NHS
Surrey Downs
Clinical Commissioning Group

List of Procedures with Restrictions and Thresholds

Policy number:	TNRF 2 (CL03)
Version:	3.6
Ratified by:	CCG Governing Body
Name of originator/author:	Dr. Liz Saunders
Name of responsible committee/individual:	Clinical Governance, Clinical Quality and Patient Safety Committee
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Improving care together across Surrey Downs

Summary

The Surrey Collaborative Clinical Commissioning Groups (CCG's) have considered evidence of clinical effectiveness, information on current activity, resources, costs, experience and provision across the South East Coast in order to formulate the following thresholds and restrictions.. The CCG has also undertaken a comparative analysis with Policies adopted by CCGs in Brighton, Kent and London and acknowledges with thanks the permission given to utilise their policy statements

This document will be updated periodically as specific conditions and procedures are reviewed in the light of new clinical evidence. This will be in line with the Surrey Priorities Committee's work plan

The specific OPCS codes to which each of the treatments would be assigned are listed in the document embedded below and will be updated as and when national PbR guidance is released. Local coding will also be monitored and reflected in the listing.

Version History

Version	Date	Author	Status	Comment
1	March 2013	Amended from NHS Surrey policy CLIN 13 (b) version 1 October 2012.	Final	For approval by Executive Committee and Governing Body March 2013
2	July 2013	Amended from NHS Surrey policy CLIN 13 (b) version 1 October 2012.	Final	Final version approved by Governing Body 19 July 2013
3	February 2015	Amended from NHS Surrey policy CLIN 13 (b) version 2 by Dr. Liz Saunders. Approved by Surrey Priorities Committee	Final	Changes agreed by Priorities Committee: TNRF2 003; Adenoidectomy, criteria added TNRF2 005; Grommets, thresholds clarified TNRF2 006; Pinnaplasty age limits increased TNRF2 009; D&C, NICE criteria added TNRF2 013; Labiaplasty criteria added Arthroscopy of hand and wrist removed from policy Arthroscopy of elbow removed from policy TNRF2 016; Balloon kyphoplasty criteria clarified

3	February 2015	Amended from NHS Surrey policy CLIN 13 (b) version 2 by Dr. Liz Saunders. Approved by Surrey Priorities Committee	Final	TNRF2 020; Hallux valgus, new criteria added TNRF2 023; Vertebroplasty, criteria clarified TNRF2 038; Radiofrequency denervation for facet joints, criteria clarified Metal on metal hip resurfacing removed and transferred to TNRF policy TNRF2 026; Blepharoplasty moved from TNRF1 policy and new criteria introduced TNRF 030; Breast reduction moved from TNRF1 policy. TNRF2 031; Criteria for removal and replacement of breast implants added. Varicose veins new criteria introduced. TNRF2 025; Chalazion criteria clarified TNRF2 019; Ganglion criteria clarified TNRF2 027/028/029; Hernia repair criteria clarified TNRF2 037; Circumcision criteria clarified
3.1	May 2015	Updates and Reformatting	Final	TNRF2 040; Hyperhidrosis, treatment of – criteria added TNRF2 039; Male Breast Reduction for Gynaecomastia criteria added TNRF2 033; Open MRI addition to criteria
3.2	January 2016	Updates as agreed by Surrey Priorities Committee	Final	Radiofrequency denervation for facet joints moved to TNRF1 policy TNRF2 002; Viral Wart procedures – criteria amended TNRF2 010; Female genital prolapse – criteria clarified TNRF2 023A; Total Hip Replacement – criteria added TNRF2 023B; Total Knee Replacement – criteria added TNRF2 023C; Hip Impingement Syndrome – criteria added TNRF 2 034; Epidural Injections for Sciatica – criteria amended Radiofrequency Spinal Denervation moved to TNRF1 policy TNRF2 026; Blepharoplasty/Ptosis Criteria amended
3.3	July 2016	Updates as agreed by Surrey Priorities Committee	Final	Inserted: Patients should be encouraged to stop smoking prior to surgery into each criteria TNRF2 030; Female Breast Reduction – Non-smoker removed from criteria

				TNRF2 035; Facet Joint Injections – criteria reworded TNRF2 025; Excision of Chalazion – criteria reworded
3.4	October 2016	Updates as agreed by Surrey Priorities Committee	Final	TNRF2 034; Epidural injections for Sciatica – criteria reworded TNRF2 035; Facet Joint Injections – criteria reworded TNRF2 042; Gallstones, surgical treatment of – criteria inserted
3.5	April 2017	Updated as agreed by Surrey Priorities Committee	Final	TNRF2-004: – Bone Anchored Hearing Aid removed from policy, managed by NHS England. Continuous positive pressure for the obstructive sleep apnoea / hypoapnoea syndrome – Removed from policy. TNRF2 022: Trigger Finger, surgical techniques for the treatment of – Criteria revised. TNRF2 038: Varicose Veins – criteria amended.
3.6	May 2017	Updated as agreed by Surrey Priorities Committee	Final	Policy renamed TNRF2 041: Bariatric Surgery – criteria inserted TNRF2 024: Cataract – criteria revised

Equality Statement

The CCG's aim to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the Human Rights Act 1998 and promotes equal opportunities for all.

This document has been assessed to ensure that no-one receives less favourable treatment on grounds of their gender, sexual orientation, marital status, race, religion, age, ethnic origin, nationality, or disability.

Members of staff, volunteers or members of the public may request assistance with this policy if they have particular needs. If the person requesting assistance has language difficulties or difficulty in understanding this policy, the use of an interpreter will be considered. The CCG's embrace the four staff pledges in the NHS Constitution. This policy is consistent with these pledges

Equality Analysis

This policy has been subject to an Equality Analysis, the outcome of which is recorded below.

