nasal sprays or strips.
- Use of ear plugs whilst asleep.
- Reduction of evening alcohol if relevant.
- Stop smoking.
- Self-training to alter their sleep position to avoid lying on their back. Please indicate in any referral, how the patient has altered sleep position.
- Use of a mandibular device (not funded by the NHS).

**Policy statement:** Sperm and Egg Storage

**Status:** Individual Prior Approval

See Assisted Conception

**Policy statement:** Spinal Cord Stimulation

**Status:** Individual Prior Approval – for individual prior approval form click here

NHS England fund spinal cord stimulators for those patients receiving care in specialised centres.

The South East Essex CCG’s only fund applications for spinal cord stimulators for patients who meet the pro-forma (see prior approval form) requirement in line with NICE Guidance:


The South East Essex CCG’s currently will fund spinal cord stimulators or batteries (including rechargeable batteries) for those patients who already are in receipt of this treatment. IFR submissions will be required for high frequency stimulators as these are considered an exceptionality.

**Policy statement:** Spinal Surgery for Non-Acute Lumbar Conditions

**Status:** Threshold

For South East Essex, referrals for Musculoskeletal (MSK) secondary care outpatient services are subject to Prior Approval, see Policy statement for Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management.

South East Essex CCG’s only commission spinal surgery for non-acute lumbar conditions on a restricted basis.

Funding for patients to receive non-acute* spinal surgery will only be made available under the following circumstance:

**Surgical discectomy** (standard or microdiscectomy) in selected patients with sciatica secondary to disc prolapse where conservative management for at least 4-6 weeks has failed.

**Lumbar decompression is funded for the following indication:**
For sciatica with nerve root compression or severe central spinal stenosis with claudication symptoms in one of both legs.
South East Essex CCG’s do **not** fund spinal surgery for lower back pain.

NHS England commissions the following and their policies can be found at the following link http://www.england.nhs.uk/ourwork/d-com/spec-serv/policies/

- All spinal deformity surgery (adults and children).
- All spinal reconstruction surgery (adults and children).
- Palliative or curative spinal oncology surgery (adults and children).
- Revision surgery for which the primary surgery is specialist, for example,
  - Revision surgery with instrumentation for over 2 levels.
  - All primary thoracic and primary anterior lumbar surgery.
  - Posterior cervical decompression surgery using instrumentation.
  - Cervical corpectomy.

**Policy statement:** Synthetic Mesh

| Status: | Threshold |

South East Essex CCG’s fund the use of Synthetic mesh in line with the East of England Prescribing Authorities Committee guidance (November 2014).

**Synthetic mesh**

Synthetic materials are available as both absorbable and non-absorbable mesh. Compared with biologic grafts, advantages of synthetic materials include: greater availability (does not require harvesting), lack of risk of donor-to-host infectious disease transmission, and cost-effectiveness.

The majority of meshes currently available for incontinence and prolapse surgery are type-I meshes which are constructed using monofilament fibres and have a large pore size (greater than 90 microns) and have lower rates of infection and erosion (Royal College of Obstetricians and Gynaecologists, 2010).

Type-II and type-III mesh materials are constructed using multifilamentous materials and have small pore sizes. As a result of these characteristics, they can harbour bacteria and, by so doing, promote bacterial growth (Royal College of Obstetricians and Gynaecologists, 2010).

A review of the evidence for synthetic mesh highlighted the following (see Appendix 1 for more detail on the evidence reviewed):

- Adult inguinal hernias should be repaired using flat mesh (or non-mesh Shouldice repair, if experience is available). There is insufficient evidence to make a recommendation on the use of mesh for femoral hernia repair.
- Abdominal surgery for apical pelvic-organ prolapse as per NICE guidance is supported where arrangements for consent, audit and clinical governance are in place.

**Policy decision**

1. Synthetic mesh has been shown to be effective in the following cases:

- Adult inguinal hernias repaired using flat mesh (or non-mesh Shouldice repair, if experience is available).
Abdominal surgery for apical pelvic-organ prolapse is supported as per NICE guidance.

The operation should only be carried out by surgeons specialising in the management of pelvic-organ prolapse and female urinary incontinence.

**The South East Essex CCG’s fund synthetic mesh to the following funding levels:**

<table>
<thead>
<tr>
<th>Size</th>
<th>Upper cost per single dressing (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smaller than 10X10 cm</td>
<td>70</td>
</tr>
<tr>
<td>10x10 cm</td>
<td>180</td>
</tr>
<tr>
<td>10x15 cm</td>
<td>200</td>
</tr>
<tr>
<td>15-20x20 cm</td>
<td>350</td>
</tr>
<tr>
<td>&gt;20x20 cm</td>
<td>750</td>
</tr>
</tbody>
</table>

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**Policy statement:** Tattoo Removal  
**Status:** Threshold

See Laser Treatment for Tattoo Removal.

---

**Policy statement:** Temporomandibular Joint Replacement (TMJ)  
**Status:** Not Funded

Temporomandibular Joint Replacement is considered a LOW PRIORITY due to limited evidence of clinical effectiveness.

**Criteria:**
The affected patients usually have severe disease of the temporomandibular joint which may be more serious if patients cannot open their mouths adequately, as dentistry, anaesthesia and resuscitation may be severely complicated and even life-threatening. In such rare cases, TMJ replacement may be considered.

**Contraindications:**
- Active or chronic infection
- Patient conditions where there is 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.).

**Rationale**
There is limited evidence of effectiveness for this procedure. There are no RCTs, no agreed diagnostic classification scheme or universally accepted outcome measures or evidence on the relative cost effectiveness of total TMJ replacement. The research community in the USA have expressed caution about using irreversible surgery for TMJ disorders.

In rare cases of patients with extremely severe cases of TMJ disorder with re-ankylosis who cannot open their mandible and who are at great risk from failure to maintain the airway, there may be a case for total TMJ replacement. If this surgical service development were to proceed then it must be on condition that all patients should give full informed consent and be included in a national register using valid outcome measures. The surgery should only be offered by specialist reconstructive maxillo-facial units.

**Policy statement:** Temporalmandibular Joint (TMJ) Retainers & Appliances

**Status:** Not Funded

South East Essex CCG’s will not fund TMJ appliances unless in exceptional cases.

For example, the following situations might be considered exceptional:
- Patient has unsuccessfully tried alternative, cheaper treatments including: analgesics, muscle relaxants, stress reduction and self-massage, soft diet.

