North East London Commissioning Alliance

North East London

Evidence Based Interventions Policy

Procedures not routinely funded (Individual Funding Requests (IFR)) or requiring prior approval

Barking & Dagenham, City & Hackney, Havering, Newham, Redbridge, Tower Hamlets, Waltham Forest Clinical Commissioning Groups (North East London (NEL) CCGs)

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Background

The NEL Evidence Based Interventions Policy (NEL EBI) is a list of treatments/interventions that are only funded by the NHS when a patient meets certain clinical threshold criteria. This policy applies to adult patients aged 18 and over only, unless specified otherwise in the body of text within each policy.

Policy development is an on-going process resulting from the publication of new evidence regarding clinical effectiveness. Policy reviews will be undertaken in response to NICE Guidance/Guidelines, health technology assessments etc.

NEL EBI Policy is a clinically led and evidence based programme. In developing the NEL EBI, we have taken into account clinical advice from local clinicians, national clinical evidence and guidelines i.e. NICE. A network of clinicians from all seven North East London CCGs have been involved in the development of this policy and in reviewing and updating specific sections.

We know that some procedures are currently carried out on patients, where the evidence for intervention is not strong and more conservative approaches to the management of conditions would be more appropriate and present less risks than surgical intervention. We need to ensure that in making decisions on how we fund treatments, that our patients realise the best clinical and quality outcomes. Having a policy to govern these procedures that is adhered to will ensure that patients do not undergo unnecessary surgical interventions or procedures where clinical evidence is not strong or where in some cases carries significantly greater risk and cost, than alternative treatment options. Adherence to an effective policy will also ensure that surgical capacity is available for those patients that really need a procedure to be carried out that is supported by clinical evidence.

We need to continue to prioritise those services that deliver the greatest health gain for local people. By ceasing to make some services routinely available and putting in place stricter criteria for accessing other services, we believe that will be able to protect the most important services so that they can be available when people need them whilst at the same time continuing to live within our financial means.

To achieve this aim, we will ensure the current NEL EBI Policy is:

1. Consistently applied across the seven North East London Clinical Commissioning Groups (Barking & Dagenham, City & Hackney, Havering, Newham, Redbridge, Tower Hamlets, and Waltham Forest) to avoid any postcode related inequity or inequality.

2. Presented using unambiguous language, which is easy for clinicians and patients to interpret.

3. Regularly reviewed, updated and reissued using the most up to date and validated evidence base.

4. Effectively and consistently communicated to health care professionals within the footprint.

5. An open and transparent process, adhering to local governance policies.

Where possible, references to the evidence/ guidelines underpinning individual clinical policies have been added to the relevant sections. However, it should be noted that an assumption is made that if National guidelines are updated that would impact upon this policy they will be taken into account when assessing eligibility for a particular treatment. **Obtaining funding approval and due process.**

There are two main routes by which funding can be sought and obtained as outlined below:

Funding for any of the procedures or interventions contained in this policy will be subject to (a) if an exceptional case is made through an individual funding request (IFR) OR (b) prior approval. Further details are described below:

Prior Approval - This means the CCG will fund treatment if the patient meets the stated clinical threshold for care. Before the procedure is undertaken Prior Approval must be sought and obtained. A GP or Consultant must seek approval for an individual before treatment is carried out. In the majority of cases this will be requested by the treating clinician with the exception of the following procedures where the GP will have more information regarding the patient's clinical condition.

- Tonsillectomy (page 12)
- Chalazia removal (page 9)
- Abdominal wall hernia management and repair (page 25)

IFR (Not routinely funded) - The statement "NEL CCGs will not routinely fund" means it is primarily a commissioning decision not to routinely fund. In these circumstances a clinician may still request funding for that treatment but this will only be approved if an Individual Funding Request (IFR) proves exceptional clinical need and is approved by the IFR panel (Please refer to IFR Policy).