		Yes, No or N/A	Comments
1.	Does the document/guidance affect one group less or more favourably than another on the basis of:		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	Yes	Changes to circumcision need to be considered. This will require an evidence review, which will be completed early in 2015 The policy has been changed to take account of the need to consider a number of interventions, which may be part of the Gender Dysphoria clinical pathway.
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Pregnancy and Maternity	Yes	Female sterilization reversal Policy differences in surrounding geographical areas are not based on NICE guidance but are based on local variations/ priorities/ clinical judgement. It is for this

			reason the Priorities Committee has decided not to change or review them in depth at present but instead adhere to the NICE Guidance.
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	Yes	Assistive Communication Assessments and Equipment – there needs to be a clearer justification as to why there was a decision previously not to fund equipment-only assessments. This is awaiting an evidence review, which will be completed in April 2015.
	Is there any evidence that some groups are affected differently?	No	
	If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?	n/a	
	Is the impact of the document/guidance likely to be negative?	Yes	See comments above for pregnancy and maternity, disability and gender
	If so, can the impact be avoided?	n/a	
	What alternative is there to achieving the document/guidance without the impact?	n/a	
	Can we reduce the impact by taking different action?	n/a	

Contents

1. Dental

Policy Number	Procedure / Treatment	Guidance Notes
n/a	Impacted third molars	This service is commissioned and applications are managed by the NHS England
n/a	Dental Extraction of non-impacted teeth	This service is commissioned and applications are managed by the NHS England

2. Dermatology

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 001	Removal of benign skin lesions	Where malignancy is suspected, the patient should be referred to an appropriate service. Clinically benign lesions should not be removed for cosmetic reasons and such procedures will not be funded. Please provide details as to the nature of the lesion, the size and how it is affecting the patient. Removal of benign skin lesions is available as a treatment option for patients where the lesion is associated with any one of the following: • Repeated infection, inflammation or discharge • Bleeding in the course of normal everyday activity • Pain • Obstruction of an orifice to the extent that function is or is likely

		to become impaired • Pressure symptoms, e.g. on an organ, nerve or tissue; Or where the lesion is: • Is subject to recurrent trauma, or • If left untreated, would require a more invasive intervention for removal. All clinicians must be prepared to justify to the CCG the criteria applicable for the treatment of any benign skin lesions. Any treatment of skin lesions outside of the criterion will not be funded by SD CCG. Kent, Surrey & Sussex PR 2012-07 **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 002	Viral Warts Procedures	Viral warts are usually of aesthetic significance only and surgical removal and / or laser treatment is not routinely funded by the CCG. The CCG will fund removal of viral warts in patients who are immunocompromised. There are no restrictions of genital or anal warts. • The patient is immunocompromised **OR** • Does the patient have genital/anal warts **Patients should be encouraged to stop smoking prior to surgery**

3. ENT

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 003	Adenoidectomy	Adenoidectomy for Otitis Media in children will not be routinely funded but, combined with grommets, will be considered in children who fulfill the criteria (see section on grommets). NICE Guidance on Otitis Media recommends that adjuvant adenoidectomy is not recommended in the absence of persistent and/or frequent upper respiratory tract symptoms **Patients should be encouraged to stop smoking prior to surgery**
N/A	Bone-anchored hearing aid - unilateral	This service is commissioned and applications are managed by the NHS England
N/A	Bone-anchored hearing aids - bilateral	There is insufficient evidence to justify the use of bilateral bone anchored hearing aids (i.e. one on each side).
N/A	Cochlear implants	This service is commissioned and applications are managed by the NHS England
TNRF2 005	Grommets	Grommets for children should be undertaken in accordance with NICE Clinical Guidance 60 (Feb 2008) Surgical Management of Otitis Media with Effusion in Children (Under 12 years old). The stated threshold for surgical intervention (under 12s) is: 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) should be considered for surgical intervention. This procedure is not routinely funded for people over the age of 12 except under the following conditions:

		• A middle ear effusion causing measured conductive hearing loss and i resistant to medical treatments. The patient must be experiencing disability due to deafness **OR** • Persistent Eustachian tube dysfunction resulting in pain (e.g. whilst flying) **OR** • As one possible treatment for Meniere's disease **OR** • Severe retraction of the tympanic membrane if the clinician feels this may be reversible and reversing it may help avoid erosion of the ossicular chain or the development of cholesteatoma **OR** • Grommet insertion as part of a procedure for the diagnosis or management of head and neck cancer and/or its complications. **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 006	Pinnaplasty / Otoplasty	This procedure is not routinely funded for adults on cosmetic grounds. Royal College of Surgeons Commissioning Guidance recommends pinnaplasty for children aged 5-18. The CCG will consider funding for children when: • the child is aged between 5 and 18 years old And • the surgeon has defined the deformity to the ear(s) as severe enough to require surgical correction And • the child has clearly expressed concerns to the clinician which in their opinion or following a psychological assessment, it is considered that this is likely to be remedied through correction of the ear deformity. Details of the child's psychosocial concerns must be clearly described in the IFR application. **Patients should be encouraged to stop smoking prior to surgery**

