Improving care together across Surrey Downs

NHS
Surrey Downs
Clinical Commissioning Group

Title of paper:	TNRF1 (Treatments Not Routinely Funded) & TNRF2 Policy Updates and Reformatting		
Author:	Philippa Mardon		
Exec Lead:	James Blythe		
Date:	10th July 2015		
Meeting:	Governing Body		
Agenda item:	8	Attachment:	05
For:	Agreement		

Executive Summary:

The polices relating to Treatments not routinely funded TNRF 1(CLO 2) and List of Procedures with Restrictions and Thresholds TNRF 2 (CLO 3) have been reformatted to include numbered procedures and the OPCS codes have been removed and included as an embedded document as they relate only to NHS organisations who wish to monitor the cost of these procedures via the payments by results system.

TNRF 2 (CLO 3) has also been updated to include amendments to the criteria for 3 of the procedures. Identified in red text.

Compliance section

Please identify any significant issues relating to the following

Risk Register and Assurance Framework	None identified
Patient and Public Engagement	None identified
Patient Safety & Quality	None identified

Financial implications	None identified
Conflicts of interest	None identified
Information Governance	None identified
Equality and Diversity	None identified
Any other legal or compliance issues	None identified

Accompanying papers (please list):

CLO 2 – TNRF1
CLO 3 – TNRF2

Summary: What is the Governing Body being asked to do and why?

Note that the both policies have been reformatted to number each individual procedure and the document has been reformatted to better present the information.

To agree the amendments in CLO 3 – TNRF2

TNRF2 040; Hyperhidrosis, treatment of – criteria added

TNRF2 039; Male Breast Reduction for Gynaecomastia criteria added

TNRF2 033; Open MRI addition to criteria

List of Procedures That Are Not Routinely Funded Requiring Individual Funding Applications

Policy number:	TNRF 1 (CL02)
Version:	2
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
Date issued:	(Treatments Not Routinely Funded policy April 2008).Low Priority Procedures Policy (LPP) came into effect on 1st January 2010.This list of treatments that are not routinely funded (TNRF) requiring individual funding (IFR) applications was implemented on 19th December 2014 by the CCG Governing Body
Last review date:	November 2014
Next review date:	September 2016

Improving care together across Surrey Downs

Equality Statement

The Surrey Collaborative Clinical Commissioning Groups (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 treatment 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:		
	Gender (Men and Women)	Yes	The introduction of criteria for labiaplasty should beneficially impact women by making it clearer when intervention is likely to be successful. Changes to breast related procedures for both men and women will be considered pending the outcome of evidence reviews in early 2015
	Race (All Racial Groups)	No	
	Disability (Mental, Physical and Carers of Disabled people)	No	
	Religion or Belief	No	
	Sexual Orientation (Heterosexual, Homosexual and Bisexual)	No	
	Pregnancy and Maternity	Yes	Female sterilisation reversal – variations in policies in surrounding 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.
	Marital Status (Married and Civil Partnerships)	No	
	Transgender	Yes	The policy now includes the need to consider interventions that may be part of the Gender Dysphoria clinical pathway through the IFR application process.
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?	N/A	
4.	Is the impact of the document/guidance likely to be negative?	No	
5.	If so, can the impact be avoided?	N/A	
6.	What alternative is there to achieving the document/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	

For advice in respect of answering the above questions, please contact the Corporate Office, of your CCG. If you have identified a potential discriminatory impact of this procedural document, please contact as above.