**Policy statement:** Tier Three Weight Management

**Status:** Threshold

South East Essex CCG’s commission Tier Three Weight Management on a restricted basis in line with the NHS England criteria for Bariatric Surgery (see policy for bariatric surgery) as below:

- Patients aged 17 years or over.
- Registered with a Practice within South East Essex, or if unregistered, residing in South East Essex.
- Morbid or severe obesity has been present for at least four years.
- Record of previous success/attempts to lose weight during last 12 months.
- Meeting the following criteria:
  - a BMI of ≥ 35 kg/m² and type 2 diabetes
  - This recommendation may be reduced by 2.5 kg/m² of BMI in Asians
  - In exceptional circumstances a patient with BMI < 35 kg/m² may be referred
  - a BMI of 40 or ≥ 35 kg/m² and obesity-related comorbidity eg metabolic syndrome, hypertension, obstructive sleep apnoea (OSA), functional disability, infertility and depression if specialist advice is needed regarding overall patient management.
- Willingness to commit to changing their behaviours.

### Tinnitus

**Policy statement:**

<table>
<thead>
<tr>
<th>Status:</th>
<th>Threshold</th>
</tr>
</thead>
</table>

South East Essex CCG’s provides funding for investigation of tinnitus if the patient has:

- Consistent bilateral tinnitus (persistent for over 20 weeks) **and** hearing loss.
- Unilateral tinnitus (persistent over 2 months).
- Bilateral tinnitus (persistent over 2 months)

### Tonsillectomy

**Policy statement:**

<table>
<thead>
<tr>
<th>Status:</th>
<th>Threshold</th>
</tr>
</thead>
</table>

Suspected or confirmed malignancy – this is an absolute indication to refer, please use the two week cancer referral form.

South East Essex CCG’s commission tonsillectomy on a restricted basis for those patients who meet the SIGN Guidance 117 (April 2010) attached or one of the conditions listed below (refer to checklist form):

1. Sore throats that are due to acute tonsillitis **and**
2. Episodes of sore throat that are disabling and prevent normal functioning **and**
3. Seven or more well documented clinically significant, adequately treated sore throats in the preceding year. **or**
4. Five or more such episodes in each of the preceding two years. **or**
5. Three or more such episodes in each of the preceding three years. **or**
6. Failure to thrive in paediatrics patients where recurrent tonsillitis is considered a contributory factor.

**OR** the patient should have one of the following conditions:
- Intractable cough with a high level of streptococcal antibody for longer than one year;
- Severe halitosis which has been demonstrated to be due to tonsil crypt debris for longer than one year. (diagnosed by an ENT surgeons)
- Lymphoma and Ca tonsil,
- Obstructive sleep apnoea where the patient has had one or more of a positive sleep study, demonstrable significant impact on quality of life and/or a strong clinical history suggestive of sleep apnoea.
- Peritonsillar abscess not responding to antibiotics and incisional drainage.

GPs should not refer unless the above criteria have been met, and referrals must include objective information to demonstrate this.

Once a decision is made for tonsillectomy, this should be performed as soon as possible, to maximise the period of benefit before natural resolution of symptoms might occur (without tonsillectomy).

**Rationale:**
Tonsillectomy offers relatively small clinical benefits compared with non-surgical treatment, measured best in terms of time off school. The benefit in the year after the operation is roughly 2.8 days less taken away from school.

Tonsillectomy carries a risk of mortality estimated to lie between 1 in 8,000 and 1 in 35,000 cases.

A Cochrane systemic review concluded that: “There is no evidence from randomised controlled trials to guide the clinician in formulating the indications for surgery in adults or children”.

The frequency of sore throat episodes and upper respiratory infections reduces with time whether Adenotonsillectomy has been performed or not.
For South East Essex, referrals for Musculoskeletal (MSK) secondary care outpatient services are subject to Prior Approval, see Policy statement for Musculoskeletal (MSK) Outpatient Services including Orthopaedics, Rheumatology and Pain Management.

For policy see Minor Hand Conditions.

Policy statement: Vaginal Labia Refashioning
Status: Not Funded

South East Essex CCG’s do not routinely commission elective vaginal labia reduction/refashioning or vaginoplasty as this is considered to be a cosmetic procedure, except in the circumstances outlined below.

Any referrals will be reviewed on an exceptional treatment case basis by the Individual Funding Request panel.

In all cases, medical photography will be required as part of the IFR submission.

**Labiaplasty**
Labiaplasty is generally a cosmetic procedure to improve appearance alone and is not routinely funded.

Requests for labiaplasty will be considered for the following indication:
- Where repair of the labia is required after trauma.
- Where the labia are directly contributing to recurrent disease or infection

**Vaginoplasty**
Non-reconstructive vaginoplasty or “vaginal rejuvenation” is used to restore vaginal tone and appearance and is not routinely funded.

Requests for vaginoplasty will be considered 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
- Female genital mutilation.

**Hymenorrhaphy** – refer to policy for Hymenorrhaphy.
Or hymen reconstruction surgery, is a cosmetic procedure and is not routinely funded.

Policy statement: Vaginal/Uterovaginal Prolapse
Status: Threshold

South East Essex CCG’s will only fund surgical interventions for Uterovaginal Prolapse in the following circumstances:
In cases of mild to moderate symptomatic cystoceles where trial of a pessary has failed.

In cases of mild to moderate symptomatic rectoceles.

In severe cases of prolapse or procidentia

Initially, patients should be assessed and managed conservatively in primary care. Also refer to sections below on vaginal pessaries and surgery.

1. **Watchful waiting**, with observation for the development of new symptoms or complications is appropriate if the prolapse is minimal (Stage I), or asymptomatic

2. **Conservative treatment options**

   2.1 **Lifestyle modification**
   - Treatment of conditions that increase intra-abdominal pressure: constipation, chronic cough, overweight/obesity; reduction of heavy lifting (while POP has been associated with these factors, the role of lifestyle modification in prevention/treatment has not been investigated)

   2.2. **Pelvic floor muscle exercises**
   - Role in managing prolapse unclear; probably not useful if the prolapse extends to or beyond the vaginal introitus.
   - Cochrane review 2006: concluded evidence was insufficient (from 3 randomised trials) to judge the value of conservative management of POP, & that further trials were needed
   - The pilot study for the Pelvic Organ Prolapse Physiotherapy (POPPY) multi-centre trial suggested that pelvic floor muscle training delivered by a physiotherapist to symptomatic Stage I or II POP women in an outpatient setting may reduce the severity of prolapse

   2.3. **Local (vaginal) oestrogen creams and oral treatments see CCG formulary**
   See Medicines Management and further information on criteria for funding, please see the Medicines Management section of each CCG website at:

   - Castle Point and Rochford CCG: https://www.castlepointandrochfordccg.nhs.uk/
   - Southend CCG: http://www.southendccg.nhs.uk/

3. **Vaginal pessary insertion** – those participating in active vaginal intercourse should be offered surgery once occult urodynamic stress incontinence has been explored.