A copy of the relevant IFR policy can be obtained from the IFR team by contacting the following:

For City and Hackney, Newham, Tower Hamlets and Waltham Forest**:**

Email: nelcsuwelc-ifr@nhs.net or Tel. 020 3688 1290

For Barking and Dagenham, Havering and Redbridge:

Email: nelcsubhr-ifr@nhs.net or Tel. 020 3688 1290

Exceptional cases must have exceptional clinical circumstances supported by robust clinical evidence. We have defined exceptionality as an unusual clinical factor (or factor affecting the clinical condition) about the patient that suggests that they are:

Significantly different to the general population of patients with the condition in question

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

The fact that a treatment is likely to be effective for a patient is not, in itself, a basis for exceptionality. If a patient's clinical condition matches the 'accepted threshold indicators' for a treatment that is not funded, their circumstances are not, by definition, exceptional.

Any procedures carried outside of the funding governance arrangements outlined above will be subject to challenge and carries a significant risk of non-payment to the provider.

Performance monitoring arrangements

Performance measures and audits will be used to monitor provider activity. These will be carried out as instructed by individual CCGs. Any procedures carried out that are not in line with this policy will be investigated and, where appropriate, challenged for non-payment.

Prior Approval and IFR – Any procedures carried outside of the funding governance arrangements previously outlined will be subject to challenge and carries a risk of non- payment to the provider

Retrospective audits - The frequency, scope and depth for the said audits will be agreed with providers who will be given appropriate notice pending any such audits and or reviews. All providers will be asked to clarify any activity or procedure codes that fail to comply with those set out within the policy. These will be subject to challenge as is relevant and where appropriate challenged for non-payment.

Coding; CCGs and Providers will work collectively to agree, maintain and review coding as required to support policy implementation.

All providers will be asked to clarify any activity or procedure codes that fail to comply with those set out within the policy. These will be subject to challenge as is relevant and where appropriate challenged for non-payment

Equality statement

NEL CCGs have a duty to have due regard for the need to reduce health inequalities in access to health services and health outcomes achieved as detailed in the Health and Social Care Act 2012. NEL CCGs have committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. In carrying out its functions, NEL CCGs will have due regard to the different needs of protected equality groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

NEL CCGs have completed an Equality Impact Assessment (EIA) and Full Quality Impact Assessment (fQIA) for this policy update.

Exclusions to this policy

The policy does not apply to the following:

- Patients diagnosed with cancer or suspected of having cancer: diagnoses should be dealt with via a two-week wait referral and NOT via an Individual Funding Request (IFR) or Prior Approval (PA) application.
- Policies will not apply to those patients where the treatment is in relation to their cancer pathway eg. breast reconstruction following breast cancer.
- If Mental Health affects functionality then it should be considered for funding. Although in such cases there should be evidence of the patient having received psychological treatment prior to the procedure.
- Children (aged under 18) unless otherwise stated within individual treatment/intervention policy.
- Emergency or urgent care.
- Where NHS England commission the service as part of specialist commissioning arrangements.
- If a clinician considers the need for referral/treatment on clinical grounds outside of the Prior Approval (PA) criteria, please refer to the CCG Individual Funding Request policy for further information.

In relation to the above exclusions, the provider should be able to demonstrate the clinical need as part of the payment verification process.

Implementation time scales

This policy will be used to assess all patients being referred for assessment or treatment from 01 November 2019. The NEL EBI will be reviewed one year from the date of implementation. A formal Clinical Review Group (CRG) will be reinstated and the Nationally mandated policies will be adopted without further consultation.

Category 1 Procedures: Individual funding request (IFR)

This list includes procedures that are not routinely commissioned by NEL CCGs, and therefore funding is only available through an IFR panel. Only IFR applications that demonstrate clear clinical exceptionality will be processed. Please refer to the local IFR policy for further guidance before completing an application form.

Acupuncture	Alternative therapy	27
Herbal medicines	Alternative therapy	27
Homeopathy	Alternative therapy	27

* Appendix A provides more clinical guidance for category 1 – IFR procedures.