Names and Organisation of Individuals who carried out the Assessment	Date of the Assessment
Laura Saunders – Public Health Surrey County Council, Public Health Lead	22nd October 2014
Justin Dix – Surrey Downs CCG, Governing Body Secretary	

Version Control

Version	Date	Author	Status	Comment
1	March 2013	Amended from NHS Surrey policy CLIN 13 (a) version 1 Oct 2012.	Draft	Adapted for approval by the Executive and Governing Body
	April 2013	Adapted for CCG	Draft	For approval by Executive Committee
	July 2013	Adapted for CCG	Final	For approval by CCG Governing Body
	July 2013	Adapted for CCG	Final	Final version approved by Governing Body 19 July 2013
2	August 2014	Dr. Liz Saunders	Final	Changes approved by Priorities Committee: • Breast Reduction removed and transferred to LoPRT policy. Breast augmentation: need for approved Gender Dysphoria cases to be considered via IFR process. • Blepharoplasty/ptosis surgery removed and transferred to LoPRT policy. • Benign skin lesions removed as already in LoPRT policy. Surgery for hyperhidrosis under review. • Rhinoplasty removed as already in LoPRT policy. • Labial reduction removed and transferred to LoPRT policy. • Metal on metal hip resurfacing new addition. Removed from LoPRT policy. • Varicose veins removed as already in LoPRT policy. Surgery for blushing and sweating are under review. • Extracorporeal electrophoresis for chronic graft-versus-host disease in cutaneous T Cell Lymphoma removed as it is standard practice. • FES for drop foot: details of commissioning added

Contents

1. Alternative Therapies 2
2. Cosmetic/plastic surgery 2
   2.1 Body Contouring Procedures 2
   2.2 Breast Surgery for: 4
   2.3 Facial Procedures 5
   2.4 Skin and Subcutaneous Procedures 5
3. Dermatology 6
4. Dental 6
5. Ear Nose and Throat 7
6. Gynaecology 7
   7.1 Pain Management 7
8. Neurology/neurosurgery 8
9. Oncology 8
10. Ophthalmology 9
11. Weight Management 9
12. Other Surgery 9
13. Urology 10
14. Other Procedures/Equipment 10

Appendix 1: NICE Interventional Procedure Guidance

Treatments not routinely funded

The Clinical Commissioning Group's (CCG's) have considered evidence of clinical effectiveness and experience, information on current activity, resources, costs and provision across the South East Coast in order to formulate the following recommendations. 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. There is no blanket ban on these procedures. There is an established mechanism for dealing with individual funding requests (IFR)/exceptions. The application form for clinicians wishing to request funding for individuals that are eligible against the definitions of a "rarity request" or an "exceptionality request" as set out in the CCGs Policy and Operating Procedures for dealing with Individual Funding Requests (IFRs).

The specific OPCS codes to which each of the treatments could 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.

All procedures contained in this policy will require an Individual Funding Request application before the procedure can take place (unless related to the treatment of cancer). This policy will be updated periodically as new clinical evidence emerges and in line with the Surrey Priorities Committee work plan.

1. Alternative Therapies

Code	Procedure / Treatment	TNRF Guidance Notes
TNRF 1 – 001	Acupuncture	This procedure is not routinely funded.
TNRF 1 - 002	Aromatherapy	This treatment is not routinely funded. (It is only available as part of palliative care packages)
TNRF 1 - 003	Chinese medicines	This treatment is not routinely funded.
TNRF 1 - 004	Chiropractic therapy	This treatment is not routinely funded.
TNRF 1 - 005	Clinical ecology	These procedures are not routinely funded.
TNRF 1 - 006	Herbal remedies	This treatment is not routinely funded.
TNRF 1 - 007	Homoeopathy	This treatment is not routinely funded.
TNRF 1 - 008	Hydrotherapy, unless part of an established care package	This treatment is not routinely funded.
TNRF 1 - 009	Hypnotherapy	This procedure is not routinely funded.
TNRF 1 - 010	Massage	This treatment is not routinely funded. (It is only available as part of commissioned palliative care packages)
TNRF 1 - 011	Osteopathy	This treatment is not routinely funded.
TNRF 1 - 012	Reflexology	This procedure is not routinely funded.

