Thinking Differently

NHS
Dudley
Clinical Commissioning Group

Procedures of Limited Clinical Priority Guideline & Commissioning Policy

UNIQUE REFERENCE NUMBER: CD/XX/070/V2.2
DOCUMENT STATUS: Approved by Clinical Development Committee 23 March 2016
DATE ISSUED: 1 April 2016
DATE TO BE REVIEWED: 1 April 2019

VERSION	DATE	AMENDMENT HISTORY
CD/XX/070/V1	19.08.2015	First draft presented to Clinical Development Committee
CD/XX/070/V2	23.03.2016	Revised draft approved by Clinical Leads at Dudley CCG
CD/XX/070/V2.1	14.04.2016	Revision made to section 27 approved by Clinical Leads – CCG
CD/XX/070/V2.2	29.05.2016	Revision made – section 38 added approved by Clinical Leads - CCG

REVIEWERS

This document has been reviewed by:

NAME	DATE	TITLE/RESPONSIBILITY
Dr S Mann	March 2016	GP - Clinical Executive for Acute & Community – Dudley CCG
Dr J Darby	March 2016	GP - Board Member – Dudley CCG
Dr A Malik	March 2016	GPwSI – Commissioning – Dudley CCG
Dr R Gee	March 2016	GP Engagement Lead – Dudley CCG
Neill Bucktin	March 2016	Head of Commissioning – Dudley CCG
Anthony Nicholls	March 2016	Head of Intelligence and Analytics – Dudley CCG
Nickie Burgess	March 2016	Head of Contracting – Dudley CCG
M Curran	March 2016	Commissioning Manager – Planned Care – Dudley CCG
V Adams	March 2016	Pathway Efficiency Manager – Dudley CCG
Dianne Castree	March 2016	Contracts Manager - DGFT
Mr M Weller	March 2016	Medical Service Head - DGFT
Mr M Waites	March 2016	Clinical Director - DGFT
Dr G Stewart	March 2016	Clinical Director - DGFT
Mr M Jindal	March 2016	Consultant – ENT, DGFT
Alifia Tameem	March 2016	Clinical Service Lead - Pain Management - DGFT
Jennie Muraszewski	March 2016	Director of Operations - Surgery, Women and Children - DGFT
Ned Hobbs	March 2016	Divisional Manager - Surgery, Women and Children - DGFT
Nurgis Shafiq	March 2016	IFR Team Manager – Arden & GEM CSU

APPROVALS

This document has been approved by:

NAME	DATE	TITLE/RESPONSIBILITY	VERSION
Clinical Development Committee (CDC)	19 August 2015	Approved at Clinical Development Committee	V1
Dr S Mann Dr J Darby Dr A Malik	23 March 2016 29 May 2016	Chair of CDC and Clinical Executive for Acute & Committee GP – Board Member GPwSI – Commissioning	V2

NB: The version of this policy posted on the intranet must be a PDF copy of the approved version.

ENGAGEMENT

This document has been presented for comments at the following forums:

- GP Locality Meetings – October 2015
- Primary Care Operation Group – February 2016
- Local Medical Committee – February 2016

Distributed electronically to all GP Surgeries, Arden & GEM Commissioning Support Unit and all Acute Trusts across the Black Country.

DOCUMENT STATUS

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of the document are not controlled.

Introduction

This policy describes the exclusions and access criteria in respect of procedures of limited clinical priority and its application in accordance to both the clinical and administrative adherence protocols detailed in this policy.

This policy does not apply to cosmetic treatments and procedures which are covered by a separate policy (please refer to Aesthetic Procedures Guidelines and Commissioning Policy). It incorporates the evidence relating to clinical and cost-effectiveness.

Definitions

Exceptional clinical circumstances refers to a patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients with the same medical condition and at the same stage of progression as the patient.

There can be no exhaustive definition of the conditions which may potentially fall within the definition of an exceptional case. The word "exception" means "a person, thing or case to which the general rule is not applicable". The following criteria, however, are indicative of the presence or absence of exceptionality in the present context:

- To be an exception, there must be unusual or unique clinical factors about the patient that suggest that he or she is:

    I. Significantly different from the wider group of patients with the same condition; or

    II. Likely to gain significantly more benefit from the intervention than might be expected from the average patient with the same condition.

- The fact that a treatment is likely to be effective for a patient is not, in itself, a sufficient basis for establishing an exception.

- If a patient's clinical condition matches the 'accepted indications' for a treatment, but the treatment is not funded, then the patient's circumstances are not, by definition, exceptional.

It is for the requesting clinician to make the case for clinically exceptional circumstances.

Social value judgments are not relevant to the consideration of exceptional status.

An ***Individual Funding Request (IFR)*** is a request received from a provider or clinician which seeks funding for a single identified patient for a specific treatment.

Background

Dudley Clinical Commissioning Group operates within finite budgetary constraints. The policy makes explicit the need for Dudley CCG to prioritise resources and provide interventions with the greatest proven health gain. The intention is to ensure equity and

fairness in respect of access to NHS funding for interventions and to ensure that interventions are provided within the context of the needs of the overall population and the evidence of clinical and cost effectiveness.

To do this the policy provides:

- The list of interventions 'not routinely funded' by Dudley CCG
- The specified criteria required for the funding of certain other interventions

Please note that the policy guidance relating to these interventions should be read with reference to the principles detailed below, which includes the definition of exceptionality from the Collaborative Commissioning Policy - Individual Funding Requests version 1.6 dated March 2014 agreed and implemented by:

- NHS Birmingham Cross City Clinical Commissioning Group
- NHS Birmingham South Central Clinical Commissioning Group
- NHS Solihull Clinical Commissioning Group
- NHS Dudley Clinical Commissioning Group
- NHS Sandwell and West Birmingham Clinical Commissioning Group
- NHS Walsall Clinical Commissioning Group
- NHS Wolverhampton Clinical Commissioning Group

Commissioners, General Practitioners, Service Providers and Clinical Staff treating residents of Dudley CCG are expected to implement this policy. When interventions are undertaken on the basis of meeting criteria specified within the policy, **this should be clearly documented within the clinical notes and accompanied with the EMIS Template Referral**. Failure to do so will be considered by Dudley CCG as lack of compliance.

Dudley CCG explicitly recognise that for each of the interventions listed in the policy there may be exceptional clinical circumstances in which to fund these interventions. Whilst it is not feasible to consider every possible scenario within this document, they will be considered on a case by case basis to enable due consideration of the individual merits of each case.

Thus, funding for 'interventions not routinely funded' and for interventions where specified criteria are not met will be considered by Dudley CCG following application to the respective IFR Panel.

This policy will be reviewed regularly to ensure that it reflects developments in the evidence base regarding clinical and cost effectiveness.

Implementation

Patients with problems/conditions that require treatments included in this policy should only be referred to a Consultant/Specialist **after a clinical assessment** is made by the GP and there is a symptomatic or functional requirement for surgery.

GPs wishing to seek a specialist opinion for patients who meet this policy criterion should complete the relevant EMIS Template and refer via E-Referral system when making a referral to secondary care to ensure the patient has been assessed in line with this policy.

Please note: - patients who do not meet the criteria will be 'rejected' by the provider in line with E-referral Guidance.

For further details on the application process – please refer to the Dudley CCG Referral Management Protocols and Procedure Document.

Consultants in secondary care and provider finance departments need to be aware that Dudley CCG will not pay for the procedures listed in this policy unless the patient meets the criteria outlined in this policy.

This is not a blanket ban. Dudley CCG recognises there will be exceptional, individual or clinical circumstances when funding for treatments designated as low priority will be appropriate.

Individual treatment requests should only occur in clinically exceptional circumstances where the patient does not meet the core criteria. In this instance the completion of an Individual Funding Request is required.

Individual Funding Requests should ONLY be sent to NHS.net accounts or Safe Haven fax:

Dudley CCG
C/O Arden & GEM Commissioning Support Unit
IFR Team
Kingston House
438-450 High Street
West Bromwich
B70 9LD
Telephone: 0121 612 1661
Fax: 0121 285 5990
Email: ifr.dudley@nhs.net

Monitoring

This policy will be subject to continued monitoring using: Policy Audit Reports consisting of 400 records audit per annum, split into 4 quarterly audits of 100 records.

The commissioner will negotiate with the supporting CSU for the CCGs to request and audit list of patient notes for audit to assure the objectivity of this audit.

Specific guidelines included:

Ref	Procedures or Guidelines
1	Adenoidectomy
2	Insertion of Grommets
3	Routine Ear Irrigation
4	Surgery for Snoring
5	Tonsillectomy
6	Carpal Tunnel Syndrome
7	Dupuytren's Disease
8	Ganglion
9	Trigger Finger
10	Autologous Cartilage Transplantation
11	Arthroscopy for Knee Osteoarthritis
12	Elective Hip Surgery
13	Knee Replacement Surgery
14	Spinal Fusion for Chronic Back Pain
15	Joint Injections
16	Cholecystectomy for Gallstones
17	Male Circumcision
18	Surgical Haemorrhoidectomy
19	Varicose Veins
20	Removal of Anal Skin Tags
21	Hysterectomy for Heavy Menstrual Bleeding
22	Diagnostic Hysteroscopy for Menorrhagia
23	Dilation and Curettage (D & C) for Menorrhagia
24	Reversal of Male Sterilisation
25	Reversal of Female Sterilisation
26	Routine Doppler Ultrasound of Umbilical and Uterine Artery in Antenatal Care
27	Non Specific, Specific and Chronic Back Pain
28	Cataract Surgery
29	Laser Surgery for Short Sight (Myopia)
30	Dental – Apicectomy, Dental Implants, Wisdom Teeth Removal
31	Botulinum Toxin Type A for Hyperhidrosis
32	Botulinum Toxin Type A for Spasticity
33	Complementary Medicines/Therapies
34	Extracorporeal Shockwave Therapy for Refractory Plantar
35	Extracorporeal Shockwave Therapy for Refractory Achilles Tendinopathy
36	Hyperbaric Oxygen Therapy
37	Inpatient Cognitive Behaviour Therapy (Residential Placements) for Chronic Fatigue Syndrome (CFS)/Mylagic Encephalomyelitis (MS)
38	Inguinal Hernia Repair