** See breast reduction and correction of breast symmetry

Category 2 Procedures: Prior Approval (PA)

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Detailed Procedure Criteria Guidance

Dermatology & Skin

Category 1 Procedures: Individual funding request (IFR)

Face lifts and brow lifts (rhytidectomy)
Hair transplantation
Repair of split ear lobes
Tattoo removal
Treatment for hair loss (alopecia)
Treatment for scarring and skin hyper- or hypo- pigmentation

Category 2 Procedures: Prior Approval (PA)

Excision of skin and subcutaneous lesions
Criteria
This policy refers to the following benign lesions when there is diagnostic certainty and they do meet the criteria listed below: • benign moles (excluding large congenital naevi) • solar comedones • corn/callous • dermatofibroma • lipomas • milia • molluscum contagiosum (non-genital) • epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts) • seborrhoeic keratoses (basal cell papillomata) • skin tags (fibroepithelial polyps) including anal tags • spider naevi (telangiectasia) • non-genital viral warts in immunocompetent patients • xanthelasmata • neurofibromata **With prior approval, NEL CCGs will fund benign skin lesions which are listed above when one of the following criteria are met:** **1.** The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires two or more courses of antibiotics (oral or intravenous) per year **OR** 2. The lesion causes regular pain **OR** 3. The lesion is obstructing an orifice or impairing field vision **OR** 4. The lesion significantly impacts on function e.g. restricts joint movement **OR** 5. The lesion causes pressure symptoms e.g. on nerve or tissue **OR** 6. If left untreated, more invasive intervention would be required for removal **OR** 7. Facial viral warts

OR

8. Facial spider naevi in children causing significant psychological impact

Lipomas on the body > 5cms, or in a sub-facial position, with rapid growth and/or pain. These should be referred to Sarcoma clinic.

The following are outside the scope of this policy recommendation:

• Lesions that are suspicious of malignancy should be treated or referred according to NICE skin cancer guidelines.
• Any lesion where there is diagnostic uncertainty, pre-malignant lesions (actinic keratoses, Bowen disease) or lesions with pre-malignant potential should be referred or, where appropriate, treated in primary care.
• Removal of lesions other than those listed above.

Referral to dermatology or plastic surgery:
• The decision as to whether a patient meets the criteria is primarily with the referring clinician. If such lesions are referred, then the referrer should state that this policy has been considered and why the patient meets the criteria.
• This policy applies to all providers, including general practitioners (GPs), GPs with enhanced role (GPwer), independent providers, and community or intermediate services.

Hair epilation

Criteria

With prior approval, NEL CCGs will fund hair epilation when either criteria 1(a) or criteria 1(b) AND 2 are met:

1(a). Have undergone reconstructive surgery leading to abnormally located hair-bearing skin to the face, neck, upper chest or hands (areas not covered by normal clothing)

OR

1(b). Are undergoing treatment for pilonidal sinuses to reduce recurrence for patients who do not meet these criteria

AND

2. Confirmation that the patient has not had more than six NHS/private treatments in the past

In the event that NHS funding is agreed up to a maximum of six treatments.

Additional information

An IFR application will ONLY be considered (for facial, neck or upper chest areas not covered by normal clothing) on completion of the relevant section explaining for the benefit of the IFR panel why the patient differs from the cohort of similarly hirsute patients such that they are likely to gain more health benefit from depilation which is not available to other similar patients.

Because NEL CCGs do not fund maintenance treatment for hirsuitism, it is not considered appropriate to commission an intervention whose effects are likely to be transitory and psychological distress would be likely to recur. Severe hirsuitism due to an endocrine disorder may be referred to an endocrinology department but this is not an indication for NHS funding of epilation. NEL CCGs will fund radiosurgery for the treatment of symptomatic trichiasis.

Keloid and other scar revision

Criteria

NEL CCGs will not fund surgical procedures to re-fashion keloid scars for cosmetic purposes.