2. Cosmetic/plastic surgery

2.1 Body Contouring Procedures

Code	Procedure / Treatment	TNRF Guidance Notes
TNRF 1 - 013	Apronectomy/Abdominoplasty	This procedure is not routinely funded
TNRF 1 - 014	Removal of excess skin following weight loss	This procedure is not routinely funded, in line with South East Coast Policy Recommendation Committee (PR 2009-09). Bariatric Surgeons, GPs and other clinicians supporting

		patients in losing weight should document discussions with patients regarding the possibility of being left with excess skin after profound weight loss, and inform patients that surgery to remove excess skin is not routinely available on the NHS. Where appropriate, this should be part of the consent process.
TNRF 1 - 015	Body contouring	This procedure is not routinely funded
TNRF 1 - 016	Brachioplasty/Upper arm lift	This procedure is not routinely funded
TNRF 1 - 017	Buttock Lift	This procedure is not routinely funded
TNRF 1 - 018	Calf implants	This procedure is not routinely funded
TNRF 1 - 019	Excision of redundant skin or fat	This procedure is not routinely funded
TNRF 1 - 020	Liposuction	The CCG will not routinely fund cosmetic liposuction. (Liposuction may be used as part of other surgery, e.g. thinning of transplanted flap).
TNRF 1 - 021	Neck lift	This procedure is not routinely funded
TNRF 1 - 022	Plastic operations on umbilicus	This procedure is not routinely funded
TNRF 1 - 023	Refashioning of scar	This procedure is not routinely funded
TNRF 1 - 024	Submental lipectomy	This procedure is not routinely funded
TNRF 1 - 025	Thigh lift	This procedure is not routinely funded
TNRF 1 - 026	Upper arm reduction	This procedure is not routinely funded

2.2 Breast Surgery for:

Code	Procedure / Treatment	TNRF Guidance Notes
TNRF 1 - 027	Breast augmentation	This procedure is not routinely funded. This recommendation does not apply to patients undergoing breast reconstruction as part of treatment for breast cancer; South East Coast Policy Recommendation 2011-03. Patients requiring this procedure as part of a Gender Dysphoria care pathway approved by NHS England will be considered on an IFR basis.
TNRF 1 - 028	Breast Implant Removal	Surrey Downs CCG will consider a funding application for the removal of breast implant(s) where it is clinically indicated. The CCG will not fund replacement implants.
N/A	Breast reduction	See TNRF 2 List of Procedures with Restriction/Thresholds Policy
TNRF 1 - 028	Mastopexy	This procedure is not routinely funded. Mastopexy is not funded within the local NHS for any patient group. This recommendation does not apply to patients undergoing breast reconstruction as part of treatment for breast cancer; South East Coast Policy Recommendation 2011-06.
TNRF 1 - 029	Correction of inverted nipple	This procedure is not routinely funded. Nipple eversion is not funded within the local NHS for any patient group. This recommendation does not apply to patients undergoing breast reconstruction as part of treatment for breast cancer; South East Coast Policy Recommendation 2011-07.
N/A	Gynaecomastia	See TNRF 2 List of Procedures with Restriction/Thresholds Policy

2.3 Facial Procedures

Code	Procedure / Treatment	TNRF Guidance Notes
N/A	Blepharoplasty / Ptosis Surgery	See List of Procedures with Restriction/Thresholds Policy
TNRF 1 - 031	Face lift	This procedure is not routinely funded
TNRF 1 - 032	Brow lift	This procedure is not routinely funded
TNRF 1 - 033	Correction of brow ptosis	This procedure is not routinely funded