Intervention	1. Adenoidectomy
Policy	*Adenoidectomy will not be funded as an isolated procedure; it will be funded only if undertaken in conjunction with Tonsillectomy or Grommets.
Rationale	An adenoidectomy is a quick operation to remove the adenoids – small lumps of tissue at the back of the nose, behind the palate. Adenoids are part of the immune system, which helps fight infection and protects the body from bacteria and viruses. Adenoids are only present in children. They start to grow from birth and are biggest when your child is approximately three to five years old. But by age seven to eight they start to shrink and by the late teens, are barely visible. By adulthood, the adenoids will have disappeared completely. The adenoids disappear because – although they may be helpful in young children – they're not an essential part of an adult's immune system.
Minimum Eligibility Criteria	*Adenoidectomy will not be funded as an isolated procedure; it will be funded only if undertaken in conjunction with Tonsillectomy or Grommets. (Please refer to relevant guidance/policy for Tonsillectomy and/or Grommets). *Please note – It is recognised there may be a small cohort of pre GCSE age children who do not grow out of enlarged adenoids and suffer nasal obstruction as a consequence, where surgery maybe clinically justified. Dudley CCG will consider surgery via the prior approval scheme for this small cohort of patients. Applications will need to demonstrate justification of surgery.
Evidence for inclusion and threshold	• Royal College of Surgeons Commissioning Guide for Rhinosinusitis (2013): The Royal College of Surgeons of England and ENT UK (2013). Commissioning guide: Rhinosinusitis, Available from: http://www.rcseng.ac.uk/providers-commissioners/docs/rcseng-ent-uk-commissioning-guide-for-rhinosinusitis • Robb PJ et al (2009), Tonsillectomy and adenoidectomy in children with sleep-related breathing disorders: consensus statement of a UK multidisciplinary working party, Annals of the Royal College of Surgeons of England, 91, 371-373. Available from http://europepmc.org/articles/PMC2758429;jsessionid=MVfPN7W1Ky1PN4EiKikL.52

Intervention	2. Insertion of Grommets
Policy	The persistence of OME and hearing loss should be confirmed over a period of 3 months before intervention is considered. The child's hearing should be re-tested at the end of this time. During the active observation period, advice on educational and behavioural strategies to minimise the effects of the hearing loss should be offered.
Rationale	Grommets are small tubes that are put inside children's ears to help drain away sticky fluid that is trapped there and to aid their hearing. Evidence suggests that the benefit of grommets on children's hearing gradually decreases in first year of insertion. Potentially adverse effects on the tympanic membrane (e.g. tympanosclerosis) are common after grommet insertion. The following criteria are based on the findings of a Cochrane review (2005) and NICE clinical guidelines (2008).
Minimum Eligibility Criteria	• 5 or more documented episodes of OME **OR** • Children with persistent OME over a period of 3 months, with a hearing level in the better ear of 25–30 dBHL or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available) **OR** • Children with OME with a hearing loss less than 25–30 dBHL in the better ear but where the impact of the hearing loss on a child's development. • Where clinically appropriate, softband bone conduction aids will be funded for children up to 18 years of age.
Management	Management of OME in children with Down's syndrome: The care of children with Down's syndrome who are suspected of having OME should be undertaken by a multidisciplinary team with expertise in assessing and treating these children. Hearing aids should routinely be offered to children with Down's syndrome and OME with hearing loss. Before ventilation tubes are offered as an alternative to hearing aids for treating OME in children with Down's syndrome, the following factors should be considered: • the severity of hearing loss • the age of the child • the practicality of ventilation tube insertion • the risks associated with ventilation tubes • the likelihood of early extrusion of ventilation tubes Management of OME in children with cleft palate: The care of children with cleft palate who are suspected of having OME should be undertaken by the local otological and audiological services with expertise in assessing and treating these children in liaison with the regional multidisciplinary cleft lip and palate team. Insertion of ventilation tubes at primary closure of the cleft palate should

	be performed only after careful otological and audiological assessment. Insertion of ventilation tubes should be offered as an alternative to hearing aids in children with cleft palate who have OME and persistent hearing loss.
Evidence for inclusion and threshold	NICE Clinical Guideline 60 - Surgical Management Of OME http://guidance.nice.org.uk/CG60 Position Paper ENT UK 2009 – OME (Glue Ear) / Adenoid and Grommet NICE clinical guideline Surgical management of otitis media with effusion in children (=<12) CG60 (2008) http://www.nice.org.uk/guidance/CG60 NICE clinical guideline Surgical management of **otitis media with effusion** in children (=<12 yr) CG60 (2008): 1.3 Appropriate time for intervention 1.3.1 The persistence of bilateral OME and hearing loss should be confirmed over a period of 3 months before intervention is considered. The child's hearing should be re-tested at the end of this time. 1.3.2 During the active observation period, advice on educational and behavioural strategies to minimise the effects of the hearing loss should be offered. 1.4 Children who will benefit from surgical intervention 1.4.1 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. 1.4.2 Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25–30 dBHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant **1.7 Management of OME in children with Down's syndrome** 1.7.1 The care of children with Down's syndrome who are suspected of having OME should be undertaken by a multidisciplinary team with expertise in assessing and treating these children. 1.7.2 Hearing aids should routinely be offered to children with Down's syndrome and OME with hearing loss. 1.7.3 Before ventilation tubes are offered as an alternative to hearing aids for treating OME in children with Down's syndrome, the following factors should be considered: -the severity of hearing loss -the age of the child -the practicality of ventilation tube insertion -the risks associated with ventilation tubes -the likelihood of early extrusion of ventilation tubes **1.8 Management of OME in children with cleft palate** 1.8.1 The care of children with cleft palate who are suspected of having OME should be undertaken by the local otological and audiological services with expertise in assessing and treating these children in liaison with the regional multidisciplinary cleft lip and palate team. 1.8.2 Insertion of ventilation tubes at primary closure of the cleft palate should be performed only after careful otological and audiological assessment. 1.8.3 Insertion of ventilation tubes should be offered as an alternative to

	hearing aids in children with cleft palate who have OME and persistent hearing loss. **Royal College of Surgeons (2013) Commissioning guide: Otitis media with effusion**: 'Otitis media with effusion (OME) is most common in young children, with a bimodal peak at 2 and 5 years of age; 80% of children will have had at least one episode of OME by the age of 10 years NICE clinical guideline CG60 on surgical management of OME recommends that persistent bilateral OME and hearing loss should be confirmed over a period of 3 months before intervention is considered and that a child's hearing should be re-tested at the end of this time. "The Department of Health report on Improving Access to Audiology Services in England states that commissioners should carry out a rigorous needs assessment of the local population and review existing provision of audiology services to identify gaps and the potential for improvements. This may also provide the opportunity to review current practice and develop a single integrated care pathway with clinicians and other health and social care and educational professionals, for example, paediatricians, audio vestibular physicians, health visitors, school nurses, speech and language therapists and teachers. The pathway should identify clear criteria for referral and support consistent thresholds for surgical or alternative management of OME in line with NICE clinical guideline CG60 on surgical management of OME*".*

Intervention	3. Routine Ear Irrigation
Policy	Routine ear irrigation will not be funded in a Secondary Care setting.
Rationale	Routine ear syringing is not a procedure routinely carried out in a secondary care setting. Treatment should be delivered in primary care prior to referral to secondary care.
Minimum Eligibility Criteria	This will only be funded in clinically exceptional circumstances and clinicians will need to demonstrate exceptionality via an Individual Funding Request.
Evidence for inclusion and threshold	SIGN Guidance – Ear Care Best Practice Statement: http://www.healthcareimprovementscotland.org/previous_resources/best_practice_statement/ear_care.aspx

Intervention	4. Surgery for Snoring
Policy	Surgery for snoring is not funded unless supported by sleep study.
Rationale	There is no evidence to support funding for surgery for snoring where sleep apnoea is not implicated. This policy explicitly refers to isolated snoring. It is recognised that some patients may have snoring in conjunction with obstructive sleep apnoea (OSA) – if such patients are considered eligible for surgery this will be funded only when it is required for treatment of their OSA.
Minimum Eligibility Criteria	Surgery for snoring will only be considered for OSA when supported by a sleep study.
Evidence for inclusion and threshold	• Jones TM et al. Acoustic analysis of snoring before and after palatal surgery. ERJ June1, 2005 vol. 25 no. 6 1044-1049. • Franklin KA et al. Effects and side-effects of surgery for snoring and obstructive sleep apnoea--a systematic review. Sleep, 2009 Jan 1;32(1):27-36. • Brouillete RT, Fernbach SK, Hunt CE. Obstructive sleep apnoea in infants and children. *Journal of Pediatrics* 1982;**100**(1):31-40 • Ryan, C.F (2005). Sleep 9: An approach to treatment of obstructive sleep apnoea/hypopnoea syndrome including upper airway surgery. Thorax (60);595-604.

Intervention	5. Tonsillectomy
Policy	Unless the following criteria are met tonsillectomy for recurrent sore throats is not funded.
Rationale	Tonsillitis is inflammation of the tonsils. It's usually caused by a viral infection or a bacterial infection. It's a common type of infection in children, although it can sometimes affect adults. The symptoms of tonsillitis include: • sore throat that can feel worse when swallowing • high temperature (fever) over 38C (100.4F) • coughing • headache If test results show that tonsillitis is caused by a bacterial infection, a short course of oral antibiotics may be prescribed. In most cases, tonsillitis gets better within a week. However, a small number of children and adults have tonsillitis for longer or it keeps returning. This is known as chronic tonsillitis and surgical treatment may be needed. Surgery to remove the tonsils (a tonsillectomy) is usually only recommended in cases where there have been several severe episodes of tonsillitis over a long period of time, or if repeated episodes disrupt normal activities. Information should be provided and reassurance given if no further treatment or referral for tonsillectomy is deemed necessary at this stage. This discussion should be documented.
Minimum Eligibility Criteria	Tonsillectomy for recurrent tonsillitis or its complications (e.g. quinsy) Each episode of tonsillitis should be documented in the patient's medical records and characterised by at least one of the following: • Tender anterior cervical lymph nodes • Tonsillar exudates • Tonsillar enlargement giving rise to symptoms of upper airways obstruction Tonsillectomy will be commissioned if **one or more** of the following criteria are met; • 7 or more documented clinically significant, adequately treated episodes in the preceding year; **OR** • 5 or more documented episodes in each of the preceding two years **OR** • 3 or more documented episodes in each of the preceding three years. **AND** • If symptoms are disabling and prevent normal functioning