With prior approval, NEL CCGs will fund symptomatic keloid scars when one of the following criteria are met:

1. Interferes with physical function

OR

2. Causes pain or itchiness for six months and is unrelieved by standard medication

Additional information

Corticosteroid injections and Haelan tape should be considered the first line treatment for keloid scars. The aim of injections and tape is to improve the appearance of the scar. Patients should be informed of the need to wear the tape for 12 hours daily for at least three months.

Patients should be informed that having surgery on a scar will in itself leave a new scar that will take up to two years to improve in appearance. If surgery is used to treat a hypertrophic scar, there is a risk that the scarring may be worse after the surgery.

Low-dose, superficial radiotherapy may reduce the recurrence rate of hypertrophic and keloid scars after surgery. Because of the possibility of long-term side effects, it is only reserved for the most serious cases. IFR applications should be submitted for this intervention describing the clinical exceptionality in any case.

Ophthalmology

Category 1 Procedures: Individual funding request (IFR)

Laser surgery for short sightedness

Category 2 Procedures: Prior Approval (PA)

Cataract surgery

Criteria

This policy relates to cataract surgery only, as described in detail below.

The policy does not apply to:

- Patients with confirmed or suspected malignancy
- Patients with acute trauma or suspected infection
- Children under the age of 18

With prior approval, NEL CCGs will fund cataract surgery when both of the following criteria are met:

1. Patient has a best corrected visual acuity of 6/9 or worse in either the first or second eye

AND

2. Patient has impairment in lifestyle such as substantial effect on activities of daily living, leisure activities, and risk of falls

Additional information

All patients should be given the opportunity to engage with shared decision making at each point in the pathway to cataract surgery (e.g. optometrists, GPs, secondary care), to ensure they are well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration.

- Surgery is also indicated for management of cataract with coexisting ocular comorbidities. A full list of these ocular comorbidities can be found below.*

- Where patients have a best corrected visual acuity better than 6/9, surgery should still be considered where there is a clear clinical indication or symptoms affecting lifestyle. For NHS treatment to be provided, there needs to be mutual agreement between the provider and the responsible (i.e. Paying) commissioner about the rationale for cataract surgery prior to undertaking the procedure).

*List of ocular comorbidities

- Glaucoma
- Conditions where cataract may hinder disease management or monitoring, including diabetic and other retinopathies including retinal vein occlusion, and age related macular degeneration; neuro-ophthalmological conditions (e.g. visual field changes); or getting an adequate view of fundus during diabetic retinopathy screening
- Occuloplastics disorders where fellow eye requires closure as part of eyelid reconstruction
- Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty)
- Corneal or conjunctival disease where delays might increase the risk of complications (e.g. cicatrising conjunctivitis)
- Severe anisometropia in patients who wear glasses
- Posterior subcapsular cataracts

Chalazia removal

Criteria

With prior approval, NEL CCGs will fund incision and curettage (or triamcinolone injection for suitable candidates) of chalazia when one of the following criteria have been met:

1. Has been present for more than six months and has been managed conservatively with warm compresses, lid cleaning and massage for four weeks

OR

2. Interferes significantly with vision

OR

3. Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy

OR

4. Is a source of infection that has required medical attention twice or more within a six month time frame

OR

5. Is a source of infection causing an abscess which requires drainage

OR

6. If malignancy (cancer) is suspected e.g. Madarosis/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions

Surgery on the upper or lower eyelid (blepharoplasty)

Criteria

With prior approval, NEL CCGs will fund surgery on the upper or lower eyelid when one of the following criteria are met:

1. Impairment of visual field(s) in the relaxed, non-compensated state where visual field test results show that eyelids impinge on visual fields reducing them to 1200 laterally and 400 vertically

OR

2. Patients who have severe headache as a result of frontalis muscle overaction when trying to overcome brow ptosis, upper eyelid ptosis or excess dermatochalasis should be allowed corrective surgery

Additional information

These procedures should only be carried out in the ophthalmology department under the care of an oculoplastic surgeon.