2.4 Skin and Subcutaneous Procedures

Code	Procedure / Treatment	TNRF Guidance Notes
TNRF 1 - 034	Hair transplant /Hair graft/ Hair replacement /Intralace hair system for abnormal hair loss	Procedures for this are not routinely funded. (Hair pieces and wigs for patients experiencing total hair loss as a result of alopecia totalis, cancer treatment, previous surgery or trauma are available from local NHS Trusts).
TNRF 1 - 035	Irregularities of aesthetic significance	Procedures for this are not routinely funded
TNRF 1 - 036	Repair of chronic tear of lobe of external ear	This procedure is not routinely funded
TNRF 1 - 037	Repair of chronic clefts due to avulsion of body piercing	This procedure is not routinely funded
TNRF 1 - 038	Skin grafts for scars	This procedure is not routinely funded. The CCG will fund this treatment for burns and as part of reconstruction following major trauma).
TNRF 1 - 039	Tattoo removal	This procedure is not routinely funded

3. Dermatology

Code	Procedure / Treatment	TNRF Guidance Notes
TNRF 1 - 040	Chemical peels	This procedure is not routinely funded
TNRF 1 - 041	Dermabrasion of skin	This procedure is not routinely funded
TNRF 1 - 042	Electrolysis	This procedure is not routinely funded with the exception of the treatment of ingrowing eyelashes, which is routinely funded
TNRF 1 - 043	Hirsutism procedures	Hair removal procedures for hirsutism are not routinely funded.
TNRF 1 - 044	Iontophoresis, botox or surgical procedures for Hyperhidrosis	This procedure is not routinely funded but hyperhidrosis surgery is under review
TNRF 1 - 045	Laser therapy / Laser treatment/ Tunable dye laser for aesthetic reasons	These procedures are not routinely funded
TNRF 1 - 046	Tattooing of the skin	This procedure is not routinely funded. Removal of nipple tattooing will be funded as part of breast reconstruction for cancer patients.

4. Dental

Code	Procedure / Treatment	TNRF Guidance Notes
N/A	Dental Implants	This service is commissioned and applications are managed by the NHS England Area Team.
N/A	Orthodontics (Grade 3.5 and below on the Index of Orthodontic Treatment Need)	This service is commissioned and applications are managed by the NHS England Area Team.

N/A	Orthognathic surgery	This service is commissioned and applications are managed by the NHS England Area Team.

5. Ear Nose and Throat

Code	Procedure / Treatment	TNRF Guidance Notes
TNRF 1 - 047	Procedures to correct Rhinophyma	Surgical procedures/treatments for this condition are not routinely funded.

6. Gynaecology

Code	Procedure / Treatment	TNRF Guidance Notes
TNRF 1 - 048	Reversal of female sterilisation	The CCG will not routinely fund female sterilisation reversals. Patients who have a sterilisation procedure should be made aware that subsequent reversal of sterilisation will not normally be available on the NHS.
N/A	Labial reduction	See TNRF 2 List of Procedures with Restriction/Thresholds policy

7. Musculoskeletal

7.1 Pain Management

Code	Procedure / Treatment	TNRF Guidance Notes
TNRF 1 - 057	Epidural Injections for non-radicular pain	This procedure is not routinely funded
TNRF 1 - 058	Radiofrequency Denervation (RFD) to treat osteoidosteoma	This procedure is not routinely funded

7.2 Orthopaedic		
TNRF 1 - 059	Metal-on-metal hip resurfacing	This procedure is not routinely funded in line with South East Coast policy.

8. Neurology/neurosurgery

Code	Procedure / Treatment	TNRF Guidance Notes
N/A	Cerebellar stimulator implants	This service is commissioned and applications are managed by the NHS England Area Team.
N/A	Spinal cord stimulation (SCS) for ischaemic pain	This service is commissioned and applications are managed by the NHS England Area Team.
N/A	Neurosurgery for cerebral metastases	This service is commissioned and applications are managed by the NHS England Area Team.

9. Oncology

Code	Procedure / Treatment	TNRF Guidance Notes
N/A	Indwelling pleural catheter for the treatment of malignant pleural effusions in a community setting.	This service is commissioned and applications are managed by the NHS England Area Team.
N/A	Stereotactic Radiation Therapy	This service is commissioned and applications are managed by the NHS England Area Team.