   - Cochrane review 2004: no RCTs of pessary use in women with prolapse; there is no consensus on the use of different types of device, the indications, nor the patterns of replacement & follow-up care; evidence or pessary selection and management is incomplete so trial and error, expert opinion, and experience remain the best guides for use and management of the pessary
   - Although not supported by definitive evidence, current opinion is that pessaries are effective1 & should be considered before surgery in women who have symptomatic prolapse; they can be attempted in all POP cases irrespective of stage
     - For short-term relief before surgery, or in the long-term if surgery is not wanted or recommended
To predict surgical outcomes or unmask occult urodynamic stress incontinence before surgery, as part of the investigation of continent women with POP (so that the decision to perform a concomitant continence procedure along with pelvic reconstruction can then be individually tailored)

- Risk factors for unsuccessful fitting include: short vaginal length <6 cm and wide introitus fingerbreadths; local oestrogens may play a role in successful fitting
- Failure to retain the pessary has been associated with increasing parity and previous hysterectomy; and discontinuation with history of hysterectomy or prolapse surgery, and stress incontinence;
- Follow-up: no clear consensus on how often to follow up; after 3 months & then every 6 months, if there are no complications, has been suggested;
- Complications tend to occur in women who are not regularly followed up; self-care of pessary is also important to minimise adverse events; however, many patients find insertion & removal of most pessary types challenging

4. Surgery - those participating in active vaginal intercourse should be offered use of pessaries prior to surgical intervention for those women who have symptomatic prolapse. Or to unmask occult urodynamic stress incontinence before surgery Refer to section on use of vaginal pessaries above

- Assessed as effective, but with a close risk/benefit in mild cases; a combination of procedures may be required and reoperation is required in 29% of cases
- Types of repair surgery vary depending on type of POP & associated symptoms, whether the woman is sexually active & her fitness for surgery

4.1. Reconstructive surgery (abdominal or vaginal approach)

- 2010 Cochrane review of surgical management of POP: found 40 RCTs with a variety of types of POP5
  - There was not enough evidence on most types of common prolapse surgery nor about the use of mesh or grafts in vaginal prolapse surgery
  - Impact of POP surgery on bowel, bladder and sexual function can be unpredictable and may make symptoms worse or result in new symptoms such as leakage of urine (unmask occult SI) or problems with intercourse
  - Uterine/vaginal vault prolapse: abdominal sacral colpopexy may be better than vaginal sacrospinous colpopexy – it was associated with a lower rate or recurrent vault prolapse and dyspareunia; these benefits must be balanced against a longer operating time, longer time to return to activities of daily living and increased cost of the abdominal approach
  - Posterior vaginal wall prolapse/rectocele: posterior vaginal wall repair may be better than transanal repair in terms of recurrence of prolapse (limited evidence)
  - Value of the addition of a continence procedure to a prolapse repair operation in women who are dry before operation remains to be assessed
• Use of mesh/graft inlays (biological or synthetic):
  o 2010 Cochrane review: use of mesh or grafts at the time of anterior vaginal wall repair reduces the risk of recurrent anterior wall prolapse on examination; however, evidence of benefit to the woman, including symptoms and quality of life improvement, is lacking for the use of grafts over native tissue repairs
  o 2008 NICE guidance: surgical repair of vaginal wall prolapse using mesh

See Synthetic Mesh and Biological Mesh

4.2 Obliterative Surgery

  o Corrects POP by moving the pelvic viscera back into the pelvis & closing of the vaginal canal; vaginal intercourse is no longer possible

<table>
<thead>
<tr>
<th>Clinical scenarios where surgery will not be routinely funded</th>
<th>Clinical scenarios where referral for specialist assessment is necessary to determine suitability for surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic pelvic organ prolapse</td>
<td>Failure of pessary</td>
</tr>
<tr>
<td>Mild pelvic organ prolapse (unless combined with urinary/faecal incontinence)</td>
<td>Women with symptomatic prolapse (including those combined with urethral sphincter incompetence or faecal incontinence)</td>
</tr>
<tr>
<td></td>
<td>Prolapse combined with urethral sphincter incompetence/ urinary incontinence or faecal incontinence</td>
</tr>
<tr>
<td></td>
<td>Women with moderate to severe prolapse who want definitive treatment</td>
</tr>
</tbody>
</table>

**Recommendations**

- Initially, patients should be assessed and managed conservatively in primary care
- All patients should have a trial of ring pessary, including suitable candidates for surgery, as part of the investigation of continent women with prolapse; the decision to perform a concomitant continence procedure along with pelvic reconstruction can then be individually tailored

**Patient information:**
http://www.nhs.uk/conditions/Prolapse-of-the-uterus/Pages/Introduction.aspx

**Policy statement:** Varicose Veins

**Status:** Threshold

South East Essex CCG’s will not normally fund surgical treatment for those veins that present a largely cosmetic problem or that cause simple aching that could be adequately controlled by properly measured surgical hosiery.

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 cream

Back to Index
- recurrent superficial thrombophlebitis (at least two minor episodes)
- bleeding associated with varicose veins (at least two minor or one major bleed)
- post phlebitic syndrome (PTS).

Policy statement: **Vasectomies – General Anaesthetic**

**Status:** Threshold

South East Essex CCG’s commission vasectomies under general anaesthetic on a restricted basis.

This policy is for circumstances when vasectomy should be performed *under general anaesthetic*. In other cases a referral should be made to a Primary Care Provider.

Only in the following circumstances will a vasectomy under general anaesthetic be funded:

- Previous documented adverse reaction to local anaesthesia.
  OR
- Scarring or deformity distorting the anatomy of the scrotal sac or content making identification and/or control of the spermatic cord through the skin difficult to achieve.