	There are a small proportion of patients with specific clinical conditions or syndromes, who require tonsillectomy as part of their on-going management strategy, and who will not necessarily meet the SIGN guidance (e.g. those presenting with psoriasis, nephritis, Periodic fever, aphthous stomatitis, pharyngitis and adenitis (PFAPA) syndrome Children or adults with sleep disordered breathing/apnoea confirmed with sleep studies undergo procedure in line with recognised management of these conditions. Note: When in doubt implement a six month period of watchful waiting Adenoidectomy will not be funded as an isolated procedure; it will be funded only if undertaken in conjunction with Tonsillectomy or Grommets. EMIS templates and guidance will aid GPs to refer only those cases that are appropriate. If a referral letter does not clearly indicate that the criteria is met, the referral will be rejected based on inadequate information.
Evidence for inclusion and threshold	• SIGN Management of **sore throat and indications for tonsillectomy** (2010): http://www.sign.ac.uk/pdf/sign117.pdf • Royal College of Surgeons Commissioning guide: **Tonsillectomy** (2013): https://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/tonsillectomy

Intervention	**6. Carpal Tunnel Syndrome**
Policy	Unless one or more of the minimum criteria are met, surgical treatment will not be funded.
Rationale	Many cases of carpal tunnel syndrome will resolve spontaneously and can be managed conservatively with physiotherapy, wrist splints, NSAIDS and steroid injections. There are recognised criteria whether surgical release may be beneficial.
Minimum Eligibility Criteria	Unless one or more of the minimum criteria are met, surgical treatment will not routinely be funded; • Acute severe symptoms uncontrolled by conservative treatment **OR** • Chronic mild to moderate symptoms that have not responded to 4 months of conservative management (Injection and splints) **OR** • Neurological deficit i.e. sensory blunting or weakness **AND** • Supported by Nerve Conductions studies
Evidence for inclusion and threshold	Sholten R et al (2009) 'Surgical Treatment options for Carpal Tunnel Syndrome ' 2009 Cochrane Neuromuscular Disease Group Cochrane Library Verdugal R et al (2008) ' Surgical versus Non Surgical Treatment for Carpal Tunnel Syndrome' 2008 Cochrane Neuromuscular Disease Group Cochrane Library

Intervention	7. Dupuytren's Disease
Policy	Unless one or more of the minimum criteria are met, surgical treatment will not routinely be funded.
Rationale	Dupuytren's contracture is a benign, slowly progressive condition of unknown origin. The disease is characterised by a thickening of the connective tissue in the palm of the hand, leading to difficulties in extending the fingers. Most individuals with Dupuytren's contracture are affected in both hands. The most commonly involved digit is the ring finger, followed by the little finger and then the middle finger. Treatment seeks to restore hand function and prevent progression, because the underlying disease will remain. Both surgical and nonsurgical options exist. Data are lacking on the effectiveness of most non-surgical treatments for Dupuytren's contracture, such as vitamin E cream and ultrasonic therapy.
Minimum Eligibility Criteria	British Society for Surgery of the Hand recommendations for Treatment **Mild** **Description:** • No functional problems • No contracture. • Mild metacarpo-phalangeal joint contracture only (<30 degrees) • Intervention: • Reassure. • Observe **Moderate** **Description:** • Notable functional problems or moderate metacarpo-phalangeal joint contracture (30 - 60 degrees). • Moderate proximal inter-phalangeal joint contracture (<30 degrees). • First web contracture] **Intervention:** • Needle fasciotomy if appropriately trained; for MCPJ contracture • Possibly collagenase • Refer for surgery – limited fasciectomy **Severe** **Description:** • Severe contracture of both metacarpo-phalangeal (>60 degrees) joint and proximal inter-phalangeal joint (>30 degrees). **Intervention:** • Refer for surgery • Limited fasciectomy • Dermofasciectomy
Evidence for inclusion and threshold	NICE Guidance on Needle Fasciotomy for Dupuytren's Contracture Interventional Procedure Guidance 43 Feb 2004 http://guidance.nice.org.uk/IPG43

Intervention	8. Ganglion
Policy	Unless the minimum criteria is met, surgical removal of ganglion will not be funded.
Rationale	A ganglion is a non-cancerous fluid-filled lump which can occur near joints or tendons. It is most commonly found on the wrist or hands. A ganglion that does not cause symptoms is best left alone.
Minimum Eligibility Criteria	Unless one or more of the minimum criteria are met, surgical removal of ganglion will not routinely be funded; • Ganglia - symptomatic (painful) or neurovascular compromised **OR** • Ganglia arising in the base of the digitis –(symptomatic and/or painful)
Evidence for inclusion and threshold	Vroon P et al (2009) 'Interventions for Ganglion Cysts in Adults' Protocol Cochrane Neuromuscular Disease Group Cochrane Library British Society for Surgery of the Hand (BSSH) protocol for Wrist Ganglia 2011 http://www.bssh.ac.uk/patients/commonhandconditions/ganglioncysts/ganglion_cyst_leaflet.pdf

Intervention	9. Trigger Finger
Policy	A trigger finger does not straighten easily, the cause is not clear. It sometimes settles and goes away without treatment. An injection of steroid will usually cure the problem. A trigger finger (also known as stenosing tenosynovitis) is a finger that becomes 'locked' after it has been bent (flexed). It is difficult to straighten out without pulling on it by the other hand.
Rationale	**Criteria Rationale**: Management should be in accordance with British Society for Surgery of the Hand (BSSH) recommendations; **Mild** ("pre-triggering") • History of pain or of catching or "click" • Tender A1 pulley; but fully mobile finger **Treatment recommendation is Analgesia** **Moderate:** • Triggering with: • A - Difficulty actively extending finger • B - Need for passive finger extension • Loss of complete active flexion **Treatment option is Steroid injection to flexor sheath** ***Severe** • Fixed contracture **Treatment option is Trigger Finger Release**
Minimum Eligibility Criteria	Surgical treatment will only be commissioned if • Patient has moderate trigger finger which has failed to respond to conservative measures (at least 2 steroid injections; **OR** • Patient has fixed deformity that cannot be corrected (severe–fixed contracture or failed non operative treatment)
Evidence for inclusion and threshold	BSSH (2011) BSSH Evidence for Surgical Treatment (BEST): Trigger Finger (Thumb) [Online] Available from: http://www.bssh.ac.uk/education/guidelines/trigger.pdf [Retrieved 25 January 2011]

Intervention	10. Autologous Cartilage Transplant
Policy	Autologous Cartilage Transplant will not routinely be funded except as part of a randomised controlled trial.
Rationale	NICE guidance states that autologous chondrocyte implantation (ACI) is not recommended for the treatment of articular cartilage defects of the knee joint, except in the context of ongoing or new clinical studies that are designed to generate robust and relevant outcome data, including the measurement of health-related quality of life and long-term follow-up. Patients should be fully informed of the uncertainties about the long-term effectiveness and the potential adverse effects of this procedure.
Minimum eligibility criteria	Only considered as part of a randomised controlled trial or in clinically exceptional circumstances which can be demonstrated via an Individual Funding Request.
Evidence for inclusion and threshold	NICE Guidance TAG 16 (review) - Cartilage injury - autologous chondrocyte implantation: http://www.nice.org.uk/page.aspx?o=72659 National Public Health Service. *Autologous chondrocyte implantation for the ankle joints*. Cardiff: NPHS; 2006.

Intervention	11. Arthroscopy for Knee Osteoarthritis
Policy	Arthroscopy referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis and will only be funded in accordance with the criteria specified below: The person has knee osteoarthritis with a clear history of mechanical locking (not gelling), 'giving way' or x-ray evidence of loose bodies.
Rationale	Osteoarthritis is the most common disease of the joints, and one of the most widespread of all chronic diseases. Frequently described as 'wear and tear', its prevalence increases steadily with age and by retirement age the associated radiological changes can be observed in over half the population. Symptoms can vary from minimal to severe pain and stiffness, but overall the disease is responsible for considerable morbidity and is a common reason for GP consultation. Unfortunately, it is also difficult to treat and inevitably a wide range of potential therapies have been advocated, both by conventional and complementary practitioners, and not necessarily with strong supporting evidence. The exact incidence and prevalence of osteoarthritis is difficult to determine because the clinical syndrome of osteoarthritis (joint pain and stiffness) does not always correspond with the structural changes of osteoarthritis (usually defined as abnormal changes in the appearance of joints on radiographs). This area is becoming more complex with sensitive imaging techniques such as magnetic resonance imaging, which demonstrate more frequent structural abnormalities than detected by radiographs. Magnetic resonance imaging (MRI) is of great aid in the diagnosis of knee lesions. Most diagnostic studies comparing MRI and arthroscopy have shown good diagnostic performance in detecting lesions of the menisci and cruciate ligaments.
Minimum Eligibility Criteria	Arthroscopy referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis and will only be funded in accordance with the criteria specified below.