TNRF2 007	Rhinoplasty and Septorhinoplasty	These procedures are not routinely funded. The CCG will only fund these procedures for the following conditions: • Correction of nasal deformity causing nasal blockage. **OR** • Correction of nasal deformity arising from direct nasal trauma. **OR** • Correction of nasal deformity associated with named facial congenital disorders. These procedures should not be carried out for cosmetic reasons **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 008	Tonsillectomy	This procedure is not routinely funded except in persons who meet the criteria in the SIGN 117 guidance published April 2010: • Sore throats that are due to acute tonsillitis **AND** • Episodes of sore throat that are disabling and prevent normal functioning **AND** • Seven or more well documented clinically significant, adequately treated sore throats in the preceding year. **OR** • Five or more such episodes in each of the preceding two years. **OR** • Three or more such episodes in each of the preceding three years. Other indications of why tonsillectomy is required can also include peritonsillar abscess or pharyngeal obstruction/ obstructive sleep apnoea. **Patients should be encouraged to stop smoking prior to surgery**

4. Gynaecology

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 009	Dilation and Curettage	CCG will fund dilation and curettage for diagnostic purposes for suspected malignancy and for evacuation of retained products of conception. NICE Heavy Menstrual Bleeding CG 44 states that D&C is not recommended alone as a diagnostic tool or as a therapeutic treatment for heavy menstrual bleeding. Vacuum aspiration is the preferred treatment for removing retained products of conception. D&C for the investigation of abnormal uterine bleeding is appropriate in the following circumstances: Transvaginal ultrasound with Pipelle endometrial aspirate has failed due to cervical stenosis or pain and facilities for a hysteroscopy with targeted biopsy are unavailable **OR** Hysteroscopy with targeted biopsy has failed/is not possible due to cervical stenosis, pain or inability to dilate the cervix **OR** Transvaginal ultrasound has demonstrated focal pathology and facilities for a hysteroscopy with targeted biopsy are unavailable **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 010	Female genital prolapse (surgical management of)	This procedure is not routinely funded for asymptomatic or mild pelvic organ prolapse. Referral for specialist assessment is indicated for: • Prolapse combined with urethral sphincter incompetence or

		faecal incontinence **OR** • Moderate to severe symptoms **OR** • Failure of pessary **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 011	Female Sterilisation	Sterilisation will not be available on non-medical grounds unless the woman has had at least 12 months' trial using Mirena or Implanon and found it unsuitable. The CCG will fund this procedure: • Where sterilisation is to take place at the time of another procedure such as caesarean section **OR** • Where there is a clinical contraindication to the use of a Mirena/Implanon **OR** • Where there are severe side effects with the use of Mirena/Implanon **OR** • Where there is an absolute clinical contraindication to pregnancy. These are: • young women (under 45 years of age) undergoing endometrial ablation for heavy periods • women with severe diabetes • women with severe heart disease **AND** • Women should be informed that vasectomy carries a lower failure rate in terms of post-procedure pregnancies and that there is less risk related to the procedure

		Patients should be encouraged to stop smoking prior to surgery
TNRF2 012	Hysterectomy for heavy menstrual bleeding	This procedure will only be funded in line with NICE guidance (CG44). NICE: Pharmaceutical treatment should be considered as first line intervention for women with no structural or histological abnormality suspected or fibroids less than 3cm in diameter. In women with heavy menstrual bleeding alone, with a uterus no bigger than a 10 week pregnancy, endometrial ablation should be considered preferable to hysterectomy. Hysterectomy should only be considered when: • other treatment options have failed, are contraindicated or are declined by the woman • there is a wish for amenorrhoea • the woman (who has been fully informed) requests it • the woman no longer wishes to retain her uterus and fertility **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 013	Labiaplasty	**NHS England Interim Policy** The CCG Policy is line with the NHS England interim policy for Labiaplasty, which states that: "Labiaplasty is generally a cosmetic procedure to change appearance alone and is not routinely funded. Requests for Labiaplasty are considered with the following indications: • Where the labia are directly contributing to recurrent disease or infection (this could include ulceration/maceration) **OR**

		• Where the repair of the labia is required after trauma. **Patients should be encouraged to stop smoking prior to surgery**

5. Musculoskeletal

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 014	Arthroscopy of the knee	Arthroscopy of the knee can be undertaken where a competent clinical examination (or MRI scan if there is diagnostic uncertainty or red flag symptoms/signs/conditions) 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 **OR** Meniscal surgery (repair or resection) **OR** Ligament reconstruction/repair (including lateral relapse) **OR** Synovectomy **OR** Treatment of articular defects e.g. micro-fracture

		Knee arthroscopy should not be carried out for any of the following indications: • Investigation of knee pain Treatment of osteoarthritis (except in line with NICE guideline (CG59) **Patients should be encouraged to stop smoking prior to surgery**
N/A	Arthroscopy of the hand / wrist	Removed from policy as no thresholds are utilized
N/A	Arthroscopy of the elbow	Removed from policy as no thresholds are utilized
TNRF2 015	Carpal tunnel syndrome (Surgical techniques for the treatment of)	The CCG will only fund this intervention if: Acute, severe symptoms persist after conservative therapy with either local corticosteroid injection by a trained, competent practitioner, and/or nocturnal splinting; **OR** Mild to moderate symptoms persist for at least 4 months after conservative therapy with either local corticosteroid injection (if appropriate) and/or nocturnal splinting (used for at least 8 weeks); **OR** There is neurological deficit e.g. sensory blunting, muscle wasting or weakness of thenar abduction, or proven neurophysiological changes; **OR** Severe symptoms significantly interfere with daily activities. <u>Patients who are diabetic, and those who are aged 65 and over, should be referred urgently, without first attempting conservative therapies</u> **Patients should be encouraged to stop smoking prior to surgery**