Policy statement: **Wigs and Fabric Supports**

**Status:** Not Funded

The South East Essex CCG’s are not responsible for funding wigs and fabric supports, this is the responsibility of the NHS Trust providing the care or issuing the wig or fabric support. For those requiring further information this can be found at the following:


Policy statement: **Wisdom Teeth**

See Dental Procedures.
## Appendix 1 – Individual Prior Approval and Individual Funding Request Forms

<table>
<thead>
<tr>
<th>CCG Requiring Individual Prior Approval</th>
<th>Procedure</th>
<th>Individual Prior Approval Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>South east Essex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Assisted Conception (IVF) – South east Essex CCG (Castle Point and Rochford CCG and Southend CCG)</td>
<td><a href="#">Fertility Services Commissioning Policy</a></td>
</tr>
<tr>
<td>Yes</td>
<td>Benign Skin Lesion</td>
<td><a href="#">Benign Skin Lesion Q2</a></td>
</tr>
<tr>
<td>Yes</td>
<td>Exogen Ultrasound Bone Healing</td>
<td><a href="#">Exogen Q3</a></td>
</tr>
<tr>
<td>Yes</td>
<td>Laser Treatment – see Benign Skin Lesion form</td>
<td><a href="#">Benign Skin Lesion Q2</a></td>
</tr>
<tr>
<td>Yes</td>
<td>Musculoskeletal (MSK) Outpatient Services</td>
<td>Refer to MSK Service (CATS)</td>
</tr>
<tr>
<td>Yes</td>
<td>Open MRI</td>
<td><a href="#">Open MRI</a></td>
</tr>
<tr>
<td>Yes</td>
<td>Spinal Cord Stimulation</td>
<td><a href="#">Spinal Cord Stimulation</a></td>
</tr>
</tbody>
</table>

**INDIVIDUAL FUNDING REQUEST**

[IFR Policy](#)
Appendix 2 – Equality Impact Assessment
Service Restriction Policy

This leaflet contains information about the local NHS’s Service Restriction Policy (SRP), and what it means for you if you do not qualify for the treatment or procedure you have requested.

What is the Service Restriction Policy (SRP)?

The SRP sets out a range of treatments and procedures that are not clinically effective for everyone and can only be offered when specific clinical criteria are met. The SRP is based on best clinical practice, and balances the benefits and the risks of treatment options for patients.

You can see the full Service Restriction Policy on your local Clinical Commissioning Group’s website – details are at the bottom of this leaflet.

What happens if I do not meet the clinical criteria for the treatment or procedure I want?

Your local NHS Clinical Commissioning Group (CCG) will not normally pay for treatments that fall outside the criteria as set out in the SRP. If your condition does not currently meet the clinical criteria for the treatment or procedure you have requested, your condition may continue to be managed and reviewed if appropriate by your GP or lead clinician.

Decisions are based on strict clinical criteria and so are usually clear-cut. If you are not happy with the decision you can ask your GP to apply again with more clinical information. The decision is based on clinical evidence, so if you submit new evidence we will re-examine your case.

Castlepoint and Rochford CCG
www.castlepointandrochfordccg.nhs.uk
cpr.ccg@nhs.net
01268 594528

Southend CCG
www.southendccg.nhs.uk
southend.ccg@nhs.net
01702 314299
Specialist Fertility Services Commissioning Policy

<table>
<thead>
<tr>
<th>Author:</th>
<th>EoE CCG Fertility Consortium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version No:</td>
<td>4</td>
</tr>
<tr>
<td>Policy Effective from:</td>
<td>1st December 2014</td>
</tr>
<tr>
<td>Review Date:</td>
<td>December 2015</td>
</tr>
</tbody>
</table>

This policy replaces all previous versions. Where patients have commenced treatment in any cycle prior to this version becoming effective, they are subject to the eligibility criteria and scope of treatment set out in the relevant version.

Previous versions of this policy:

Version 1 – Effective 15 August 2008 to 30 June 2010
Version 2 – Effective 1 July 2010 to 31 May 2011
Version 3 – Effective 1 June 2011 to 30th November 2014
| **Document Reader Information** |
|-------------------|-----------------|
| **Policy**        | HR/Workforce Management Planning CI |
| **ESCP**         | Estates Performance IM&T Finance Partnership Working |
| **Document Purpose** | Policy |
| **Reference Number** | |
| **Title** | Fertility Services Commissioning Policy |
| **Author** | EoE CCG Fertility Consortium |
| **Publication Date** | December 2014 |
| **Target Audience** | CCGs, NHS Trusts, Tertiary Providers, commissioners, directors of finance, GPs, fertility nurses, service users |
| **Circulation List** | All of the above |
| **Description** | The EOE Consortium Commissioning Policy for Fertility Services |
| **Cross Reference** | EOE Consortium Fertility Services Specification NICE Guideline CG156 |
| **Superseded Docs** | Individual PCTs documentation in the EOE commissioning fertility services |
| **Action required** | For dissemination within primary, secondary and tertiary care providers |
| **Contact details** | Head of Commissioning, Castle Point and Rochford Clinical Commissioning Group Phoenix Court | Christopher Martin Road | Basildon | SS14 3HG www.castlepointandrochfordccg.nhs.uk |
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<td>Specialist Fertility services policy and criteria</td>
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<td>Referrals</td>
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<tr>
<td>5</td>
<td>Eligibility Criteria for Accessing Fertility Services</td>
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</tr>
</tbody>
</table>
Fertility treatment and referral criteria for tertiary level assisted conception

1. Introduction

1.1.1 This Commissioning Policy sets out the criteria for access to NHS funded specialist fertility services for the population of the east of England CCG consortium, along with the commissioning responsibilities and service provision.

1.1.2 This policy is specifically for those couples who do not have a living child from their current or any previous relationships, regardless of whether the child resides with them. This includes any adopted child within their current or previous relationships; this will apply to adoptions either in or out of the current or previous relationships.

1.1.3 The paper specifically sets out the entitlement and service that will be provided by the NHS for In Vitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI). These services are commissioned by Clinical Commissioning Groups and provided via tertiary care providers.

1.1.4 It is the purpose of the criteria set out in this policy to make the provision of fertility treatment fair, clear and explicit. This paper should be read in conjunction with NICE Guidance CG156 “Fertility: assessment and treatment for people with fertility problems” (2013) available on their website at http://publications.nice.org.uk/fertility-cg156

1.2 Review

This policy will be reviewed annually and within 3 months of any legislative changes that should or may occur in the future. The date of the next review will be December 2015.
2. Commissioning responsibility

2.1.1 Specialist fertility services are considered as Level 3 services or tertiary services. Preliminary Levels 1 & 2 are provided and commissioned within primary care and secondary services such as acute trusts. To access Level 3 services the preliminary investigations should be completed at Level 1 & 2.