NEL CCGs will not fund ptosis repair, upper eyelid blepharoplasty and brow lift for cosmetic reasons. This will include corrective surgery for patients who are dissatisfied with the cosmetic appearance post-surgery of any of the procedure mentioned above.

Ears, Nose & Throat (ENT)

Category 2 Procedures: Prior Approval (PA)

Grommets for glue ear in children

Criteria

The NHS should only commission this surgery for the treatment of glue ear in children when the criteria set out by the NICE guidelines are met.

With prior approval, NEL CCGs will fund grommets for glue ear when criteria 1, 2 and 3 are met. Or exclusively when either 4(a) or 4(b) are met:

1. All children must have had specialist audiology and ENT assessment

AND

2. Persistent bilateral otitis media with effusion for at least three consecutive months

AND

3. Hearing level in the better ear of 25-30dbHL or worse averaged at 0.5, 1, 2 & 4kHz

OR exclusively in one of the following circumstances

4(a). Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25-30dbHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant

OR

4(b). Healthcare professionals should also consider surgical intervention in children who cannot undergo standard assessment of hearing thresholds where there is clinical and tympanographic evidence of persistent glue ear and where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant

Additional information

This guidance does not apply to children with Down's Syndrome or Cleft Palate, who may be offered grommets after a specialist Multi-Disciplinary Team (MDT) assessment in line with NICE guidance.

It is also good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum.

For further information, please see: https://www.nice.org.uk/Guidance/CG60.

The risks to surgery are generally low, but the most common is persistent ear discharge (10-20%) and this can require treatment with antibiotic eardrops and water precautions. In rare cases (1-2%) a persistent hole in the eardrum may remain, and if this causes problems with recurrent infection, surgical repair may be required (however this is not normally done until around 8-10 years of age).

Pinnaplasty/otoplasty (correction of prominent or bat ears)

Criteria

With prior approval, NEL CCGs will fund pinnaplasty/otoplasty when all of the following criteria are met:

1. The patient is under the age of 18 at the time of referral for significant prominent or bat ears

AND

2. Where the prominence measures >30mm (using the measuring guide below)

Measuring guide

One of the most consistent methods for measuring the degree of prominence is the helical-mastoid (H-M) distance. Typically, the H-M distance is 18-20 mm. As the H-M distance increases, the ear is perceived to be increasingly prominent.

Measure from the posterior aspect of the Helix.

Prominence = H-M distance > 20mm

Pinnaplasty/otoplasty will only be considered in patients who have a >30mm prominence, unless there are other considerations e.g. in helping to retain hearing aids. In which case an IFR application would be required clearing setting out the patient's clinical exceptionality.

Rhinoplasty/Septoplasty/Rhinoseptoplasty (surgery to reshape the nose)

Criteria

Rhinoplasty, commonly known as a 'nose job', is a plastic surgery procedure for correcting and reconstructing the form, restoring the functions, and aesthetically enhancing the nose by resolving nasal trauma (blunt, penetrating, blast), congenital defect, respiratory impediment, or a failed primary rhinoplasty.

a) Rhinoplasty, Septoplasty and Septorhinoplasty are not routinely commissioned for cosmetic reasons.

b) Rhinoplasty, Septoplasty and Septorhinoplasty are restricted for non- cosmetic/other reasons.

The CCG will fund this treatment if the patient meets the following criteria:

- Documented medical problems caused by obstruction of the nasal airway **AND** all conservative treatments have been exhausted.
  OR
- Correction of complex congenital conditions e.g. Cleft lip and palate

For the purposes of this eligibility criteria, a medical problem is defined as a medical problem that continually impairs sleep and/or breathing.

This means (for patients who DO NOT meet the above criteria or require the procedure for cosmetic reasons) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Surgical treatment of chronic sinusitis

Criteria

ENT referral is appropriate for suspected:

Complications, e.g. periorbital infection or suspected sinonasal tumour.