TNRF2 016	Balloon kyphoplasty for vertebral compression fractures	NICE Interventional Procedure Guidance 166 supports the use of balloon kyphoplasty if the procedure is undertaken following discussion with a specialist multidisciplinary team that includes a radiologist and a spinal surgeon. The guidance also states that there should be good imaging facilities, arrangements for access to a spinal surgery service and that clinicians reach an appropriate level of expertise before carrying out the procedures. In particular, they must follow the manufacturer's instructions for making the cement, to reduce the risk of embolisation. The CCG expect this service to be provided at centers that fulfill all the conditions stipulated by NICE **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 017	Discectomy for Lumbar Disc Prolapse (elective)	This procedure is not routinely funded unless: The patient has had appropriate imaging e.g. MRI or CT showing disherniation (protrusion, extrusion, or sequestered fragment) at a level and side corresponding to the clinical symptoms **AND** the patient has radicular pain (below the knee for lower lumbar herniations; into the anterior thigh for upper lumbar herniations) consistent with the level of spinal involvement **OR** there is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30o and 70o or positive femoral tension sign) **AND** symptoms persist despite some non-operative treatment for at least 6 weeks (e.g. analgesia, physiotherapy, bed rest, etc.), provided that analgesia is adequate and there is no imminent risk of neurological

		deficit **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 018	Dupuytren's contracture – Surgical Treatment / Interventional Procedures, including Needle Fasciotomy	The CCG will only fund surgical treatment/interventional procedures if: • There is a metacarpophalangeal joint contracture of 30° or more • Any degree of proximal interphalageal joint contracture • Is the patient under 45 years of age with disease affecting 2 or more digits and loss of extension exceeding 10° or more? If an exact measurement is not possible, the clinical assessment should include an evaluation of the extent of disease and an estimate of severity/deformity. **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 019	Ganglions: Wrist and surgical techniques for treatment of	This procedure is not routinely funded except in severe cases. Classification: • Mild - Asymptomatic lump • Moderate – 1) Symptomatic lump; long duration of symptoms - pain lasting 3-6 months (2) Occult ganglia – hidden ganglion (3) Cancer-phobia – excessive fear of malignancy • Severe – 1) Nerve or blood vessel compression with restriction of activities of daily living or (2) concern regarding diagnosis. Treatment: All patients should be informed that most ganglia resolve

		spontaneously with the passage of time. For mild and moderate cases - reassurance and observation. Aspiration of cancer reassurance - refer for ultrasound / MRI if concerns re diagnosis. **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 020	Hallux valgus: Surgical treatment of	Hallux valgus is a common foot condition which can present with a very broad range of symptoms, from the purely cosmetic to major deformity, pain and disability. Some feet deteriorate over time. Surgery is simpler and more successful in the earlier stages but prophylactic or cosmetic surgery is not justified, even with the lower risks and higher success rates of modern techniques. Several types of operation are available, each appropriate to particular clinical circumstances. Surgery is offered if symptoms are severe or deteriorating and the risk-benefit ratio is judged favourable. During clinical consultation, the following principles influence whether or not to offer surgery and can be used to select those patients most suitable for referral to the specialist orthopaedic foot and ankle service. Surgery is more likely to be appropriate if any of the following is present and not responsive to conservative treatment: • functional impairment which is significant • daily bunion pain • inability to wear suitable shoes • any pain under the ball of the foot • the second toe starting to lift or flex (clawing), whether the bunion itself is painful or not

		• the deformity is severe and/or deteriorating (e.g. shoes wearable last year no longer fit) • severe pain Conservative management techniques include: • Avoiding high heel shoes and wearing wide fitting leather shoes which stretch; • Exercises specifically designed to alleviate the effects of a bunion and keep it flexible; • Applying ice and elevating painful and swollen bunions; • Use of bunion pads, splints, insoles or shields Significant functional impairment is considered as: • Symptoms which prevent the patient fulfilling vital work or educational responsibilities, **OR** • Symptoms which prevent the patient carrying out vital domestic or carer activities. Before consulting a specialist for surgery, patients must accept that they will be unable to drive for 6 weeks (or 2 weeks after surgery on the left foot if driving an automatic car) and will be off work for 2 weeks for a sedentary job. In addition to the above criteria, smoking cessation and weight management should be considered as an integral part of appropriate clinical management prior to consideration of any elective surgery (with referral to appropriate services if indicated). Current evidence on safety and efficacy in relation to the correction of hallux valgus using minimal access techniques is inadequate NICE (IPG 332) **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 021	Spinal fusion for the treatment of lower back pain	This procedure will only be funded in line with NICE guideline (CG88) iv. This treatment will be funded for patients who:

		• Have completed an optimal package of care, but have failed all conservative treatment. **AND** • Still have severe lower back pain for which they would consider surgery **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 022	Trigger finger: surgical techniques for the treatment of	One in five patients with Trigger Finger will improve without any intervention other than resting the hand and allowing the inflammation time to settle. Surrey CCGs will only fund surgical techniques for the treatment of Trigger Finger when the following criteria are met: The patient has failed to respond to conservative treatment which includes two corticosteroid injections. (Please note: Referral for surgery should only be considered if the patient has failed to respond to both steroid injections. Given steroid injections take time to be effective, any referral or request for funding for surgery must not be made until at least 3 months has elapsed after the second corticosteroid injection). **OR** The patient has a fixed flexion deformity that cannot be corrected **OR** The patient has diabetes. In this case the patient should be referred without first attempting conservative management **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 023	Vertebroplasty (Percutaneous)	This procedure will only be funded in line with NICE IPG 12.