2.1.2 Specialist Fertility Treatments within the scope of this policy are:
- In-vitro fertilisation (IVF) and Intra-cytoplasmic sperm injection (ICSI)
- Surgical sperm retrieval methods
- Donor Insemination (DI)
- Intra Uterine Insemination (IUI) unstimulated
- Sperm, embryo and male gonadal tissue cryostorage and replacement techniques
- Egg donation where no other treatment is available
- Blood borne viruses (ICSI + sperm washing)
- Egg and sperm storage for patients undergoing cancer treatment

2.1.3 Treatments excluded from this policy:
- Pre-implantation Genetic Diagnosis and associated IVF/ICSI. This service is commissioned by NHS England
- Specialist Fertility Services for members of the Armed Forces are commissioned separately by NHS England
- Surrogacy

2.1.4 Formal IVF commissioning arrangements will support the implementation of this policy including a contract between ENHCCG (with delegated responsibility for procurement) and each tertiary centre. Quality Standards and clinical governance arrangements will be put in place with these centres. Outcomes will be monitored and performance managed in accordance with the Human Fertilisation & Embryology Authority Licensing requirements or any successor organisations.

2.1.5 This policy is specifically for those couples who do not have a living child from their current or any previous relationships, regardless of whether the child resides with them. This includes any adopted child within their current or previous relationships; this will apply to adoptions either in or out of the current or previous relationships.

2.1.6 Couples who do not meet the criteria and consider they have exceptional circumstances should be considered under the Individual Funding Request (IFR) policy of their CCG. All IFR funding queries should be directed to the IFR team of the relevant CCG who may liaise with the central contracting team. Funding of such exceptional cases is the responsibility of the CCG.

2.1.7 Couples will be offered a choice of providers that have been commissioned by the CCG.
3. Specialist Fertility services policy and criteria

3.1.1 The CCG only commissions the following fertility techniques regulated by the Human Fertilisation & Embryology Authority (HFEA).

3.2 In-Vitro Fertilisation (IVF)

3.2.1 An IVF procedure includes the stimulation of the women’s ovaries to produce eggs which are then placed in a special environment to be fertilised. The fertilised eggs are then transferred to the woman’s uterus.

3.2.2 For women less than 40 years this policy supports a maximum of 4 embryo transfers with a maximum of 2 fresh cycles of IVF, with or without ICSI, this includes any abandoned cycles. In women aged under 40 years any previous full IVF cycles, whether self- or NHS-funded, will count towards the total number of full cycles offered by the relevant CCG.

3.2.3 For women age 40-42 years NHS treatment limit will be determined by local CCG policy up to maximum of 2 embryo transfers, including a maximum of 1 fresh cycle of IVF, or IVF with ICSI, provided the following 3 criteria are met:
   • They have never previously had IVF treatment
   • There is no evidence of low ovarian reserve
   • There has been a discussion of the additional implications of IVF and pregnancy at this age.

3.2.4 A full cycle of IVF treatment, with or without intracytoplasmic sperm injection (ICSI), should comprise 1 episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryo(s). This will include the storage of any frozen embryos for 1 year following egg collection. Patients should be advised at the start of treatment that this is the level of service available on the NHS and following this period continued storage will need to be funded by themselves or allowed to perish.

3.2.5 An embryo transfer is from egg retrieval to transfer to the uterus. The fresh embryo transfer would constitute one such transfer and each subsequent transfer to the uterus of frozen embryos would constitute another transfer.

3.2.6 Before a new fresh cycle of IVF can be initiated any previously frozen embryo(s) must be utilized.

3.2.7 Where couples have previously self-funded a cycle then the couples must utilise the previously frozen embryos, rather than undergo ovarian stimulation, egg retrieval and fertilisation again.

3.2.8 Embryo transfer strategies:
   • For women less than 37 years of age only one embryo or blastocyst to be transferred in the first cycle of IVF and for subsequent cycles only one embryo/blastocyst to be transferred unless no top quality embryo/blastoctyst available then no more than 2 embryos to be transferred
   • For women age 37-39 years only one embryo/blastoctyst to be transferred unless no top quality embryo/blastoctyst available then no more than 2 embryos to be transferred.
   • For women 40-42 years consider double embryo transfer.

3.2.9 A fresh cycle would be considered completed with the attempt to collect eggs and transfer of a fresh embryo.
3.2.11 If a cycle is commenced and ovarian response is poor, a clinical decision would need to be taken as to whether a further cycle should be attempted, or if the use of a donor egg may be considered for further IVF cycles.

3.2.12 If any fertility treatment results in a live birth, then the couple will no longer be considered childless and will not be eligible for further NHS funded fertility treatments, including the implantation of any stored embryos. Any costs relating to the continued storage of the embryos beyond the first calendar year of the retrieval date is the responsibility of the couple.

3.2.13 Clinical Indications:

3.2.14.1 In order to be eligible for treatment, Service users should have experienced unexplained infertility for three years or more of regular intercourse or 12 cycles of artificial insemination over a period of 3 years. There is no criterion for couples with a diagnosed cause of infertility – see below:

(a) Tubal damage, which includes:
   • Bilateral salpingectomy
   • Moderate or severe distortion not amenable to tubal surgery

(b) Premature Menopause (defined as amenorrhoea for a period more than 6 months together with a raised FSH (follicle stimulating hormones) >25 and occurring before age 40 years)

(c) Male factor infertility. Results of semen analysis conducted as part of an initial assessment should be compared with the following World Health Organization reference values*:
   • semen volume: 1.5 ml or more
   • pH: 7.2 or more
   • sperm concentration: 15 million spermatozoa per ml or more
   • total sperm number: 39 million spermatozoa per ejaculate or more
   • total motility (percentage of progressive motility and non-progressive motility): 40% or more motile or 32% or more with progressive motility
   • vitality: 58% or more live spermatozoa
   • sperm morphology (percentage of normal forms): 4% or more.

(d) Ovulation problems adequately treated but not successfully treated i.e no successful pregnancy achieved

(e) Endometriosis where Specialist opinion is that IVF is the correct treatment

(f) Cancer treatment causing infertility necessitating IVF/ICSI (eligibility criteria still apply)

3.3 Surgical Sperm Recovery

3.3.1 Surgical sperm retrieval methods included for service provision are testicular sperm extraction (TESE) and percutaneous epididymal sperm aspiration (PESA).

3.3.2 Micro surgical Sperm recovery is not routinely funded and must be considered as an IFR application to the relevant CCG.