10. Ophthalmology

Code	Procedure / Treatment	TNRF Guidance Notes
TNRF 1 - 049	Arteriovenous crossing sheatotomy for branch retinal vein occlusion	This procedure is not routinely funded. If NHS clinicians undertake this procedure as part of a research project, the CCG should be notified and informed of research governance arrangements.
TNRF 1 - 050	Excimer laser surgery for short sight/long sight or Astigmatism/ Xanthelasma	This procedure is not routinely funded

11. Weight Management

Code	Procedure / Treatment	TNRF Guidance Notes
N/A	Bariatric surgery in adults	This service is commissioned and applications are managed by the NHS England Area Team.

12. Other Surgery

Code	Procedure / Treatment	TNRF Guidance Notes
Under Review	Endoscopic thoracic sympathectomy for facial blushing. Endoscopic thoracic sympathectomy for sweating.	These procedures are under review
N/A	Gender reassignment	This Gender Dysphoria service is commissioned and applications are managed by the NHS England Area Team. 'Non-core' procedures are the commissioning responsibility of the CCG but are not routinely funded, i.e. Breast Reduction, Facial Feminisation Surgery, Lipoplasty/contouring and gametes storage so can only be considered as part of an IFR application.

13. Urology

Code	Procedure / Treatment	TNRF Guidance Notes
TNRF 1 - 060	Penile Implants	This procedure is not routinely funded.
TNRF 1 - 061	Reversal of vasectomy	This procedure is not routinely funded. Patients who have a sterilisation procedure should be made aware that subsequent reversal of sterilisation will not normally be available on the NHS.
TNRF 1 - 062	Retractile penile surgery	This procedure is not routinely funded.

14. Other Procedures/Equipment

Code	Procedure / Treatment	TNRF Guidance Notes
TNRF 1 - 051	Intralace hair system for abnormal hair loss	This procedure is not routinely funded
N/A	Prostheses for body parts (Prosthetic components not covered by the NHS contract will not be funded)	A range of prosthetics are available on the NHS. Prosthetic components not routinely provided by the NHS will not be funded. This service is commissioned and applications are managed by the NHS England Area Team.
TNRF 1 - 052	Surgical implantation of bioelectrical or kineplastic equipment in limbs	A range of prosthetics are available on the NHS. Prosthetic components not covered by the NHS contract will not be funded.
N/A	Extracorporeal photopheresis for the treatment of chronic graft versus host disease for cutaneous T cell lymphoma	Removed as this is standard practice.
N/A	Hyperbaric oxygen therapy for wound healing	This service is commissioned and applications are managed by the NHS England Area Team.

TNRF 1 - 053	Manual lymphatic drainage(MLD)	This procedure is routinely funded as part of an episode of secondary care for the management of lymphoedema. MLD provided by independent/private practitioners is not routinely funded.
TNRF 1 - 054	Polysomnography in the investigation of children with sleep-related disorders	This procedure is not routinely funded
TNRF 1 - 055	NHS patient transfers to private treatment providers.	When clinicians retire from the NHS they may continue to practice privately. Patients may wish to continue seeing them rather than see a new NHS clinician. The CCG will not routinely fund private consultations or treatment where previously provided as an NHS funded service.
N/A	Residential pain management programmes	This service is commissioned and applications are managed by the NHS England Area Team.
TNRF 1 - 056	Trans-cranial doppler ultra-sonography with frequent transfusion to prevent stroke in children with sickle cell disease	This procedure is not routinely funded.
N/A	Functional electrical stimulation (FES) in dropped foot	Advice may be given about other aspects of mobility/postural management such as use of vehicles, static seating, standing frames etc. NHS England would in certain circumstances supply items for use in specialised centres whilst an inpatient. If the device is to be used within the community, it would be commissioned by the patient’s CCG. However, NHS England specialist centres are available to offer advice.