		This procedure should only be undertaken when there are arrangements for good access to a spinal surgery service, and with prior discussion between a specialist multidisciplinary team that includes a radiologist and a spinal surgeon. Clinicians should receive training to reach an appropriate level of expertise before carrying out this procedure. In particular, they must follow the manufacturer's instructions for making the cement, to reduce the risk of embolisation. The procedure should be limited to patients whose pain is refractory to more conservative treatment. • The patients pain is refractory to more conservative treatment **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 023 A	Total Hip Replacement for Osteoarthritis	Funding THR for OA **only** when all other treatment options and conservative measures have failed. These include : • Medication: oral/topical NSAIDS[1] and paracetamol based analgesics **AND** • Patient Education **AND** • Physiotherapy and exercise **AND**

		Healthy lifestyle improvements: • It is strongly advised to reduce weight where indicated and to reduce BMI so that it is within the healthy range. Patients who smoke should have been encouraged to stop smoking 8 to 12 weeks before referral to reduce the risk of surgery and post-surgery complications. Patients should be routinely offered referral to smoking cessation services to reduce these surgical risks. **The following criteria must <u>also</u> be met:** • Intense to severe persistent pain which leads to severe functional limitations **OR** • Moderate functional limitation affecting the patients quality of life despite 3 months of conservative measures **<u>Exceptions should include:</u>** • Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this • Patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 023 B	Total Knee Replacement	The CCG will **ONLY** fund TKR for OA in patients meeting the following criteria. It is presumed that all referrals meet these criteria prior to referral unless exceptional in which case the referral should document explicitly the reason for exceptional circumstances. Prior conservative management should have been tried and failed and must include all of the following: a. <u>Medication</u>

		- analgesics; - anti-inflammatory medications. b. <u>Physiotherapy (as recommended by NICE)</u> - muscle strengthening; - supervised physical therapy. c. <u>Patient education</u> - benefits of eliminating damaging influences on knees; - benefits of activity modifications; - support aids. d. <u>Healthy lifestyle improvements</u> - it is strongly advised to reduce BMI to (evidence suggests less than 35 kg/m_2)as this may reduce complications and improve outcomes. Patients with a BMI greater than 35 kg/m_2 should be routinely offered referral to a weight management service to reduce these risks; - patients who smoke should have been encouraged to stop smoking 8 to 12 weeks before referral to reduce the risk of surgery and post-surgery complications. Patients should be routinely offered referral to smoking cessation services to reduce these surgical risks. **<u>And when</u>** the following criteria have been met : a. Uncontrolled, intense, persistent pain resulting in substantial impact on quality of life and moderate functional limitations which have failed a reasonable period of maximal conservative treatment; The above being evidenced by XRay/MRI Scan showing bone on bone damage **AND** b. Symptoms refractory to at least 3 months conservative management for the condition. The policy does not affect criteria for Immediate/Urgent Referral to

		Orthopaedic Services in respect of : - Evidence of infection in the knee joint; - Symptoms indicating a rapid deterioration in the joint; - Persistent symptoms that are causing severe disability. *Glucosamine products and hyaluronic acid are not routinely funded. Hyaluronic acid will only be made available on an individual basis for patients whom other pharmacological options have been intolerable, ineffective or have been unable to undergo surgery. **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 023 C	Hip Impingement Syndrome	**Open or arthroscopic femero-acetabular surgery for hip impingement is commissioned if the following criteria are met:** • Labral tear or impingement has been confirmed on MRI; **AND** • Where hip arthroscopy is supported in the washout of an infected native hip joint in patients refractory to medical management, patients with underlying disease or patients who are immunosuppressed. • Where hip arthroscopy is supported for the removal of radiologically proven loose bodies within the hip joint with an associated acute traumatic episode. Arthroscopy is not supported as a diagnostic tool where there is suspicion of loose bodies. • The clinician has ensured that the patient understands what is involved, is aware of the serious known complications outlined in NICE patient information and agrees to the treatment knowing that there is only evidence of symptom relief in the short and medium term, **AND** • The surgeon must have completed specialist training and have experience of providing arthroscopic hip surgery; **AND**

		• The provider will provide full data on 100% patients undergoing this procedure to the British Hip Society register (currently being established to support assessment of long term outcomes); **AND** • The provider will undertake local review of cases to monitor safety and short term outcomes **Patients should be encouraged to stop smoking prior to surgery**

6. Ophthalmology

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 024	Cataract Surgery	Any suspicion of cataracts in children should be referred urgently. Please ensure the referring optometrist or GP has discussed the risks and benefits and ensured the patient understands and is willing to undergo surgery prior to referral. Adults with a visual acuity of 6/9 or better in either eye are considered a low priority for cataract surgery. Referrals from community services should only be made after an assessment by an optometrist unless there are exceptional reasons why this is not possible. Optometrists should take into account the referral thresholds and the impact of the cataract(s) on the patient's life. Is the surgery for the first or second eye?