3.3.3 Sperm recovery techniques outlined in this section are not available to patients who have undergone a vasectomy.
3.4 Donor insemination

3.4.1 The use of donor insemination is considered effective in managing fertility problems associated with the following conditions:
- obstructive azoospermia
- non-obstructive azoospermia
- severe deficits in semen quality in couples who do not wish to undergo ICSI.
- Infectious disease of the male partner (such as HIV)
- Severe rhesus isoimmunisation
- Where there is a high risk of transmitting a genetic disorder to the offspring

3.4.2 Donor insemination is funded up to a maximum of 6 cycles of Intrauterine Insemination (IUI).

3.5 Donor semen as part of IVF/ICSI

3.5.1 Donor semen is used for same sex couples as part of IVF/ICSI treatment.

3.5.2 Funded up to same number of cycles of IVF.

3.6 Intra Uterine Insemination (IUI)

3.6.1 NICE guidelines state that unstimulated intrauterine insemination as a treatment option in the following groups as an alternative to vaginal sexual intercourse:
- people who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem who are using partner or donor sperm
- people with conditions that require specific consideration in relation to methods of conception (for example, after sperm washing where the man is HIV positive)
- people in same-sex relationships

3.6.2 Due to poor clinical evidence, a maximum of 6 cycles of IUI (as a replacement for IVF/ICSI and without donor sperm) will only be offered under exceptional circumstances and an IFR application for funding must be made to the CCG.

3.7 Egg donation where no other treatment is available

3.7.1 The patient may be able to provide an egg donor; alternatively the patient can be placed on the waiting list, until an altruistic donor becomes available. If either of the couple exceeds the age criteria prior to a donor egg becoming available, they will no longer be eligible for treatment.

3.7.2 This will be available to women who have undergone premature ovarian failure (amenorrhoea >6 months and a raised FSH >25) due to an identifiable pathological or iatrogenic cause before the age of 40 years or to avoid transmission of inherited disorders to a child where the couple meet the other eligibility criteria.
3.8 Egg and Sperm storage for patients undergoing cancer treatments

3.8.1 When considering and using cryopreservation for people before starting chemotherapy or radiotherapy that is likely to affect their fertility, follow recommendations in ‘The effects of cancer treatment on reproductive functions’ (2007).

3.8.2 When using cryopreservation to preserve fertility in people diagnosed with cancer, use sperm, embryos or oocytes.

3.8.3 Offer sperm cryopreservation to men and adolescent boys who are preparing for medical treatment for cancer that is likely to make them infertile.

3.8.4 Local protocols should exist to ensure that health professionals are aware of the values of semen cryostorage in these circumstances, so that they deal with the situation sensitively and effectively.

3.8.5 Offer oocyte or embryo cryopreservation as appropriate to women of reproductive age (including adolescent girls) who are preparing for medical treatment for cancer that is likely to make them infertile if:
   - they are well enough to undergo ovarian stimulation and egg collection and
   - this will not worsen their condition and
   - enough time is available before the start of their cancer treatment.

3.8.6 Cryopreserved material may be stored for an initial period of 10 years.

3.8.7 Following cancer treatment, couples seeking fertility treatment must meet the defined eligibility criteria.

3.9 Pre-implantation Genetic Diagnosis (PGD)

3.9.1 This policy does not include pre-implantation genetic screening as it is not considered to be within the scope of fertility treatment. This service is commissioned by NHS England. Providers should seek approval from Specialist Commissioning NHS England.

3.10 Chronic Viral Infections

3.10.1 The need to prevent the transmission of chronic viral infections, during conception, such as HIV, Hep C etc requires the use of ICSI technology.

3.10.2 As per NICE guidance (section 1.3.9). Do not offer sperm washing not offered as part of fertility treatment for men with hepatitis B.

3.10.3 This may not be a fertility treatment, but should be considered as a risk reduction measure for a couple who wish to have a child, but do not want to risk the transmission of a serious pre-existing viral condition to the woman and therefore potentially her unborn baby.
3.11 Privately funded care

3.11.1 This policy covers NHS funded fertility treatment only. For clarity, Patients will not be able to pay for any part of the treatment within a cycle of NHS fertility treatment. This includes, but is not limited to, any drugs (including drugs prescribed by the couple’s GP), recommended treatment that is outside the scope of the service specification agreed with the Secondary or Tertiary Provider or experimental treatments.

3.11.2 Where a patient meets this eligibility criteria but agrees to commence treatment on a privately funded basis, they may not retrospectively apply for any associated payment relating to the private treatment.

3.12 Surrogacy

3.12.1 Surrogacy is not commissioned as part of this policy. This includes part funding during a surrogacy cycle.

4 Referrals

4.1 Couples who experience problems with their fertility will attend their GP practice to discuss their concerns and options. The patients will be assessed within the Primary and Secondary Care setting.

4.2 A decision to refer a couple for IVF or other fertility services will be based on an assessment against this eligibility Criteria which is based on the NICE guidelines and the HFEA recommendations as detailed in the clinical pathways.

4.3 Referral to the tertiary centre will be via a consultant gynaecologist or GP with Special Interest (GPSI) in primary care.