	• The person has knee osteoarthritis with a clear history of mechanical locking (not gelling), 'giving way' or x-ray evidence of loose bodies. **Arthroscopy solely for diagnosis of knee conditions should only be undertaken in patients that an MRI scan is contraindicated**.
Evidence for inclusion and threshold	• Ruth Crawford, Gayle Walley, Stephen Bridgman, and Nicola Maffulli (2007) Magnetic resonance imaging versus arthroscopy in the diagnosis of knee pathology, concentrating on meniscal lesions and ACL tears: a systematic review British Medical Bulletin 2007; 84: 5–23 DOI:10.1093/bmb/ldm022 • NICE CG 59 2008 • The National Collaborating Centre for Chronic Conditions • Funded to produce guidelines for the NHS by NICE 2008 'Osteoarthritis National clinical guideline for care • and management in adults' Published by the Royal College of Physicians 2008

Intervention	**12. Elective Hip Surgery**
Policy	Referral for elective hip surgery should be considered for people with osteoarthritis who experience the following joint symptoms- • Pain • Stiffness • reduced function The NHS Hip Arthroplasty Surgery Decision Making Tool should be used when arthroplasty is being considered. Patients should be informed that the decision to have surgery can be a dynamic process and a decision to not undergo surgery does not exclude them from having surgery at a future point in time. Hip preserving operations include surgery for impingement and osteotomy for mal-alignment where there is the potential for developing early osteoarthritis, is best performed in centres undertaking high volumes of surgery on young adults' hips.
Rationale	As per NICE guidance, prosthesis should only be used if the evidence shows they require revision at a rate of less than 1 in 10 (10%) in 10 years.
Minimum Eligibility Criteria	Hip replacement/Hip Resurfacing Techniques is commissioned when a patient meets the following criteria; The patient has a BMI less than or equal 35 * supported by a primary care referral **AND** • Conservative means (e.g. Analgesics, NSAIDS, physiotherapy, advice on walking aids, home adaptations, curtailment of inappropriate activities and general counselling as regards to the potential benefits of joint replacement) have failed to alleviate the patients pain and disability **AND** • Pain and disability should be sufficiently significant to interfere

	with the patients' daily life and or ability to sleep/patients whose pain is so severe **AND** • Patient must accept and want surgery **OR** • The destruction of their joint is of such severity that delaying surgical correction would increase technical difficulty of the procedure. • *Patients with a BMI > 35 need to have ***documented evidence*** of completing a primary care weight reduction programme in order to ***attempt*** to reduce their BMI prior to referral. **Total Hip Replacement-** After appropriate diagnosis, consider total hip replacement when a patient meets **all** of the following: • Pain is inadequately controlled by medication • There is restriction of function • The quality of life is significantly compromised • There is narrowing of the joint space on radiograph **Hip Resurfacing Techniques**- (primary resurfacing arthroscopy of joint) Except in the following, metal on metal hip resurfacing techniques are not routinely funded: • Those who qualify for primary total hip replacements **AND** • are likely to outlive conventional primary hip replacements
	• Royal College of Surgeons Commissioning Guide for Painful Osteoarthritis of the Hip (2013) *http://www.rcseng.ac.uk/healthcare-bodies/docs/Painarisingfromthehipinadults.pdf* • NICE Clinical guideline Osteoarthritis CG59 (2008): **Effects of BMI** • Journal of Arthroplasty, 2013, 28(5), p714-721, A workgroup of the American Association of Hip and, Obesity and total joint arthroplasty: a literature based review (attached) "The morbidly obese (BMI >40) and the super obese (BMI >50) have complication profiles that may outweigh the functional benefits of total joint arthroplasty. These patients should be counseled regarding these risks prior to any surgical intervention. It is our consensus opinion that consideration should be given to delaying total joint arthroplasty in a patient with a BMI >40, especially when associated with other comorbid conditions, such as poorly controlled diabetes or malnutrition."

Intervention	13. Knee Replacement Surgery
Policy	Referral for joint replacement surgery should be considered for people with osteoarthritis who experience all of the following joint symptoms; • Pain • Stiffness • Reduced function
Minimum Eligibility Criteria	Knee Replacement surgery is commissioned for patients who fulfil ALL of the following criteria; • The patient has a BMI less than or equal 35*supported by a primary care referral **AND** • Conservative means (e.g. Analgesics, NSAIDS, physiotherapy, advice on walking aids, home adaptations, curtailment of inappropriate activities and general counselling as regards to the potential benefits of joint replacement) have failed to alleviate the patients pain and disability **AND** • Pain and disability should be sufficiently significant to interfere with the patients' daily life and or ability to sleep/patients whose pain is so severe **AND** • Patient must accept and want surgery **OR** • The destruction of their joint is of such severity that delaying surgical correction would increase technical difficulty of the procedure. • * Patients with a BMI > 35 need to have *documented evidence* of completing a primary care weight reduction programme in order to *attempt* to reduce their BMI prior to referral
Evidence for inclusion and threshold	• Royal College of Surgeons Commissioning Guide for Painful Osteoarthritis of the Knee (2013) *http://www.rcseng.ac.uk/healthcare-bodies/docs/Painfulosteoarthritisoftheknee.pdf* • NICE Clinical guideline Osteoarthritis CG177 (2008): *http://www.nice.org.uk/guidance/cg177/resources/guidance-osteoarthritis-pdf* • Journal of Arthroplasty, 2013, 28(5), p714-721, A workgroup of the American Association of Hip and, Obesity and total joint arthroplasty: a literature based review • Saif Salih* and Paul Sutton (2013). Obesity, knee osteoarthritis and knee arthroplasty: a review. BMC Sports Science, Medicine and Rehabilitation:5(25) (http://www.biomedcentral.com/2052-1847/5/25) • http://www.westessexccg.nhs.uk/Downloads/Your%20NHS/Service%20Restriction%20Policies/Updated/Knee%20Replacement%20%20policy.pdf • http://www.northwestlondon.nhs.uk/_uploads/~filestore/9277007D-B6A0-4817-A767-5080E056A9E9/31%20Knee%20Replacement%20v3.pdf • http://www.cambsphn.nhs.uk/Libraries/Surgical_Threshold_Policies/PRIMARY_KNEE_REPLACEMENT_-_SEPT_2014_V7.sflb.ashx • http://www.shropshireccg.nhs.uk/download.cfm?doc=docm93jijm4n2001.pdf&ver=6416

Intervention	14. Spinal Fusion for Chronic Low Back Pain
Policy	Unless all of the following criteria are met Spinal Fusion for Chronic Low Back Pain will not routinely be funded.
Rationale	There is a body of evidence demonstrating that spinal fusion is no more clinically effective or cost-effective than a multi-disciplinary rehabilitation programme (physiotherapy, exercise and psychological input) for chronic (>1 year) degenerative back pain.
Minimum Eligibility Criteria	Unless the following criteria are met spinal fusion will not routinely be funded for chronic degenerative low back pain: • The patient has been assessed by a clinician trained in the diagnosis and management of chronic low back pain **AND** • The low back pain has lasted more than one year and is documented as significantly interfering with daily life (e.g. loss of function > 50% on EuroQol or BPI tool) **AND** • All conservative management functions, undertaken as part of a comprehensive pain management programme, have failed (physiotherapy guided exercise, maximal analgesia and muscle relaxants, psychological therapy)
Evidence for inclusion and threshold	NICE Clinical Guideline 88 - Low Back Pain

Intervention	15. Joint Injections
Policy	Wherever possible joint injections should be provided within a Primary Care setting. Joint injections in adults should not be done in a sterile theatre unless general anaesthetic or an image intensifier is required. They will routinely be funded as an outpatient procedure. (This policy statement relates only to adults (i.e. aged 19 and over), as it is recognised that children often require joint injections under general anaesthesia.)

Intervention	16. Cholecystectomy for Gallstones
Policy	The removal of the gallbladder for asymptomatic gallstones is regarded as a procedure of low clinical value and therefore not routinely funded by the Commissioner.
Rationale	Gallstones are small stones usually made of cholesterol that form in the gallbladder. In most cases they do not cause any symptoms. Gallstone disease is relatively straightforward to treat. The most widely used treatment is keyhole surgery to remove the gallbladder. Doctors refer to this as a laparoscopic cholecystectomy. Cholecystectomy is the surgical removal of the gall bladder. Prophylactic cholecystectomy is not indicated in most patients with asymptomatic gallstones. The removal of the gallbladder for asymptomatic gallstones is regarded as a procedure of low clinical value and therefore not routinely funded by the Commissioner. **Note:** Patients with suspected gallbladder carcinoma or severe complications should be referred / treated immediately, without delay.
Minimum Eligibility Criteria	**Guidance:** Cholecystectomy for Asymptomatic Gallstones is not routinely commissioned. The majority of people with gallbladder stones remain asymptomatic and require no treatment. For patients with symptoms follow Royal College of Surgeons guidance *Royal College of Surgeons Commissioning Guide: Gallstone disease (2013) and Best Practice Referral Guideline: https://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/gallstones/view* **RCS Commissioning Guide: Gallstone Disease** **High value care pathway for gallstone disease management** Patients with an incidental finding of stones in an otherwise normal gallbladder require no further investigation or referral. Most patients with symptomatic gallstones present with a self-limiting attack of pain that lasts for hours only. This can often be controlled successfully in primary care with appropriate analgesia, avoiding the requirement for emergency admission. When pain cannot be managed or if the patient is otherwise unwell (eg sepsis), he or she should be referred to hospital as an emergency. Further episodes of biliary pain can be prevented in around 30% of patients by adopting a low fat diet. Fat in the stomach releases cholecystokinin, which precipitates gallbladder contraction and might result in biliary pain. Patients with suspicion of acute cholecystitis, cholangitis or acute pancreatitis should be referred to hospital as an emergency. There is no evidence to support the use of hyoscine or proton pump inhibitors in the management of gallbladder symptoms. Antibiotics should be reserved for patients with signs of sepsis. There is no evidence of benefit from the use of non-surgical treatments in

	the definitive management of gallbladder stones (eg gallstone dissolution therapies, ursodeoxycholic acid or extracorporeal lithotripsy). **Best practice referral guidelines:** • Epigastric or right upper quadrant pain, frequently radiating to the back, lasting for several minutes to hours (often occurring at night) suggests symptomatic gallstones. These patients should have liver function tests checked and be referred for ultrasonography. • Confirmation of symptomatic gallstones should result in a discussion of the merits of a referral to a surgical service regularly performing cholecystectomies. • Following treatment for CBD stones with endoscopic retrograde cholangiopancreatography (ERCP) and sphincterotomy, removal of the gallbladder should be considered in all patients. However, in patients with significant co-morbidities, the risks of surgery may outweigh the benefits **Treatment is available for patients that are at high risk of the following**; • Patients with diabetes mellitus/transplant recipient patients/patients with cirrhosis who have been managed conservatively and subsequently develop symptoms • Where there is clear evidence of patients being at risk of gallbladder carcinoma • Confirmed episode of Gallstone induced pancreatitis • Confirmed episode of Cholecystiti • Episode of obstructive jaundice caused by biliary calculi
Evidence for inclusion and threshold	• NICE CG 188: http://www.nice.org.uk/guidance/cg188/resources/guidance-gallstone-disease-pdf

Intervention	17. Male Circumcision
Policy	Unless the following criteria is met circumcision will not be funded. N.B. Female genital circumcision is a separate issue. Any related activity would need to be in accordance with the Female Genital Mutilation Act 2003. The BMA's views on this issue are published in British Medical Association. Female genital mutilation. Caring for patients and child protection. London: BMA, 2001. An additional education resource is available from the Royal College of Nursing.
Rationale	Male circumcision is an operation to remove the foreskin (the skin covering the top of the penis). This policy only refers to male circumcision for medical reasons. Dudley CCG does not commission religious circumcision.