		If first, what is the VA of second eye?: Please indicate whether patient meets the following NICE criteria: 1. Best corrected visual acuity must be worse than 6/9 (6/9.5 and worse) in the first affected eye. **OR** 2. The patient wishes to/is required to drive and does not meet the Driving & Licensing Authority (DVLA) eyesight requirements **Cataract surgery of the second eye – will be funded if:** 1. Visual acuity meets the thresholds of 6/18 or worse. OR 2. If the first eye visual acuity has not achieved 6/9, cataract surgery for the second eye will be funded provided the visual acuity is worse than 6/9 (6/9.5 and worse) in the second eye **Exceptions:** Cataract surgery can continue to be performed for medical reasons such as glaucoma and diabetes and on patients with severe anisometropia who wear glasses. The clinical reason for the surgery should be clearly documented. **Patients should be encouraged to stop smoking prior to surgery** _____

TNRF2 025	Excision of Chalazion	This procedure is not routinely funded. Chalazia (meibomian cysts) are benign, granulomatous lesions that will normally resolve. Treatment consists of regular (four times daily) application of heat packs. The CCG will fund excision of chalazia when the following criteria are met: • Chalazion will be removed when it has been present for a minimum of 4 months **AND** • When it is causing blurred vision **OR** • When it is a source of regular infection that has required medical attention twice or more. The watchful waiting period should usually be between 4 to 6 months at the clinician's discretion as many will resolve with conservative management during that time. <u>In common with all types of lesions, the CCG will fund removal where malignancy is suspected.</u>
TNRF2 026	Blepharoplasty / ptosis surgery	This procedure will ONLY be considered for patients whose condition requires a surgical intervention which is non-cosmetic The procedure will only be offered to patients meeting the following criteria: • To repair defects predisposing to corneal or conjunctival irritation such as entropion or pseudotrichiasis (a condition which results in abnormally positioned eyelashes which grow back toward the eye, touching the cornea or conjunctiva) • In the case of ectropion or entropion the severity of the handicap caused will need to be explicitly set out. For instance persistent and troublesome epiphora resulting in watery eyes or lashes abrading the cornea which cannot be resolved by epilation • To treat periorbital effects of thyroid disease (such as swelling around the orbit of the eye), nerve palsy, blepharochalasis, floppy eyelid syndrome and chronic inflammatory skin conditions • To relieve symptoms of blepharospasm (abnormal contraction or twitch of the eyelid) or

		significant dermatitis on the upper eyelid caused by redundant tissue • Following skin grafting for eyelid reconstruction For all other individuals who <u>do not meet the above criteria</u>, the following criteria apply: • Documented complaints of interference with vision or visual field related activities such as difficulty reading or driving due to upper eye lid skin drooping, looking through the eyelids or seeing the upper eye lid skin **AND/OR** • There is redundant skin overhanging the upper eye lid margin and resting on the eyelashes when gazing straight ahead **AND/OR** • It is evidenced that where it is not overhanging, the upper lid covers the upper pupil margin **AND/OR** • Evidence from visual field testing that eyelids impinge on visual fields reducing field to 120° laterally and/or 20° or less superiorly; a degree of interpretation will need to be applied as the area of the visual field where the missing points are concentrated within the 120 to 20 range is crucial to establish the severity of the visual impairment • The test used should be monocular • Photographic evidence must be provided and must show the redundant skin overhanging the upper eyelid margin and resting on the upper eyelashes when gazing straight ahead. Photographs must be taken : • from the front with the camera at eye level, with the lid in a relaxed position, and the individual looking straight ahead (primary gaze); • the above will need to be supplemented by a picture taken from the side of the patient. NB It is recommended that the 120 point Humphrey visual field chart is used.

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7. Other Surgery

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 027	Inguinal hernia in adults (elective surgical repair of)	This procedure is not routinely funded for asymptomatic or mildly symptomatic inguinal hernias in adults. Patients should be referred for surgical assessment if they meet the following criteria: • A history of incarceration of, or real difficulty reducing, the hernia. • An inguino-scrotal hernia. • Increase in size month to month. • Pain or discomfort significantly interfering with activities of daily living. • Work related issues e.g. of work/missed work/unable to work/on light duties due to hernia. Patients with femoral hernias should be referred for consultation. NB All cases of suspected femoral hernia and groin hernias in women are routinely funded. **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 028	Umbilical hernia in adults (elective surgical repair)	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 the bowel **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 029	Incisional hernia in adults (elective surgical repair)	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, eg. Weight reduction where appropriate **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 030	Female Breast reduction (previously listed in TNRF Policy No. Change to Criteria)	Breast reduction should only be considered an option for patients who fulfill all of the following criteria: • Documented and ongoing physical symptoms of back, neck and/or shoulder pain due to large breasts (plus documented evidence of treatment for pain). • Requires more than 500g tissue removed from each breast (to be assessed by surgeon*) • BMI of <26kg/m^2. • Non-smoker

		GPs should not refer patients into secondary care if they do not fulfill the above outlined criteria (with the exception of estimating the amount of tissue*). This recommendation does not apply to patients undergoing breast reconstruction as part of treatment for breast cancer. **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 039	Male Breast Reduction for Gynaecomastia	Surgery should only be considered after conservative therapy (reassurance, discontinuation of therapy that may cause gynaecomastia as side effects) and hormonal therapies have been tried. Surgery is not generally recommended in children. Surgery for gynaecomastia should be funded if the following criteria have been met: • Patient is an adult (aged 18+) **AND** • Patient's BMI is <=25 Kg/m^2 **AND** • Patient has been diagnosed with: - Idiopathic gynaecomastia **OR** - Gynaecomastia due to exogenous androgen or oestrogen exposure **OR** - Gynaecomastia with non-hormonal drug exposure **AND** • Patient has undergone three other (conservative and hormonal) treatments before surgery is considered **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 031	Breast implant removal and replacement	Removal of implants will be considered, if at least one of the following criteria are met: Please note: Replacement of Breast Implants will not be considered.