4.4 The patient pathway and a GP referral form can be found at the end of this document.
<table>
<thead>
<tr>
<th>No</th>
<th>Criterion</th>
<th>Description</th>
</tr>
</thead>
</table>
| 1  | Ovarian Reserve Testing, use one of the following:  
   - FSH | To be eligible, the patient should have an FSH within 3 months of referral and on day 2 of the menstrual cycle of <9.  
   For women, follicle-stimulating hormones (FSH) help to control and regulate the woman’s menstrual cycle and is also partially responsible for the production of ova, or eggs, in the ovaries. If the FSH levels are either low or high, it is a clear indicator that something is out of balance within the reproductive system and may be causing issues with the couple being able to conceive. |
| 2  | Maternal age | Women aged 23 to 39 years at the start of super-ovulation (treatment) but where a woman reaches the age of 40 during treatment they will complete that cycle in the 40th year and will not be entitled to commence further cycles  
   Women aged between 40-42 may be entitled to 1 cycle of IVF but where:  
   - They have never previously had IVF treatment  
   - There is no evidence of low ovarian reserve  
   - There has been a discussion of the additional implications of IVF and pregnancy at this stage |
| 3  | Paternal Age | No paternal cut off age specified |
| 4  | Minimum / Maximum BMI | Between at least 19 and up to 30 for female and less than 35 for male. Patients outside of this range will not be added to the waiting list and should be referred back to their referring clinician and/or general practitioner for management if required. |
| 5  | Duration of sub-fertility | Unexplained infertility for 3 years or more of regular intercourse or an equivalent 12 self-funded cycles of artificial insemination over a period of 3 years. There is no criterion for cases with a diagnosed cause of infertility. |
| 6  | Previous Fertility treatment for Women <40 years | The maximum number of embryo transfers, including fresh and frozen, is 4, with a maximum of 3 fresh cycles of assisted conception (IVF or IVF with ICSI if required and including sperm retrieval where indicated).  
   Previous privately or NHS funded cycles will count towards the total number of fresh cycles funded by the NHS |
<p>| | | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>7</td>
<td>Previous fertility treatment for women ≥40 years</td>
<td>NHS treatment limit will be determined by local CCG policy up to maximum of 2 embryo transfers, including a maximum of 1 fresh cycle of IVF, or IVF with ICSI. Previous privately or NHS funded cycles will count towards the total number of fresh cycles funded by the NHS</td>
</tr>
<tr>
<td>8</td>
<td>Smoking Status</td>
<td>Couples who smoke will not be eligible for NHS-funded specialist assisted reproduction assessment or treatment Where either of a couple smokes, only couples who agree to take part in a supportive and successful programme of smoking cessation with Carbon Monoxide verification as an evidence of non-smoking status. Will be accepted onto the IVF treatment waiting list.</td>
</tr>
<tr>
<td>9</td>
<td>Parental Status</td>
<td>Couples are ineligible for treatment if there are any living children from the current or any previous relationships, regardless of whether the child resides with them. This includes any adopted child within their current or previous relationships; this will apply to adoptions either in or out of the current or previous relationships.</td>
</tr>
<tr>
<td>10</td>
<td>Previous sterilisation</td>
<td>Ineligible if previous sterilisation has taken place (either partner), even if it has been reversed.</td>
</tr>
<tr>
<td>11</td>
<td>Child Welfare</td>
<td>Providers must meet the statutory requirements to ensure the welfare of the child. This includes HFEA’s Code of Practice which considers the ‘welfare of the child which may be born’ and takes into account the importance of a stable and supportive environment for children as well as the pre-existing health status of the parents.</td>
</tr>
<tr>
<td>12</td>
<td>Medical Conditions</td>
<td>Treatment may be denied on other medical grounds not explicitly covered in this document.</td>
</tr>
<tr>
<td>13</td>
<td>Residential Status</td>
<td>The couple should either be registered with a GP in the CCG consortium for 12+ months, or if their GP registration is less than 12 month, they can be eligible if they can demonstrate residency of 12+ months in a CCG area within the consortium.</td>
</tr>
</tbody>
</table>
| 14 | The cause of Infertility | In order to be eligible for treatment, Service users should have experienced unexplained infertility for three years or more of regular intercourse or 12 cycles of artificial insemination over a period of 3 years. There is no criterion for couples with a diagnosed cause of infertility – see below:

(a) Tubal damage, which includes:
   - Bilateral salpingectomy
   - Moderate or severe distortion not amenable to tubal surgery
(b) Premature Menopause- amenorrhoea >6m and FSH >25 and aged <40
(c) Male factor infertility
(d) Ovulation problems adequately treated but not successfully treated i.e no successful pregnancy achieved
(e) Endometriosis where Specialist opinion is that IVF is the correct treatment
(f) Cancer treatment causing infertility necessitating IVF/ICSI (eligibility criteria still apply)

| 15 | The minimum investigations required prior to referral to the Tertiary centre are: | Female:
- Laparoscopy and/or hysteroscopy and/or hysterosalpingogram or ultrasound scan where appropriate
- Rubella antibodies
- Day 2 FSH.
- Chlamydia screening
- Hep B including core antibodies and Hep C and HIV status and core, within the last 3 months of treatment and repeated every 2 years.

Male:
- Preliminary Semen Analysis and appropriate investigations where abnormal (including genetics)
- Hep B including core antibodies and Hep C, within the last 3 months and repeated after 2 years.
- HIV status

| 16 | Pre-implantation Genetic Diagnosis | PGD and associated specialist fertility treatment is the commissioning responsibility of NHS England and is excluded from the CCG commissioned service.

| 17 | Rubella Status | The woman must be rubella immune

| 18 | IUI (Unstimulated) | As per NICE guidance 2013.

Maximum of 6 cycles of IUI (as a replacement for IVF/ICSI and without donor sperm) will only be offered under exceptional circumstances and an IFR application for funding must be made to the CCG.
<table>
<thead>
<tr>
<th></th>
<th>Number of cycles of IVF</th>
<th>Waiting times</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Women &lt;40yrs - 2 full cycles. If the woman reaches the age of 40 during treatment, complete the current full cycle but do not offer further full cycles. Women 40-42 yrs - 1 full cycle if following 3 criteria met: - never previously had IVF treatment, - no evidence of low ovarian reserve, - there has been a discussion of the additional implications of IVF and pregnancy at this age.</td>
<td>&gt;3yrs Access to IVF will be available after three years of unexplained infertility. However, where there is a diagnosed cause of infertility, women will be eligible to access specialist fertility and IVF services immediately following secondary care assessment and investigation (after two years) rather than undergo additional waiting</td>
</tr>
</tbody>
</table>
Couple concerned about fertility and delays in conception

Initial assessment (history and examination)

Consider referral to smoking cessation and weight management

Advise folic acid, lifestyle advice, rubella status (advise MMR)

Provide patient information on conception rates and reassurance

Known fertility (male or female)

Advise 1 year attempt to conceive or 6 cycles of artificial insemination (AI)

Mid-luteal serum progesterone to confirm ovulation

Yes

History and examination of male

Blood tests, cervical smear and chlamydia screening

Semen analysis (repeat in 6 weeks if abnormal) and Chlamydia screening

Regular cycles?