Minimum Eligibility Criteria	Circumcision will be funded in the following medical circumstances
	
	• Pathological phimosis
	• Relative indications for circumcision or other foreskin surgery include the following:
	  ○ Prevention of urinary tract infection in patients with an abnormal urinary tract
	  ○ Recurrent paraphimosis
	  ○ Trauma (e.g. zipper injury)
	  ○ Tight foreskin causing pain on arousal/ interfering with sexual function
	  ○ Congenital abnormalities

Evidence for inclusion and threshold	• The Royal College of Surgeons of England and British Associations of Urological Surgeons/ British Associations of Paediatric Surgeons/ British Associations of Paediatric Urologists (2013). Commissioning guide: Foreskin conditions. Available from: http://www.rcseng.ac.uk/providers-commissioners/docs/rcseng-baus-commissioning-guide-on-foreskin-conditions

Intervention	18. Surgical Haemorrhoidectomy
Policy	This policy is to be used where conservative treatment of haemorrhoids has previously failed.
Rationale	Haemorrhoids (Piles) are swellings that develop inside and around the back passage (anus). Symptoms range from temporary and mild, to persistent and painful. In many cases, piles are small and symptoms settle down without treatment. Haemorrhoidectomy is an operation to cut away the hemorrhoid(s) Haemorrhoidectomy for grade 1 or 2 is not routinely commissioned but may be an option to treat grade 3 or 4 piles, or for piles not successfully treated by banding or other methods.
Minimum Eligibility Criteria	Treatment of bleeding haemorrhoids depends on the degree of prolapse and severity of symptoms. In general, the treatment options vary by haemorrhoid severity or grade Surgical treatment is commissioned for patients with the following; • Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding **OR** • Irreducible and large external haemorrhoids • Note: Surgery and Stapled haemorrhoidopexy are funded procedures providing the above criteria have been met.
Evidence for inclusion and threshold	• http://www.cks.nhs.uk/haemorrhoids • NICE guidance for circular stapled haemorrhoidectomy • http://www.nice.org.uk/nicemedia/pdf/ip/IPG034aguidance.pdf • *Royal College of Surgeons (2013) Commissioning guide: Rectal Bleeding:* http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/rectal-bleeding • *NICE (2007) Technology appraisal guidance Stapled haemorrhoidopexy for the treatment of haemorrhoids (TA128):* weblink http://guidance.nice.org.uk/TA128 • *NICE Interventional procedure guidance Haemorrhoidal Artery Ligation (IPG342) (2010):*http://publications.nice.org.uk/haemorrhoidal-artery-ligation-ipg342 • *Standards Committee of the American Society of Colon and Rectal Surgeons (ASCRS), 2010* http://www.fascrs.org/gedownload!/Practice_Parameters_for_the_Management_of_Anal.3%5B1%5D.pdf?item_id=6414001&version_id=6414002

Intervention	19. Varicose Veins
Policy	Treatment is commissioned for treatment of varicose veins when **one** or more of the criteria below are met.
Rationale	Varicose veins are veins that have become wider than normal and are unable to transport blood properly so that blood collects in them. This can cause heaviness, aching, throbbing, itching, cramps and fatigue in the legs. In severe cases, patients may develop skin discoloration or inflammation and skin ulcers **Background** Varicose veins are common affecting 15% to 30% of the adult population. • They are tortuous distended bulging veins lying beneath the skin in the legs. • They commonly arise from incompetence in the long and short saphenous veins and their branches, though they may be secondary varicosities with associated deep venous disease. • They are not to be confused with intra-dermal spider veins or thread veins which lie within the skin. • Complications from varicose veins include eczema, induration [lipodermatosclerosis], pigmentation, bleeding, thrombophlebitis and ulceration. • Patients complain both of the appearance and report symptoms such as aching in the leg, pains in the leg, restlessness, cramps, itchiness, heaviness and swelling. • A link between symptoms and varicose vein severity can be difficult to establish. Referral advice has been issued by NICE in a guide to appropriate referral from general to specialist services [NICE 2001]. The advice from NICE is reiterated in the 18 Week Patient Pathway on Varicose Veins. o Most varicose veins need no treatment and many with complications can be managed in Primary Care by offering: Graduated compression stockings. These control most symptoms attributable to varicose veins, including aching and ankle swelling in addition to reducing the risk of ulceration. Stockings are available on FP10 or can be purchased from pharmacists. *Class one* stockings are suitable for mild symptoms whilst significant ankle oedema or prevention of ulcer recurrence requires a *class two* stocking. Below-knee stockings are usually effective but some patients find them uncomfortable or ineffective if varicosities are in the thigh. Thigh-length stockings may be prescribed but many patients report difficulty keeping them up. Suspender belts are effective and some manufacturers now offer graduated compression stockings with “stay-ups”. o Lifestyle support and advice. Losing weight helps and there

	are specific exercise including leg elevation at rest that also helps. ○ Reassurance. In most cases varicose veins will not result in harm, though advice about DVT prevention when flying should be given. • Varicose eczema if severe or inflamed can be treated effectively with topical steroids. • Thrombophlebitis usually responds to leg elevation, topical or systemic NSAID's and stockings. Antibiotics are occasionally required for secondary infection.
Minimum Eligibility Criteria	Treatment is commissioned for varicose veins when the patient meets **one or more** of the following; • Varicose veins which have bled and are at risk of bleeding again **OR** • A history of varicose ulceration **OR** • Signs of prolonged venous hypertension (haemasiderin pigmentation, eczema, induration lipodermatosclerosis), or significant oedema associated with skin changes) **OR** • Superficial thrombophlebitis in association with varicose veins **OR** • Significant symptoms attributable to chronic venous insufficiency which are resulting in significant functional impairment
Evidence for inclusion and threshold	• National Clinical Guideline Centre, Varicose veins in the legs: the diagnosis and management of varicose veins (2013): http://guidance.nice.org.uk/CG168 • *Royal College of Surgeons, Commissioning guide: varicose veins (2013)* http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/varicose-veins • Royal Society of Medicines (RSM) Guidelines http://www.rsm.ac.uk/academ/downloads/venous_referral_guidelines_jan11.pdf

Intervention	20. Removal of Anal Skin Tags
Policy Statement	Surgery for anal skin tags will only be performed if there is an urgent clinical need.
Rationale	Hypertrophied papillae, also called anal skin tags, fibro epithelial polyps are common; they arise due to oedema, inflammation, fibrosis. They can protrude into anal canal. They are benign. Their appearance is polypoid and they may resemble haemorrhoids. Microscopically they are projections of sub mucosa and overlying mucosa; squamous epithelium with central core of inflamed, oedematous, myxoid or fibrovascular stroma with thin walled vessels; 80% have large, multinucleated, CD34+ stellate cells, often with atypical nuclear features; frequent mast cells; no thick walled vessels, no organizing thrombi, no haemorrhage. Under the electron microscope they consist of fibroblastic and myofibroblastic stromal cells. *Urgent referral* should take place in people with suspected malignancy. For information on Haemorrhoidectomy, please refer to the Procedures of Limited Clinical Priority Policy. (Section 18)
Minimum Eligibility Criteria	Not routinely commissioned surgery for patients with anal skin tags where there is: • Haemorrhoids, pruritis or solely a cosmetic problem • Referral for non-urgent assessment and treatment: This policy supports referral where: • This policy supports the commissioning of surgery for patients with anal skin tags where this forms part of the treatment of an underlying pathology such as inflammatory bowel disease.
Evidence for inclusion and threshold	Kuehn HG,Gebbensleben O,Hilger Y,Rohde H Relationship between anal symptoms and anal findings. International Journal of Medical Sciences, 2009; 6: 1431-42 Bonheur JL,Braunstein J,Korelitz BI,Panagopoulos G Skin tags in inflammatory bowel disease: new observations and a clinical review. Inflammatory Bowel Diseases 2008; 14; 1236-9

Intervention	21. Hysterectomy for Heavy Menstrual Bleeding
Policy	Hysterectomy is not routinely commissioned as a first-line treatment solely for Heavy Menstrual Bleeding (HMB).
Rationale	NICE guidance (2007) states Hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding.
Minimum Eligibility Criteria	Hysterectomy should ONLY be considered when Treatment options both pharmacological or other surgical procedures have failed or are contraindicated.
Evidence for inclusion and threshold	• Marjoribanks J, Lethaby A, Farquhar C. Surgery versus medical therapy for heavy menstrual bleeding. Cochrane Database of Systematic Reviews 2006 (last assessed as up to date May 2010) • NICE Clinical guideline - **Heavy menstrual bleeding** CG44 (2007): http://www.nice.org.uk/guidance/cg44/resources/guidance-heavy-menstrual-bleeding-pdf

Intervention	22. Diagnostic Hysteroscopy for Menorrhagia
Policy	Menorrhagia is menstrual blood loss which interferes with a woman's physical, emotional, social, and material quality of life, and which can occur alone or in combination with other symptoms. Hysteroscopy for Menorrhagia Is not routinely commissioned by the CCG.
Rationale	There are a number of studies and systematic reviews examining the investigation and management of menorrhagia. The following policy statements for the funding of hysteroscopy in this condition are based upon 2007 NICE guidance.
Minimum Eligibility Criteria	Hysteroscopy is not routinely funded for the management of menorrhagia. N.B. It is recognised that hysteroscopy may be required to confirm placement of devices for ablative procedures, but it is anticipated that this will not attract additional funding.
Evidence for inclusion and threshold	**NICE Clinical guideline - Heavy menstrual bleeding CG44 (2007): http://www.nice.org.uk/guidance/cg44/resources/guidance-heavy-menstrual-bleeding-pdf**

Intervention	23. Dilation and Curettage (D & C) for Menorrhagia
Policy	Dilation and Curettage has been the traditional technique for obtaining samples of endometrium for pathological examination. However, 'blind' dilatation and curettage (D&C) has been shown to miss significant amounts of pathology.
Minimum Eligibility Criteria	**Guidance**: • Dilatation and curettage for Menorrhagia is not routinely commissioned • Ultrasound is the first-line diagnostic tool for identifying structural abnormalities. • Dilatation and curettage should not be used as a diagnostic tool. • Dilatation and curettage should not be used as a therapeutic treatment.
Evidence for inclusion and threshold	NICE Clinical guideline - Heavy menstrual bleeding CG44 (2007): http://www.nice.org.uk/guidance/cg44/resources/guidance-heavy-menstrual-bleeding-pdf

Intervention	24. Reversal of Male Sterilisation
Policy	Reversal of male sterilisation is not commissioned.
Rationale	Reversal of male sterilisation is a surgical procedure that involves the reconstruction of the vas deferens. Sterilisation procedures are available on the NHS and couples seeking sterilisation should be fully advised and counselled that the procedure is intended to be permanent.
Minimum Eligibility Criteria	Male sterilisation is provided by the NHS as an irreversible procedure. This should be made clear to patients at referral and prior to treatment. Reversal of NHS sterilisation is not commissioned except in clinically exceptional circumstances and not to restore fertility.
Evidence for inclusion and threshold	Royal College of Obstetricians and Gynaecologists. Guideline summary - Male and Female Sterilisation, RCOG 1998.