APPENDIX 1

NICE Interventional Procedure Guidance

NICE issues Interventional Procedure Guidance (IPGs) with the aim of protecting the safety of patients and supporting the NHS in the process of introducing new procedures. The IPGs are not covered by the Secretary of State's directions to NHS organisations to fund the implementation of NICE recommendations within a given timescale because this direction relates only to NICE Technology Appraisal Guidance (TAGs). Interventional Procedure Guidance makes recommendations on the safety of the procedure and how well it works. The guidance does not recommend whether the NHS should fund a procedure or not and these decisions are therefore for the CCGs. The CCG recognises that it is not within the remit of the NICE IPG Programme to evaluate the cost-effectiveness of interventional procedures or to advise the NHS whether interventional procedures should be funded.

Details can be found on the following website:

http://www.nice.org.uk/guidance

The specific commissioning position with respect to different categories of IPG

Special Arrangements

The CCG will not routinely fund health care interventions that are subject to a NICE IPG where the IPG states: '*current evidence on safety is inadequate, current evidence on efficacy is inadequate, evidence of safety and efficacy is on small numbers of patients and of limited quality, no major safety concerns but efficacy has not been shown, evidence is limited to a small number of patients, good short term efficacy but little evidence of long term efficacy, there is adequate evidence of safety and efficacy but the technical demands are such that is should not be used without special arrangements, evidence for short term efficacy is limited and long term outcomes are uncertain*'.

Research Only

The CCG will not routinely fund health care interventions that the NICE IPG programme has recommended should only be undertaken in the context of research. Clinicians wishing to undertake such procedures should ensure they fulfill the normal requirements for undertaking research. Where there is a possibility that there may be impacts on NHS funded care following the cessation of the trial, or a patient's completion of a trial, clinicians are strongly encouraged to discuss this with the CCG at the earliest opportunity.

Do not use

The CCG will not fund health care interventions where a NICE IPG recommends that the intervention should not be used in the NHS.

List of Procedures with Restrictions and Thresholds

Policy number:	TNRF 2 (CL03)
Version:	3.2
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
Last review date:	February 2015
Next review date:	September 2016

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		• 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 TNRF 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. • CPAP for sleep apnoea to be reviewed in 2015. • TNRF2 025; Chalazion criteria clarified • TNRF2 019; Ganglion criteria clarified • TNRF2 027/028/029; Hernia repair criteria clarified • TNRF2 037; Circumcision criteria clarified
	June 2015	Updates and Reformatting	For Governing Body Sign off	TNRF2 040; Hyperhidrosis, treatment of – criteria added TNRF2 039; Male Breast Reduction for Gynaecomastia criteria added TNRF2 033; Open MRI addition to criteria

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	No	

	lesbian, gay and bisexual people		
	• 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	

1.

	Can we reduce the impact by taking different action?	n/a	

Contents

1. **Dental** 7

2. **Dermatology** 7

3. **ENT** 8
4. **Gynaecology** 11
5. **Musculoskeletal** 14
6. **Ophthalmology** 20
7. **Other Surgery** 22
8. **Other Procedures / Equipment** 26
9. **Pain Management** 27
10. **Urology** 30
11. **Vascular Surgery** 30

1. Dental

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

2. Dermatology

Policy Number	Procedure / Treatment	LPP 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. 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
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

3. ENT

Policy Number	Procedure / Treatment	LPP 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
TNRF2 004	Bone-anchored hearing aid - unilateral	This is funded in line with South Central Priorities Committee (April 2009), for Unilateral Bone Anchored Hearing Aid: “South Central Priorities Committee has considered the evidence for clinical and cost effectiveness of bone-anchored hearing aids and consider that there is sufficient evidence to justify their use in selected groups of patients with conductive or mixed deafness, in whom air conduction hearing aids are ineffective or inappropriate. This may include patients with bilateral or unilateral hearing loss and a variety of causes of conductive or mixed deafness (including chronic suppurative otitis

		media)."
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 Area
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.
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.
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
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.