Surgical treatment of chronic sinusitis is not routinely funded by NEL CCGs and will only be considered for funding, with prior approval, where all of the following criteria are met:

1. Recurrent or chronic sinusitis of uncertain cause

AND

2. Unremitting or progressive facial pain

AND

3. A trial of intranasal corticosteroids of three months in duration has been ineffective

AND

4. A significant anatomical abnormality

Additional Information

Evidence Base: NHS Clinical Knowledge Summaries advise a trial of intranasal corticosteroids for three months for treatment in the first instance.

Sinus puncture and irrigation has a poor diagnostic yield, and carries the risk of secondary contamination.

Only short-term benefit seen in patient refractory to medical management treated with balloon catheter dilation of sinus ostia.

Tonsillectomy

Criteria

The NHS should only commission this surgery for treatment of recurrent severe episodes of sore throat when the following criteria are met, as set out by the Scottish Intercollegiate Guidelines Network (SIGN) guidance and supported by ENT UK commissioning guidance.

With prior approval, NEL CCGs will fund tonsillitis when criteria 1 and 2 and one of criteria 3(a) or 3(b) or 3(c) are met:

Section 1

1. Sore throats are due to acute tonsillitis

AND

2. The episodes are disabling and prevent normal functioning

AND

3(a). Seven or more, documented, clinically significant, adequately treated sore throats in the preceding year

OR

3(b). Five or more such episodes in each of the preceding two years

OR

3(c). Three or more such episodes in each of the preceding three years

There are a number of medical conditions where episodes of tonsillitis can be damaging to health or where tonsillectomy is required as part of the on-going management. In these instances tonsillectomy may be considered beneficial at a lower threshold than this guidance after specialist assessment. In these instances with prior approval, **NEL CCGs will fund surgery when one of the following criteria are be met:**

Section 2

1. Acute and chronic renal disease resulting from acute bacterial tonsillitis

OR

2. As part of the treatment of severe guttate psoriasis

OR

3. Metabolic disorders where periods of reduced oral intake could be dangerous to health

OR

4. PFAPA (Periodic fever, Apthous stomatitis, Pharyngitis, Cervical adenitis)

OR

5. Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous

Additional information

Further information on the SIGN guidance can be found here: http://www.sign.ac.uk/assets/sign117.pdf

Please note this guidance only relates to patients with recurrent tonsillitis. This guidance should not be applied to other conditions where tonsillectomy should continue to be funded, these include:

- Obstructive Sleep Apnoea / Sleep disordered breathing in Children
- Suspected Cancer (e.g. asymmetry of tonsils)
- Recurrent Quinsy (abscess next to tonsil)
- Emergency Presentations (e.g. treatment of parapharyngeal abscess)

It is important to note that a national randomised control trial is underway comparing surgery versus conservative management for recurrent tonsillitis in adults which may warrant review of this guidance in the near future.

Respiratory

Category 1 Procedures: Individual funding request (IFR)

Surgical interventions for snoring in the absence of obstructive sleep apnoea

Haematology

Category 1 Procedures: Individual funding request (IFR)

White cell apheresis

Breast

Category 1 Procedures: Individual funding request (IFR)

Breast augmentation
Breast lift (Mastopexy)
Male breast reduction (gynaecomastia)

Category 2 Procedures: Prior Approval (PA)

Breast reduction and correction of breast symmetry

Criteria

Section 1: Bilateral breast reduction
With prior approval, NEL CCGs will fund bilateral breast reduction when all of the following criteria are met:

1. The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain

AND

2. In cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided

AND

3. Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps)

AND

4. Breast reduction planned to be 500gms or more per breast or at least four cup sizes

AND

5. Body mass index (BMI) is <27 and stable for at least 12 months

AND

6. Women must be provided with written information to allow them to balance the risks and benefits of breast surgery

AND

7. Women should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking

AND

8. Women should be informed that breast surgery for hypermastia can cause permanent loss of lactation

Section 2: Unilateral breast reduction
This treatment is considered for asymmetric breasts as opposed to breast augmentation if there is an impact on health as per the criteria above. Surgery will not be funded for cosmetic reasons. **With prior approval, NEL CCGs will fund unilateral breast reduction when all of the following criteria are met:**

1. A difference of 150 - 200gms size as measured by a specialist

AND

2. Body mass index (BMI) is <27 and stable for at least 12 months

Additional information
Resection weights, for bilateral or unilateral (both breasts or one breast) breast reduction should be recorded for audit purposes.