Intervention	25. Reversal of Female Sterilisation
Policy	Reversal of female sterilisation is not commissioned.
Rationale	Reversal of sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes. One study of 85 women concluded that reversal of sterilisation is a safe and effective method of restoring fertility. Sterilisation procedures are available on the NHS and couples seeking sterilisation should be fully advised and counselled (in accordance with RCOG guidelines) that the procedure is intended to be permanent.
Minimum Eligibility Criteria	Reversal of Female sterilisation will not be funded. An Individual Funding Request may be submitted for consideration of the intervention, providing there is a clinical need, however, clinically exceptionality will need to be demonstrated. Funding is not available for restoration of fertility.
Evidence for inclusion and threshold	RCOG - Male and Female Sterilisation, Evidence-based Clinical Guideline Number 4 (Jan 2004) http://www.rcog.org.uk/files/rcog-corp/uploaded-files/NEBSterilisationFull060607.pdf

Intervention	26. Routine Doppler Ultrasound Of Umbilical and Uterine Artery In Antenatal Care
Policy	Routine doppler ultrasound of umbilical and uterine arteries will not routinely be funded for low risk pregnancies.
Rationale	Existing data does not provide conclusive evidence that the use of routine umbilical artery doppler ultrasound, or combination of umbilical and uterine artery doppler ultrasound in low-risk or unselected populations benefits either mother or baby. At present, doppler ultrasound examination should be reserved for use in high-risk pregnancies.
Minimum Eligibility Criteria	Routine doppler ultrasound of umbilical and uterine arteries will not routinely be funded for low risk pregnancies.
Evidence for inclusion and threshold	NICE Guidance CG 62: Antenatal care: routine care for the healthy pregnant woman: http://guidance.nice.org.uk/CG62

Intervention	27. Non Specific, Specific & Chronic Back Pain
Policy	**Back Pain** Back pain is a common problem that affects most people at some point in their life. The pain can be triggered by bad posture while sitting or standing, bending awkwardly, or lifting incorrectly. Back pain is not generally caused by a serious condition and; in most cases; it gets better within 12 weeks. It can usually be successfully treated by taking painkillers and keeping mobile In most cases, the pain disappears within six weeks but may come back (recur) from time to time. Chronic (persistent) pain develops in some cases and further treatment may then be needed. **Non Specific Back Pain** This is the type of back pain that most people will have at some point in their life. It is called nonspecific because it is usually not clear what is actually causing the pain. In other words, there is no specific problem or disease that can be identified as the cause of the pain. **Chronic Back Pain** Chronic pain tends to be very difficult to manage because of its complex natural history, unclear aetiology and poor response to therapy. Chronic pain is characterised by pain which persists despite adequate time for healing. There is no clear definition but it is often defined as pain that has been present for more than 12 weeks.
Minimum Eligibility Criteria	**For Non Specific Back Pain** • As per NICE guidance; Injections of therapeutic substances into the back for non-specific low back pain should not be offered – Not funded. • Please refer to IFR Generic policies: • Therapeutic facet joint intra-articular injections are only to be done in the context of either special arrangements for clinical governance and clinical audit or research – Not Funded. Epidural injections, either sacral or interlaminar and nerve root injections are not of value for patients with non-specific low back pain – Not Funded **For Specific Back Pain** Interventional pain therapies should be part of comprehensive treatment by a multidisciplinary team (MDT) where there should be arrangements for on-going assessment following a trial of treatment to show evidence of response. Facet Joint Injections & Medial Branch Block or Spinal/Epidural injections should be part of comprehensive treatment by an MDT. • Diagnostic Facet Joint injections are only commissioned for the assessment of patients being considered for surgical management of chronic back pain performed by a clinician trained in back pain assessment, diagnosis and management as part of an MDT

process.
- This should be used as a screening tool to improve specificity if radiofrequency lesioning is being considered **OR**

One injection will be funded if a patient meets ALL of the following criteria;

- Pain lasting more than or equal to 12 months **AND**
- Failed conservative treatment including maximum oral and topical analgesia **AND**
- A Clinician trained in back pain assessment, diagnosis and management has assessed the patient and considers it would enable mobilisation and participation in rehabilitation as part of an MDT approach **AND**
- Documented use of a standardised Pain and Quality Of Life (QOL) tool before and after procedure.

Further injections will only be funded as part of a pain management pathway if significant improvement (50%) is seen on PAIN score & QOL score.

No more than a total of TWO injection sessions will be funded.

Chronic Back Pain

Chronic pain tends to be very difficult to manage because of its complex natural history, unclear aetiology and poor response to therapy. Chronic pain is characterised by pain which persists despite adequate time for healing. There is no clear definition but it is often defined as pain that has been present for more than 12 weeks.
Chronic pain is not simply a physical problem. It is often associated with severe and extensive psychological, social and economic factors. Apart from poor general physical health and disability there may also be depression, unemployment, and family stress. Many of these factors interact and the whole picture needs to be considered when managing individual patients.
The impact of chronic pain on patients' lives varies from minor restrictions to complete loss of independence.

Eligibility Criteria

Radiofrequency & Endothermal Ablation for Chronic Back Pain - Denervation of Lumbar Spine:

Radiofrequency denervation should be part of comprehensive treatment by a multidisciplinary team. There should be ongoing assessment following a trial of treatment to show evidence of response.

- One diagnostic Medial Branch block will be funded. In the event of a positive outcome, *one further* diagnostic branch block will be funded prior to denervation techniques.

Radiofrequency denervation should only be undertaken after a successful - >50% improvement on a validated scoring tool - following one set of diagnostic local anaesthetic blocks and as part of a MDT managed

	programme of care. Repeat radiofrequency procedure may only be offered to those patients with a previous successful response (as above) if the benefits of the procedure lasted for at least 6 months for a maximum of 2 treatments consistent with facet joint injections. Repeat radiofrequency denervation is only permitted at a minimum interval of 12 months. Therefore those patients who consistently experience less than 12 months relief following two radiofrequency procedures will not be offered further radiofrequency treatment **Spinal Cord Stimulation for chronic back pain** Spinal Cord Stimulation for Chronic pain of Neuropoathic or Ischaemic origin is **ONLY** commissioned in accordance with criteria NICE TA159
Evidence for inclusion and threshold	• **Map of Medicine:** http://healthguides.mapofmedicine.com/choices/map/low_back_and_radicular_pain2.html • Royal College Surgeons guidance 2013 https://www.rcseng.ac.uk/healthcare-bodies/docs/commissioning-guides-boa/lower-back-pain-commissioning-guide • NICE TA159: http://www.nice.org.uk/guidance/ta159

Intervention	28. Cataract Surgery
Policy	A cataract is when the lens of an eye becomes cloudy and affects vision. Cataracts most commonly occur in older people and develop gradually. Cataracts can usually be treated with a routine day case operation where the cloudy lens is removed and is replaced with an artificial plastic lens (an Intraocular Implant).
Minimum Eligibility Criteria	Cataracts eye surgery is commissioned for both first and second eyes, when a patient meets the following criteria for each eye: • The patient should have sufficient cataract to account for the visual symptoms (6/9 or worse*) AND • Should affect the patient's lifestyle • Difficulty carrying out everyday tasks such as recognising faces, watching TV, cooking, playing sport/cards etc. • Reduced mobility, unable to drive or experiencing difficulty with steps or uneven ground. • Ability to work, give care or live independently is affected This information together with a report from a recent sight test should form the minimum data on the referral form. Other indications for cataract surgery include; facilitating treatment for **one or more** of the following; • Monitoring posterior segment disease e.g. diabetic retinopathy • Correcting anisometropia • Patient with Glaucoma who require cataracts surgery to contract intraocular pressure <u>Patients with Single Sight (Monocular Vision):</u> The indications for cataract surgery in patients with monocular vision and those with severe reduction in one eye e.g. dense amblyopia are the same as for patients with binocular vision, but the ophthalmologist should explain the possibility of total blindness if severe complications occur. *Please note: - Cataracts causing glare or starburst effect when driving, will be considered even if the visual acuity is better than 6/9
Evidence for inclusion and threshold	Health Information and Quality Authority (2013) Health Technology Assessment of Scheduled Surgical Procedures: Cataract Surgery. Available at: http://www.hiqa.ie/system/files/HTA-Cataract-Surgery-April13.pdf Royal College of Ophthalmology (2015) Commissioning Guide: Cataract Surgery. Available at: https://www.rcophth.ac.uk/wp-content/uploads/2015/03/Commissioning-Guide-Cataract-Surgery-Final-February-2015.pdf The Royal College of Ophthalmologists' National Ophthalmology Database shows that, for the period 2006-2010, 3%, 5% and 36% of eyes undergoing cataract surgery have preoperative visual acuities of better than or equal to 0.00, 0.18 and 0.30 logMAR respectively (equivalent to 6/6, 6/9 and 6/12 Snellen)9 indicating that before restrictions on access to cataract surgery based on visual acuity were commonplace, eyes with visual acuities of 6/9 or better accounted for less than 10% of cataract surgery. DVLA Driving Standards. Available at: https://www.gov.uk/driving-eyesight-rules

Intervention	29. Laser Surgery for Short Sight (Myopia)
Policy	Laser surgery for correction of short sight is not funded.
Rationale	Current evidence suggests that photorefractive (laser) surgery for the correction of refractive errors is safe and efficacious in appropriately selected patients. Refractive errors are usually corrected by wearing spectacles or contact lenses, and these treatments are currently not available on the NHS. Both have limitations and contact lens wear is associated with an increased risk of sight-threatening corneal infection. Surgical treatments have been developed to permanently improve refraction by re-shaping the cornea.
Minimum Eligibility Criteria	Laser surgery for correction of short sight will not routinely be funded
Evidence for inclusion and threshold	NICE IPG 164 - Photorefractive (laser) surgery for the correction of refractive errors.