4. Gynaecology

Policy Number	Procedure / Treatment	LPP 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 44iistates 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 conceptioniii. 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 • Hysteroscopy with targeted biopsy has failed/is not possible due to cervical stenosis, pain or inability to dilate the cervix • Transvaginal ultrasound has demonstrated focal pathology and facilities for a hysteroscopy with targeted biopsy are unavailable

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. • Moderate to severe symptoms. • Failure of pessary
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.

<table>
<tr><td>TNRF2 012</td><td>Hysterectomy for heavy menstrual bleeding</td><td>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.</td></tr>
<tr><td>TNRF2 013</td><td>Labiaplasty</td><td>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).
• Where the repair of the labia is required after trauma.</td></tr>
</table>

5. Musculoskeletal

Policy Number	Procedure / Treatment	LPP 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)
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. Patients who are diabetic, and those who are aged 65 and over, should be referred urgently, without first attempting conservative therapies
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
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
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 degrees or more Or any degree of proximal interphalangeal joint contracture Or patients under 45 years of age with disease affecting 2 or more digits and loss of extension exceeding 10o 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.
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.
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)
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. • still have severe lower back pain for which they would consider surgery
TNRF2 022	Trigger finger: surgical techniques for the treatment of	This procedure is not routinely funded. The CCG will fund this procedure when the following criteria are met: The patient has failed to respond to conservative treatment (including at least 2 corticosteroid injections). Or The patient has a fixed flexion deformity that cannot be corrected. Patients with diabetes should be referred without first attempting conservative management
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.

6. Ophthalmology

Policy Number	Procedure / Treatment	LPP Guidance Notes
TNRF2 024	Cataract Surgery	Any suspicion of cataracts in children should be referred urgently. 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. Referral of patients to ophthalmologists should be based on the following indications: 1. Best corrected visual acuity must be worse than 6/9 (6/9.5 and worse) in, the first affected eye OR the patient wishes to/is required to drive and, does not meet the Driving & Licensing Authority (DVLA) eyesight requirements. 2. And impairment of lifestyle such as: The patient is at significant risk of falls OR the patient's vision is substantially affecting their ability to work OR the patient's vision is substantially affecting their ability to undertake leisure activities such as reading, recognising faces or watching television. 3. And willingness to have cataract surgery. 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. Patients should only undergo surgery of the second eye when that eye meets the thresholds of 6/18 or worse visual acuity. 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. NB: This policy has been identified for a further evidence review in 2015
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 all of the following criteria are met: • The chalazia has been present for more than 6 months. • Where it is causing blurring of vision. • Where it is a source of regular infection that has required medical attention twice or more. In common with all types of lesions, the CCG will fund removal where malignancy is suspected.
TNRF2 026	Blepharoplasty / ptosis surgery	The CCG will consider funding in the following circumstances: There is documented evidence of interference with vision (such as difficulty reading, driving, looking through the eyelids or seeing the upper eyelid skin) Or There is redundant skin overhanging the upper eyelid margin and resting on the eyelashes when gazing straight ahead Or

		There is evidence that where it is not overhanging, the upper lid covers the upper pupil margin And Evidence from visual field testing shows the visual fields are reduced to 120 degrees laterally and/or 20 degrees 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. And Photographic evidence is 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 person looking ahead. • The above will need to be supplemented by a picture taken from the side of the patient. NB It is recommended that the test is monocular and that the 120 point Humphrey visual field chart is used.

7. Other Surgery

Policy Number	Procedure / Treatment	LPP 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.
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
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
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/m². • 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.
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/m² 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
TNRF2 031	Breast implant removal and replacement	Removal of implants will be considered, but not replacement, if at least one of the following criteria are met:

		• 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.
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

8. Other Procedures / Equipment

Policy Number	Procedure / Treatment	LPP 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 no routinely funded by the NHS. **NB: For further review in 2015**
TNRF2 033	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.