		• Rupture of silicone-filled implant • Implants complication by recurrent infections • Extrusion of implant through skin • Implants with Baker Class IV contracture • Implants with a contracture that interferes with mammography • Intrinsic breast disease Surrey CCGs do not replace breast implants for aesthetic reasons. Re-insertion of implants following removal: (i) Where implants were originally funded by the NHS for non-cosmetic reasons (such as breast cancer or severe trauma) then replacements should be considered in line with the reason for the original funding for implants. (ii) Where implants were originally funded solely for cosmetic reasons they will not be replaced. If implants are bilateral and one implant has to be removed for a sound clinical reason, it will not be replaced so the woman should be given the choice as to whether she wishes only one or both implants to be removed. Privately-funded implants: where implants have been previously funded privately and require removal for a sound clinical reason and this has occurred within 12 months of insertion, the applicant should in the first instance approach the private provider to correct the problem rather than pursuing NHS funding. Where cases fall outside of these criteria and there is a possibility that they may be considered either rare or exceptional or both, they can be considered through the usual IFR process.

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TNRF2 040	Hyperhidrosis, treatment of	Endoscopic Thoracic Sympathectomy surgery for severe palmar or axillary hyperhidrosis will only be funded when all routinely commissioned treatment options have failed.* In addition, the patient must be fully informed of the risks, benefits, side effects of the procedure and the characteristics of a patient likely to experience better outcomes Routinely commissioned treatment options include: • Lifestyle interventions • Aluminum chloride • Oral anticholinergics – please note that the PCN has recommended oxybutynin and propantheline as the preferred oral anticholinergics. Oral glycopyrronium is not recommended for routine prescribing and is black on the Surrey traffic light system (however patients already on treatment should be given the choice to continue) • Local surgery *(only for axillary hyperhidrosis)* • Botulinum toxin A is not routinely supported for the treatment of primary hyperhidrosis and patients should not be referred to secondary care for this treatment. • Patients should be informed of the risks of serious complications of the procedure such as hyperhidrosis elsewhere on the body in around 50% of patients, failure to reduce hyperhidrosis and some patients regret having had the procedure (especially because of subsequent and persistent hyperhidrosis elsewhere) • Funding Endoscopic Thoracic sympathectomy for craniofacial hyperhidrosis only when it coexists with facial blushing • Not funding endoscopic thoracic sympathectomy for plantar hyperhidrosis due to limited evidence on effectiveness **Patients should be encouraged to stop smoking prior to surgery**

TNRF2 042	Gallstones, surgical treatment of	Cholecystectomy will not be funded for asymptomatic gallstones Where patients are asymptomatic, an IFR application is required **Patients should be encouraged to stop smoking prior to surgery**

8. Other Procedures / Equipment

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 032	Assistive Communication Assessments (ACA) and Equipment	Assessment: The CCG will fund an ACA assessment where it has been recommended by Speech & Language Therapist for patients with ongoing complex communication needs. Equipment recommended as a result of these ACA assessments is not routinely funded by the NHS.
TNRF2 033A	Open MRI Scans	Open MRI should only be used for patients for whom it can be demonstrated that they are too obese to be able to be scanned on a closed MRI scanner or patients who have a genuine case of claustrophobia and have been offered a conventional MRI under sedation. Severely obese and claustrophobic patients should be referred for a formal suitability assessment for an open MRI by a radiologist. Any patient that requires an Open MRI scan and meets the criteria above should be referred to an appropriate Open MRI scanner facility on a Provider to Provider basis.
N/A	Continuous positive pressure for the obstructive sleep apnoea / hypoapnoea syndrome	Commissioning arrangements and criteria are to be established in 2015.
TNRF2 033B	Ketogenic diet for the treatment of neurological conditions	Ketogenic diet will only be funded for children up to the age of 18 years with:

		- intractable epilepsy **OR** glucose 1 transporter deficiency **OR** pyruvate dehydrogenase deficiency. Intractable epilepsy is defined as: “a failure of adequate trials of 2 tolerated and appropriately chosen and used anti-epileptic drugs schedules”. Children with intractable epilepsy but who are candidates for surgery may not be eligible for the diet. The CCG recommend that the classical ketogenic diet (CKD) is used as first-line for those who might be considered under the POLCE. However, other variants of the diet may be used if this diet is not tolerated or appropriate for the patient. The CCG does not recommend funding the treatment for intractable epilepsy in adults due to the limited evidence-base or for other neurological conditions such as autism and epilepsy syndromes in children and adults due to the limited evidence-base.

9. Pain Management

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 034	Epidural Injections for Sciatica	Lumbar transforaminal (Injection into opening at the side of the spine where a nerve root exits) and caudal (injection into the lowest portion of the epidural space) epidural injections for patients with radicular pain due to herniated disc (sciatica) will be funded when the following criteria have been met:

		The patient has radicular pain (below the knee for lower lumbar herniations; into the anterior thigh for upper lumbar herniations) consistent with the level of spinal involvement **OR** There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise – positive between 30° and 70° or positive femoral tension sign) **AND** Symptoms persist despite robust non-operative treatment. **Please provide evidence of robust conservative therapy (e.g. physiotherapy report) within the last 12 months.** Repeat epidural injections should only be provided as part of a comprehensive pain management programme and should only be provided 2-3 months apart provided there has been a 50% reduction in symptoms for 6 weeks. Providers will be required to obtain pre-authorisation through the Blueteq database for any second or subsequent injection **Patients should be encouraged to stop smoking prior to surgery**
TNRF2 035	Facet joint injections - Therapeutic	The CCG will fund medial branch blocks for the management of cervical, thoracic and lumbar back pain as specified below: • All conservative management options, (physiotherapy, exercise, pharmacotherapy including analgesia) have been tried and failed. **Please provide evidence of robust conservative therapy (e.g. physiotherapy report) within the last 12 months.** **AND** • The pain has resulted in moderate to significant impact on daily functioning and it has lasted 12 months or more