Intervention	30. Dental – Including Apicectomy, Dental Implants & Wisdom Teeth Removal
Statement	These areas are now commissioned by NHS England, please contact the local team for further information.

Intervention	31. Botulinum Toxin Type A for Hyperhidrosis
Policy	Botulinum Toxin for Hyperhidrosis is not routinely commissioned.
Rationale	Normal sweating helps to keep the body temperature steady in hot weather, during a high temperature (fever) or when exercising. Excessive sweating (hyperhidrosis) means sweating more than normal. Botulinum toxin injections works well for armpit sweating. Treatment consists of many small injections just under the skin in the affected areas. The Botulinum toxin stops the nerves in the skin that control the sweat glands from working. Botulinum toxin is not licensed to treat sweating of the palms and face. This is because there is a risk that the injections may stop some of the nearby small muscles of the hands or face from working. Botulinum toxin type A for hyperhidrosis is not routinely commissioned. This policy does not preclude individual patients being referred to the Individual Funding Request Panel where the referrer feels that the therapy may be appropriate and where the referrer can demonstrate that the patient's condition and presentation is clinically exceptional and significantly different from other cohort of patients.

Intervention	32. Botulinum Toxin Type A - Spasticity
Policy	Botulinum Toxin Type A will not be funded for the following treatments; • Cosmetic Reasons
Rationale	Spasticity is a significant feature of an upper motor neurone syndrome, which occurs quite commonly in many neurological conditions like stroke, multiple sclerosis, brain injury, cerebral palsy etc. It can lead to disabling complications like contractures and pressures sores, which in turn places a huge burden on the patient, family, social services and the NHS. [£10,551 for one pressure sore]. Prompt and effective management of spasticity by a multi-modal, multi-agency approach co-ordinated by an interdisciplinary team can prevent these complications. It is estimated that approximately one-third of stroke patients (van Kuijk et al 2007; Watkins et al 2002), 60% of patients with severe multiple sclerosis (MS) and 75% of patients with physical disability following severe traumatic brain injury will develop spasticity requiring specific treatment. Of these, approximately one-third may require treatment with Botulinum Toxin injections. (Verplancke et al 2005). BTA has been used for Management of spasticity since 1989 and its use is further recommended in the UK National Guidelines 2009. Effective management of spasticity using Botulinum Toxin injections can lead to benefits- at impairment level: reduce pain; prevent pressure sores and contractures; improved seating etc. at activity level: improved mobility; increase in an ability to use limbs for function like feeding, dressing, grooming; reduce carer burden and at participation level: improve self-esteem and self-image; facilitate social interaction etc. This should be supplemented by; a) Use of other pharmacological agents: oral anti-spasticity agents like baclofen, tizanidine etc, phenol nerve blockade b) Non-pharmacological interventions including effective management of noxious stimuli like constipation, bladder and skin issues c) Post injection goal-oriented therapy input and d) Liaising with and incorporating the support of allied agencies like Orthotics, Wheelchair services, Social Services etc. The clinical benefit can persist for many months (particularly when accompanied by an appropriate physical management regimen) but wears off gradually. Repeat injections generally follow a similar course. Experience in other neurological conditions has demonstrated that spasticity in adults may become biologically resistant to BTA as a result of antibody formation, especially with frequent, large dose injections (Greene and Fahn 1992, 1993; Hambleton and Moore1995). This has led to the general advice to avoid repeated injection at less than three month intervals. Although secondary non-response is theoretically an issue for the use of BTA in spasticity, it is rarely reported in practice. This may be because spasticity is often self-limiting in the course of natural recovery, e.g. following stroke or brain injury, so that long-term repeated injections are required for only a minority of patients.

Minimum Eligibility Criteria	Spasticity Botulinum Toxin Type A will be funded when medically necessary for Spasticity when the following criteria are met: 1. Spasticity due to a diagnosed neurological condition: a) Stroke b) Multiple Sclerosis [MS] c) Acquired Brain Injury- Traumatic and Non-Traumatic d) Acquired Spinal Injury: Traumatic and Non-traumatic e) Motor Neurone Disease [MND] f) Parkinson's disease g) Miscellaneous condition 2. Spasticity not responding to physical therapy and oral anti-spasticity agents 3. Focal spasticity and not generalised spasticity [therefore not needing systemic oral agents] 4. To improve function in upper and lower limbs 5. To facilitate therapy/ splinting/orthotics/positioning 6. To facilitate carer input/ reduce carer burden 7. To prevent severe complications which require expensive interventions like pressure sores, contractures etc 8. Reduce severe pain from spasticity in spite of optimal treatment with different pharmacological agents, positioning etc **Please Note:** funding will be approved on an ongoing basis however, the Provider will avoid repeated injection with intervals less than three months. **Note:** Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes clinically exceptional circumstances exist, that warrant deviation from the rule of this policy. Individual cases will be reviewed at the Individual Funding Request Panel upon receipt of a completed application form from the Patient's GP, Consultant or Clinician. Applications cannot be considered from patients personally.
Evidence for inclusion and threshold	• Royal College of Physicians **Spasticity in adults: management using botulinum toxin** National guidelines (2009): *https://www.rcplondon.ac.uk/sites/default/files/documents/spasticity-in-adults-management-botulinum-toxin.pdf* 2.1 Patients should be selected for BT on the basis of: • focal or multifocal problems due to spasticity • a dynamic spastic component as opposed to contracture • clearly identified goals for treatment and anticipated functional gains NICE Clinical guideline Spasticity **in children and young people** with non-progressive brain disorders CG145 (2012): 1.5 Botulinum toxin type A **General principles** 1.5.1 Consider botulinum toxin type A treatment in children and young people in whom focal spasticity of the upper limb is: -impeding fine motor function -compromising care and hygiene

	-causing pain -impeding tolerance of other treatments, such as orthoses -causing cosmetic concerns to the child or young person. 1.5.2 Consider botulinum toxin type A[5] treatment where focal spasticity of the lower limb is: -impeding gross motor function -compromising care and hygiene -causing pain -disturbing sleep -impeding tolerance of other treatments, such as orthoses and use of equipment to support posture -causing cosmetic concerns to the child or young person. 1.5.3 Consider botulinum toxin type A[5] treatment after an acquired non-progressive brain injury if rapid-onset spasticity is causing postural or functional difficulties. 1.5.4 Consider a trial of botulinum toxin type A[6] treatment in children and young people with spasticity in whom focal dystonia is causing serious problems, such as postural or functional difficulties or pain. 1.5.5 Do not offer botulinum toxin type A treatment if the child or young person: -has severe muscle weakness -had a previous adverse reaction or allergy to botulinum toxin type A -is receiving aminoglycoside treatment. 1.5.6 Be cautious when considering botulinum toxin type A treatment if: -the child or young person has any of the following: *a bleeding disorder, for example due to anti-coagulant therapy *generalised spasticity *fixed muscle contractures *marked bony deformity or -there are concerns about the child or young person's likelihood of engaging with the post-treatment adapted physical therapy programme (see recommendation 1.2.15). 1.5.7 When considering botulinum toxin type A treatment, perform a careful assessment of muscle tone, range of movement and motor function to: -inform the decision as to whether the treatment is appropriate -provide a baseline against which the response to treatment can be measured. A physiotherapist or an occupational therapist should be involved in the assessment. 1.5.8 When considering botulinum toxin type A treatment, give the child or young person and their parents or carers information about: -the possible benefits and the likelihood of achieving the treatment goals -what the treatment entails, including: *the need for assessments before and after the treatment *the need to inject the drug into the affected muscles *the possible need for repeat injections *the benefits, where necessary, of analgesia, sedation or general anaesthesia *the need to use serial casting or an orthosis after the treatment in some cases -possible important adverse effects (see also recommendation 1.5.10). 1.5.9 Botulinum toxin type A treatment (including assessment and administration) should be provided by healthcare professionals within the network team who have expertise in child neurology and musculoskeletal anatomy.

Intervention	33. Complementary Medicines/Therapies
Policy	**Complementary therapies listed below will not be funded.**
Rationale	Complementary and alternative therapy covers a wide range of therapies some of which lack evidence of effectiveness and are not supported by Dudley CCG. There is no national policy for the use of complementary and alternative therapies. Complementary and alternative therapies listed below are not routinely funded. Active release technique. Acupressure, Aimspro, AMMA therapy, Antineoplastons, Antineoplaston therapy and sodium Phenylbutyrate; Apitherapy; Applied kinesiology; Art therapy; Auto urine therapy;Bioenergetic therapy; Biofield Cancell (Entelev) cancer therapy; Bioidentical hormones;Carbon dioxide therapy; Cellular therapy; Chelation therapy for Atherosclerosis; Chung Moo Doe therapy; Coley's toxin; Colonic irrigation; Conceptual mind-body techniques; Craniosacral therapy; Cupping; Dance/Movement therapy; Digital myography; Ear Candling; Egoscue method; Electrodiagnosis according to Voll (EAV); Equestrian therapy; Essential Metabolics Analysis (EMA); Essiac; Feldenkrais method of exercise therapy; Flower essence; Fresh cell therapy; Functional intracellular analysis; Gemstone therapy; Gerson therapy; Glyconutrients; Graston technique; Greek cancer cure; Guided imagery; Hair analysis; Hako-Med machine (electromedical horizontal therapy); Hellerwork; Homeopathy; Hoxsey method; Humor therapy; Hydrazine sulphate; Hypnosis; Hyperoxygen therapy; Immunoaugmentive therapy; Infratronic Qi-Gong machine; Insulin potentiation therapy; Inversion therapy; Iridology; Iscador; Kelley/Gonzales therapy; Laetrile; Live blood cell analysis; Macrobiotic diet; Magnet therapy; Meditation/transcendental meditation; Megavitamin therapy; Meridian therapy; Mesotherapy; Misletoe therapy; Moxibustion (except for fetal breech presentation) - see MTH-68 vaccine; Music therapy; Myotherapy Neural therapy; Ozone therapy; Pfrimmer deep muscle therapy; Polarity therapy; (Poon's) Chinese blood cleaning; Primal therapy; Psychodrama; Purging; Qigong longevity exercises; Ream's testing; Reflexology (zone therapy); Reflex Therapy; Reiki; Remedial massage; Revici's guided chemotherapy;Rolfing (structural integration); Rubenfeld synergy method (RSM); 714-X (for cancer); Sarapin injections; Shark cartilage products ;Therapeutic Eurythmy-movement therapy; Therapeutic touch; Thought field therapy (TFT) (Callahan Techniques Training); Trager approach; Visceral manipulation therapy; Whitcomb technique; Wurn technique/clear passage therapy; Yoga.
Minimum Eligibility Criteria	This policy does not preclude individual patients being referred to the Individual Funding Request Panel where the referrer feels that the therapy may be appropriate and where the referrer can demonstrate that the patient's condition and presentation is clinically exceptional and significantly different from other cohort of patients. Funding requests are not required where particular therapies are commissioned as part of a wider treatment provided within a package of care.
Evidence for inclusion and	The House of Commons Science and Technology Committee enquiry into the provision of homeopathic services within the NHS in 2009