No

Reassessment and secondary care referral

Irregular cycles
Day 1-3 FSH, day 8 LH, testosterone and prolactin

History and examination of female

Do not offer screening for antisperm antibodies as there is no evidence of effective treatment to improve fertility

At this stage DO NOT test thyroid function, post-coital cervical mucus or endometrial biopsy

Assess and manage ovulation disorder

Investigate female infertility

Investigate male infertility

Investigate and manage tubal and uterine abnormalities

Medical and surgical management of endometriosis

Tubal and uterine surgery

Mild endometriosis

Unexplained infertility

Results normal

Wait for 3 years of attempted conception or 12 self-funded cycles of AI (including 1 year/6 cycles before secondary care referral)

Referral for Assisted Reproduction

Medical and surgical management of endometriosis

Tubal and uterine surgery

Mild endometriosis

Unexplained infertility

Results normal

Wait for 3 years of attempted conception or 12 self-funded cycles of AI (including 1 year/6 cycles before secondary care referral)

Referral for Assisted Reproduction
GP Referral Form for Fertility Assessment

EFFECTIVE FROM December 2014 – ALL NEW GP REFERRALS

Criteria for Referral for Assessment by Fertility Services:

1. In order to refer a couple for assessment all questions **MUST** be answered.

2. Please refer to your local CCG policy for details of eligibility criteria for assisted conception treatments including Intrauterine Insemination (IUI), Donor Insemination (DI), Oocyte Donation (OD) and in-vitro fertilisation (IVF).

If referring for IVF treatment, read eligibility criteria in policy (Specialist Fertility Services Commissioning Policy) prior to referral.

**Patient Information**

<table>
<thead>
<tr>
<th>Name:</th>
<th>DoB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>NHS No:</td>
</tr>
<tr>
<td></td>
<td>Home Tel No:</td>
</tr>
<tr>
<td></td>
<td>Mobile No:</td>
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</tbody>
</table>

To be completed by GP prior to referral to secondary care

<table>
<thead>
<tr>
<th>Initial Lifestyle advice</th>
<th>Tick</th>
</tr>
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<tbody>
<tr>
<td>Provide patient information on conception rates and reassurance</td>
<td></td>
</tr>
<tr>
<td>Consider referral to smoking cessation and weight management</td>
<td></td>
</tr>
<tr>
<td>Advise on alcohol intake and recreation drug use</td>
<td></td>
</tr>
<tr>
<td>Recommend folic acid supplementation</td>
<td></td>
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<tr>
<td>Other lifestyle advice (tight underwear, occupation)</td>
<td></td>
</tr>
</tbody>
</table>

Failure to conceive after 1 year attempt or 6 cycles of artificial insemination - further investigations and consider referral to secondary care.

<table>
<thead>
<tr>
<th>Investigations</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female</strong></td>
<td></td>
</tr>
<tr>
<td>Regular menstrual cycle</td>
<td>□ YES □ NO</td>
</tr>
<tr>
<td>Serum FSH Level (Day 1-3)</td>
<td></td>
</tr>
<tr>
<td>Serum LH Level (Day 8)</td>
<td></td>
</tr>
<tr>
<td>Serum Progesterone at mid-luteal:</td>
<td></td>
</tr>
<tr>
<td>Serum Prolactin:</td>
<td></td>
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<tr>
<td>Serum Testosterone</td>
<td></td>
</tr>
<tr>
<td><strong>Male</strong></td>
<td></td>
</tr>
<tr>
<td>Semen Analysis: (if abnormal repeat in 6 weeks)</td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td></td>
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</tbody>
</table>
### Motility

### Morphology

- Assess and manage ovulation disorders appropriately and consider referral to secondary care at this stage
- Refer to secondary care for further investigations for suspected uterine and tubal abnormalities
- Refer for unexplained infertility if all hormonal profile and semen analysis normal

**Other investigations (if previous result available):**

<table>
<thead>
<tr>
<th>Investigations</th>
<th>Date</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tubal Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laparoscopy &amp; Dye</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hysteroscopy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hysterosalpingogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultrasound</td>
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</tbody>
</table>

**Other screening tests:**

<table>
<thead>
<tr>
<th>Screening</th>
<th>Date</th>
<th>Result</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cervical Smear</td>
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**Referred by:**

<table>
<thead>
<tr>
<th>Signed:</th>
<th>Date:</th>
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<table>
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<tr>
<th>Print Name:</th>
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<table>
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<tr>
<th>Contact Address:</th>
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<table>
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<tr>
<th>Email:</th>
<th>Telephone No:</th>
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</table>
Self management of excessive sweating

What can I do myself to improve symptoms of excessive sweating?

- If possible, try to avoid triggers that you know make your symptoms worse. Common food and drinks that can trigger excessive sweating are:
  - Products that contain caffeine (tea, coffee)
  - Chocolate
  - Spicy or sour foods
  - Hot foods
  - Alcohol
  - Foods or drinks containing citric acid
  - Sweets.

- Use a commercial antiperspirant (as opposed to a deodorant) frequently. It says on the spray or roll-on whether it is an antiperspirant or deodorant.

- Avoid tight clothing and man made fabrics like nylon or polyester.

- Wear white (as opposed to blue) shirts or black clothing to minimize the signs of sweating.

- Consider using dress shields (also known as armpit or sweat shields) to absorb excess sweat and protect delicate or expensive clothing. These can be obtained via the internet or the Hyperhidrosis Support Group.

- For people with excessive sweating of the feet:
  - Wear moisture-wicking socks, changing them at least twice daily.
  - Use absorbent soles, and use absorbent foot powder twice daily.
  - Avoid occlusive footwear such as boots or sports shoes; wear leather shoes.
  - Alternate pairs of shoes on a daily basis to allow them to dry out fully before wearing them again.

What can I do if the above measures don’t help?

Use an antiperspirant roll-on containing 20% aluminium chloride, for example Driclor®, Anhydrol Forte®, which can be purchased from your local pharmacy or online. If the main problem of sweating is with the feet, an aluminium salt dusting powder (Zeasorb®) or aluminium chloride spray or lotion, for example Odaban® can be useful alternatives.
How should I be using these products?

- Aluminium chloride should be applied at night just before sleep and washed off in the morning.
- Apply to dry skin where you experience excessive sweating: armpits, soles of the feet, hands, or face (avoiding the eyes). Consider soaking lotion pads for application to the face.
- Avoid shaving for 24 hours before and after application.
- Apply aluminium chloride every 1-2 days, as tolerated, until the symptoms improve. From first starting treatment, it can take up to 1-2 months to be able to evaluate the full effect. If effective, you will need to repeat this when symptoms return, which may be up to every 6 weeks.

I experience irritation of the skin when using aluminium chloride, what should I do?

Skin irritation is common when using aluminium chloride products. You can reduce this by:

- Use a soap-substitute for washing instead of soap.
- Reduce the number of days per week that you apply the product.
- Use hydrocortisone cream 1% for up to 2 weeks.

Where can I find further information and support?

The International Hyperhidrosis Society at: www.sweathelp.org.

The information in the leaflet has been based on information provided in the Clinical Knowledge Summary on Hyperhidrosis, published by the National Institute for Health and Care Excellence. July 2013.