9. Pain Management

Policy Number	Procedure / Treatment	LPP Guidance Notes
TNRF2 034	Epidural Injections for Sciatica	The CCG will fund lumbar transforaminal and caudal epidural injections for patients with radicular pain due to herniated disc (sciatica) 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 30o and 70o positive femoral tension sign)

		• Symptoms persist despite some non-operative treatment for at least 3 weeks (e.g. analgesia, physiotherapy). Further Epidural injections should only be provided as part of a comprehensive pain management programme.
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 And the pain has resulted in moderate to significant impact on daily functioning 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 and the patient is not suitable for Thermal Radiofrequency Denervation (RFD) or a Pain Management Programme (PMP). For those who are not suitable for RFD or PMP (patients with multiple co morbidities; cardiological and or respiratory dysfunction; cardiac pacemaker or other nerve stimulator; frail patients; elderly patients), up to two 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).
TNRF2 036	Radiofrequency facet joint denervation (RFD) of lumbar and cervical facet joints for chronic facetal pain	Radiofrequency facet joint denervation of the medial branch of the dorsal rami of the lumbar and cervical facet joints (medial branch neurotomy) will be funded in the following circumstances: • Patients aged over 18 • Non-radicular lumbar (all levels) or cervical (C3-4 and below) facet joint pain. • Failure of a one year trial of non-invasive therapy, such as medication and physiotherapy. • One anaesthetic diagnostic block, which must be of the medial branch of the dorsal rami innervating the target facet joint. A significant reduction in pain following the block during activities that normally generate pain should be demonstrated and recorded. The pain relief must be consistent with the expected duration of the anaesthetic block. • All procedures must be performed under fluoroscopy (x-ray guidance). NICE Guidance ID CG 88 on ‘Low Back Pain’ iv indicates that radiofrequency facet joint denervation is not recommended for those with back pain of less than a year’s duration. Thermal radiofrequency denervation is provided as part of a comprehensive Pain Management Programme (PMP). Cryoneurolysis or laser denervation will not be funded. Up to four facet joint denervation’s on one occasion (one treatment episode) will be funded.
N/A	Metal-on-metal hip resurfacing	Removed from policy and moved to the TNRF 1 policy

10. Urology

Policy Number	Procedure / Treatment	LPP 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

11. Vascular Surgery

Policy Number	Procedure / Treatment	LPP Guidance Notes
TNRF2 038	Varicose Veins	Procedures for this are only funded in line with NICE threshold referral criteria for the specialist assessment of varicose veins. NICE (CG168) Varicose Veins in the Legs now recommends that all patients are offered advice, reassurance and appropriate treatments (e.g. endothermal ablation, foam sclerotherapy and surgery) or compression hosiery. NICE recommends treatment in a sequential order. Endothermal ablation is offered first if suitable, ultrasound-guided sclerotherapy is offered as a second choice and surgery reserved for when the other two procedures are not suitable.

		Thresholds: Refer patients to a vascular service if they have any of the following: • Symptomatic (pain, aching, discomfort, swelling, heaviness and itching) primary or symptomatic recurrent varicose veins. • Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency. • Superficial vein thrombosis (characterised by the appearance of hard, painful veins) and suspected venous incompetence. • A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks). • A healed venous leg ulcer. For people with confirmed varicose veins and truncal reflux: • Offer endothermal ablation • If endothermal ablation is unsuitable, offer ultrasound-guided foam sclerotherapy. • If ultrasound-guided foam sclerotherapy is unsuitable, offer surgery. • Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable. There are a number of specific 'Do Not Do' Recommendations from the guidance: • Do not carry out interventional treatment for varicose veins during pregnancy other than in exceptional circumstances. • Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable. Note that advice differs in pregnancy. • Do not use compression bandaging or hosiery for more than 7

		days after interventional treatment. Current evidence on safety and efficacy of Transilluminated powered phlebectomy for varicose veins is inadequate (IPG037).