threshold	recommended that homeopathic treatments should not be routinely available within the NHS. The committee report included a robust review of the evidence base for a variety of homeopathic treatments but found no evidence of effectiveness for any condition from published RCTs and systematic reviews. A previous report commissioned by the Association of Directors of Public Health in 2007 and more recent reviews by AETNA 3 are all consistent in confirming the lack of sufficient evidence of effectiveness of homeopathic treatments despite many years of research and hundreds of studies. There is some evidence of clinical benefit for some complementary therapies such as acupuncture, osteopathy, biofeedback and hypnotherapy for certain conditions. 1. Evidence Check 2: Homeopathy. House of Commons Science and Technology Committee Report. 2009-10. http://www.publications.parliament.uk/pa/cm200910/cmselect/cmsctech/45/45.pdf 2. Association of Public Health Report on the evidence for homeopathy (unpublished commissioned Report on the evidence for Homeopathy) 3. AETNA Clinical Policy Bulletin 0388. Complementary and Alternative Medicine. Last review date 05/04/2010. http://www.aetna.com/cpb/medical/data/300_399/0388.html

Intervention	**34. Extracorporeal Shockwave Therapy for Refractory Plantar Fasciitis**
Policy	Extracorporeal shockwave therapy for refractory plantar fasciitis will not be funded.
Rationale	Plantar fasciitis is characterised by chronic degeneration of the plantar fascia, which causes pain on the underside of the heel. It is usually caused by injury or biomechanical abnormalities and may be associated with microtears, inflammation or fibrosis. Conservative treatments include rest, application of ice, analgesic medication, non-steroidal anti-inflammatory drugs, orthotic devices, physiotherapy, eccentric training/stretching and corticosteroid injection. Extracorporeal shockwave therapy (ESWT) is a non-invasive treatment in which a device is used to pass acoustic shockwaves through the skin to the affected area. Ultrasound guidance can be used to assist with positioning of the device. Extracorporeal shockwave therapy may be applied in one or several sessions. Local anaesthesia may be used because high-energy ESWT can be painful. Different energies can be used and there is evidence that local anaesthesia may influence the outcome of ESWT. The evidence on extracorporeal shockwave therapy (ESWT) for refractory plantar fasciitis raises no major safety concerns; however, current evidence on its efficacy is inconsistent, therefore this procedure will not routinely be funded.
Minimum Eligibility Criteria	Extracorporeal shockwave therapy for refractory plantar fasciitis will not routinely be funded
Evidence for inclusion and threshold	NICE IPG 311- Extracorporeal shockwave therapy for refractory plantar fasciitis

Intervention	35. Extracorporeal Shockwave Therapy for Refractory Achilles Tendinopathy
Policy	Extracorporeal shockwave therapy for refractory Achilles tendinopathy will not be funded.
Rationale	Achilles tendinopathy is characterised by chronic degeneration of the Achilles tendon, and is usually caused by injury or overuse. Symptoms include pain, swelling, weakness and stiffness over the Achilles tendon and tenderness over the heel (insertional tendinopathy). Conservative treatments include rest, application of ice, non-steroidal anti-inflammatory drugs, orthotic devices, physiotherapy (including eccentric loading exercises) and corticosteroid injection. Surgery may be considered in some patients with refractory symptoms. Extracorporeal shockwave therapy (ESWT) is a non-invasive treatment in which a device is used to pass acoustic shockwaves through the skin to the affected area. Ultrasound guidance can be used to assist with positioning of the device. Extracorporeal shockwave therapy may be applied in one or several sessions. Local anaesthesia may be used because high-energy ESWT can be painful. Different energies can be used and there is evidence that local anaesthesia may influence the outcome of ESWT. The evidence on extracorporeal shockwave therapy (ESWT) for refractory Achilles tendinopathy raises no major safety concerns; however, current evidence on its efficacy is inconsistent, therefore this procedure will not routinely be funded.
Minimum Eligibility Criteria	Extracorporeal shockwave therapy for refractory Achilles tendinopathy will not be funded
Evidence for inclusion and threshold	NICE IPG 312 - Extracorporeal shockwave therapy for refractory Achilles tendinopathy.

Intervention	36. Hyperbaric Oxygen Therapy
Policy	Unless one or more of the criteria below are met Hyperbaric Oxygen Therapy will not be funded.
Rationale	Despite the increasing use of Hyperbaric Oxygen Therapy (HBOT) in a range of conditions there is very little evidence from clinical trials regarding its clinical effectiveness or cost effectiveness. In line with findings from the review of HBOT by NHS Quality Improvement. HBOT will be funded for conditions where there is a theoretical basis for its effectiveness, sufficient empirical evidence and clinical consensus.
Minimum Eligibility Criteria	Unless one or more of the criteria below are met Hyperbaric Oxygen Therapy will not be funded: **Emergency conditions** • Decompression illness – only for patients not covered by diver's insurance arrangements • Air and Gas Embolism • Acute Carbon monoxide poisoning **Other conditions** • Diabetic Lower Extremity Ulcers where all the conditions listed below are met: • Type I or II diabetes mellitus • Wounds/Ulcers classified as Wagner grade III only. • History of failed standard wound therapy for at least 30 days for a Wagner Grade 3 Wound/Ulcer i.e. failure of objective evidence of any improvement • For HBOT to continue at 30 day intervals, re-evaluation must show continued progression to healing • Radiation-induced Proctitis
Evidence for inclusion and threshold	The clinical and cost effectiveness of hyperbaric oxygen therap. HTA programme: HTA systematic review 2 – May 2008. NHS Quality Improvement Scotland

Intervention	37. Inpatient Cognitive Behavioural Therapy (Residential Placements) for Chronic Fatigue Syndrome (CFS)/Myalgic Encephalomyelitis (ME)
Policy	Cognitive Behavioural Therapy Residential Placements will not routinely be funded for Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME). This policy excludes Fibromyalgia.
Rationale	Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME) comprises a range of symptoms including fatigue, headache, sleep disturbance, difficulty in concentration and muscle pain. An individual's symptoms may vary in severity and there is variation between patients. Although many patients improve over time, others do not. The cause of CFS/ME is unknown. Many different interventions for CFS/ME have been investigated in clinical trials of varying quality. There is increasing evidence from good quality trials to support CBT and/or GET in the management of CFS/ME. CBT with or without GET is more effective than standard medical care and does not appear to be more expensive. There is evidence for effectiveness in both adults and children. There is currently insufficient evidence to support any other intervention in terms of clinical or cost effectiveness. This includes immunological treatments, anti-viral therapy, pharmacological treatments, dietary supplements, complementary or alternative medicine, multi-treatment regimes, buddy-mentor schemes, group therapy and 'low sugar low yeast' diets. There is currently no evidence relating to patients with severe CFS/ME (who are house or bed-bound)'. There is currently no evidence to support the use of in-patient or residential settings to deliver effective interventions for CFS/ME. There is currently no evidence to suggest that any group or sub-group of patients with CFS/ME will benefit particularly from any specific intervention or that patients who have failed to improve on one intervention may do better on another. *NOTES:* *1. Exceptional circumstances may be considered where there is evidence of significant health impairment and there is also evidence of the intervention improving health status.*
Minimum Eligibility Criteria	Cognitive Behavioural Therapy (Residential Placements) will not be funded for chronic fatigue syndrome.
Evidence for inclusion and threshold	The Treatment and Management of Chronic Fatigue Syndrome/Myalgic Encephalomyelitis in Adults and Children. Feb 2007. CRD, University of York. Chalder T et al. Inpatient treatment of CFS. Behavioural Cognitive Psychotherapy.1996;24:351-365 NICE clinical guideline 53 August 2007 Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management of CFS/ME in adults and children Fukuda et al (1994) *The Chronic Fatigue Syndrome: A Comprehensive Approach to Its Definition and Study* Annuls of Internal Medicine December 15, 1994 vol. 121 no. 12 953-959 Map of Medicine April 2011 (Appendix 1) Royal College of Paediatrics and Child Health (RCPCH). Evidence based guideline for the management of CFS/ME (Chronic Fatigue Syndrome/myalgic encephalopathy) in children and young people. London: RCPCH; 2004.

Intervention	38. Inguinal Hernia Repair
Policy	A hernia is defined as a protrusion of a sac of peritoneum, often containing intestine or other abdominal contents, from its proper cavity through a weakness in the abdominal wall. They usually present as a lump, and patients often experience pain or discomfort that can limit daily activities. In addition, hernias can present as a surgical emergency should the bowel strangulate or become obstructed due to the hernia. There are many different types of hernia; this policy relates to **inguinal** hernias only. **Please Note:** Patients need to be aware that surgery does not guarantee a successful, pain free outcome and there are both risks and benefits.
Minimum Eligibility Criteria	An inguinal hernia repair is commissioned where a patient meets **one or more** of the following; • irreducible and partially reducible inguinal hernias • patients who experience pain or discomfort that limits daily activities • patients with suspected strangulated or obstructed inguinal hernia should be referred as an emergency • all children <18 years with inguinal hernia (should be referred to a paediatric surgical provider) • all hernias in women (should be referred urgently) Note: Except for patients with minimally symptomatic inguinal hernias who have significant comorbidity (ASA 3 or 4) **AND** do not want to have surgical repair after appropriate information has been provided
Evidence for inclusion and threshold	Royal College of Surgeons (2013) Commissioning guide: Groin Hernia http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/hernia http://www.britishherniasociety.org/patients/