		• The treatment of facet joint pain is provided as part of a comprehensive pain management programme. Further facet joint injections will only be funded if the initial facet joint injection has had a proven therapeutic benefit: up to two courses of injections per year will be funded in line with the Pain Management Pathway for Chronic Facetal Pain. Intra articular injections will only be funded according to the criteria above. Note: (diagnostic facet joint injections used by spinal surgeons as part of a diagnostic pathway prior to making a decision to proceed to surgery will be funded). **Patients should be encouraged to stop smoking prior to surgery**
N/A	Metal-on-metal hip resurfacing	Removed from policy and moved to the TNRF 1 policy
N/A	Radiofrequency denervation for facet joints	Removed from policy and moved to the TNRF1 policy

10. Urology

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 037	Circumcision	This procedure is not routinely funded. The CCG will fund circumcision when the procedure is clinically indicated. Examples of clinical indications (not to be taken as an exhaustive list) are: • Severe phimosis, recurrent balanitis and where cancer is suspected

		• When congenital urological abnormalities require skin grafting • Cases of traumatic foreskin injury where it cannot be salvaged • Symptomatic cases of paraphimosis when conservative treatment has failed When there is interference with normal sexual activity in an adult male **Patients should be encouraged to stop smoking prior to surgery**

11. Vascular Surgery

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 038	Varicose Veins	Varicose veins are classified on clinical, etiological, anatomical and pathophysiological grounds, referred to as CEAP stages 2-6. The CCG will fund the following: 1. Refer CEAP C4 and above to a specialist vascular service. C2 and C3 should be monitored regularly in primary care in case they become worse. 2. Treat CEAP C2 and C3 with compression therapy except when superficial thrombophlebitis extends up to the thigh as this indicates that referral to a specialist vascular service is required (due to the risk of deep vein thrombosis).

3. Immediately refer patients with bleeding veins to a specialist vascular service.

CEAP Classification	Description	Signs
Class 1		None
Class 2	Varicose veins	None
Class 2T	Varicose veins with superficial thrombophlebitis	superficial thrombophlebitis
Class 3	Varicose Veins with limited skin changes at the ankle with the possibility of further complications	Oedema, venous eczema, superficial phlebitis
Class 4a	Skin changes ascribed to venous disease	pigmentation or eczema or both, Oedema
Class 4b	Skin changes ascribed to venous disease	lipodermatosclerosis Oedema, venous eczema
Class 5	Late stage venous disease	Severe skin changes, active or healed ulceration, bleeding from varicose vein
Class 6	active venous ulcer	active venous ulcer

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12. Weight Management

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 041	Bariatric Surgery (primary and revision surgery)	**Primary Surgery** The CCG will routinely fund Primary Bariatric Surgery for patients to meet **all** of the following criteria. • Patient is 18 years or over • Patient has a BMI of 40kg/m2 or more **OR** • A BMI between 35 kg/m2 and 40kg/m2 in the presence of other significant diseases. • Patient has undergone a formalised MDT led processes for the screening of comorbidities and the detection of other significant diseases. • Morbid/severe obesity has been present for at least five years. • The individual has attended a local bariatric surgery information session prior to referral • The individual has followed dietary and exercise advise for at least 12 months • For patients with BMI > 50 attending a specialist bariatric service, this period may include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is six months.

		• The CCG will not commission the removal of excess skin resulting from weight loss following bariatric surgery. Please ensure that the patient is aware of this policy before proceeding with Bariatric Surgery **<u>Revision Surgery</u>** **Group 1:** Patients presenting with a clinical history, symptoms and/or signs that suggest acute/acute on chronic/worsening medical and /or surgical complications related to their primary obesity operation**.** Patients must be triaged and treated immediately if classified as 'emergency'. Patients are triaged by an MDT and may be assessed as 'clinically urgent' if they are judged to have a subsequent risk of developing emergency complications if they remain untreated. This category will include patients with adverse anatomical complications or the primary surgery but exclude loss of restriction due to dilatations of the gastric pouch and/or the gastro-jejunal junction. This corrective surgery, or in rare cases reversal surgery, would be as per routine and considered as good clinical practice. Trusts (providers) should triage referral letters from GPs, hospital consultants on this basis CCGs will routinely fund Group 1 patients. **Group 2:** The patient has failed to achieve expected average weight loss targets for the primary obesity procedure performed or regained their pre-operative weight. This category will include patients who following a Gastric Bypass develop a dilated gastric pouch or gastro-jejunal anastomotic dilatation.

		This category will not include patients who have previously had vertical banded gastroplasty. **The CCG will not be routinely funding Group 2 patients. Please submit an IFR application if you feel this patient is rare or clinically exceptional.** **Group 3:** The patient has multiple, severe and life threatening co-morbidities which have persisted or re-emerged following primary obesity surgery despite strong evidence that the patient has both attended and engaged with the follow up programmed and multidisciplinary assessment has determined and agreed: • The co-morbidities are potentially life threatening or present a significant risk to health and well – being that is both severe and serious (in the short to medium term) • The presence of clear grounds of clinical exceptionality. **The CCG will not be routinely funding Group 3 patients. Please submit an IFR application if you feel this patient is rare or clinically exceptional.** **Group 4:** Some patients may have had their primary obesity surgery outside of NHS contracts at independent/private providers (including abroad) but subsequently present at NHS facilities as clinical emergencies. The NHS has a duty of care for these patients and will fund emergency and clinically urgent treatment as per Group 1. **Patients should be encouraged to stop smoking prior to surgery**