This recommendation does not apply to therapeutic mammoplasty for breast cancer treatment or contralateral (other side) surgery following breast cancer surgery, and local policies should be adhered to. The Association of Breast Surgery support contralateral surgery to improve cosmesis as part of the reconstruction process following breast cancer treatment.

Gynaecomastia: Surgery for gynaecomastia is not routinely funded by the NHS. This recommendation does not cover surgery for gynaecomastia caused by medical treatments such as treatment for prostate cancer.

Nipple inversion

Criteria

Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded.

With prior approval, NEL CCGs will fund surgical correction of nipple inversion when the following criteria is met:

1. The inversion has not been corrected by correct use of a non-invasive suction device after three months of use.

Additional information

Idiopathic nipple inversion may be corrected by the application of sustained suction. Commercially available devices are available from major chemists or online without prescription. Best results are seen where this is used correctly for up to three months.

Removal / revision of breast augmentation
Criteria
Removal **With prior approval, NEL CCGs will fund removal of breast implants when one of the following criteria are met for patients who have undergone cosmetic augmentation mammoplasty:** 1. Breast disease **OR** 2. Implants complicated by recurrent infections **OR** 3. Implants with capsule formation that is associated with severe pain **OR** 4. Implants with capsule formation that interferes with mammography **OR** 5. Intra or extra capsular rupture of silicon gel-filled implants **Revision** **With prior approval, NEL CCGs will fund reinsertion of new breast implants when criteria 1 and one of criteria 2(a) or 2(b) are met:** 1. The original implant insertion was funded by the NHS **AND** 2(a). The patient would still be eligible for breast implant under NEL CCGs commissioning policies breast augmentation **OR** 2(b). The patient would still be eligible for breast implant under NEL CCGs commission policy for correction of asymmetry NEL CCGs will not contribute funding to procedures funded privately, irrespective of whether part of that procedure involves removal of breast implants.

Orthopaedics

Category 1 Procedures: Individual funding request (IFR)

Autologous chondrocyte (cartilage) implantation
Injections for non-specific low back pain
Knee arthroscopy for patients with osteoarthritis
Lumbar disc replacement
Ozone discectomy
Spinal fusion for non-radicular back pain

Category 2 Procedures: Prior Approval (PA)

Bunion surgery (Hallux Valgus)

Criteria

With prior approval, NEL CCGs will fund bunion surgery where one of the following criteria are met:

1. Significant pain on walking not relieved by chronic standard analgesia

OR

2. Deformity such that fitting adequate footwear is difficult

OR

3. Overlapping or underlapping of adjacent toe(s)

OR

4. Hammer toes

OR

5. Recurrent or chronic ulceration

OR

6. Bursitis or tendinitis of the first metatarsal head

Dupuytren's contracture release

Criteria

Treatment is not indicated in cases where there is no contracture, and in patients with a mild (less than 20°) contractures, or one which is not progressing and does not impair function.

With prior approval, NEL CCGs will fund intervention/treatment in the form of (collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy) when one of the following criteria are met:

1. Finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint

OR

2. Severe thumb contractures which interfere with function

With prior approval, NEL CCGs will fund, in line with NICE Guidance, collagenase when 1 or 2(a) and 2(b) of the following criteria are met:

1. Participants in the ongoing clinical trial (HTA-15/102/04)

OR

2. Adult patients with a palpable cord if:

(a) there is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° or first web contracture) plus up to two affected joints

AND

(b). needle fasciotomy is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon

EXOGEN bone healing

Criteria

With prior approval, NEL CCGs will fund EXOGEN ultrasound bone healing system when the following criteria are met:

1. Long bone fractures that have failed to heal after nine months (non-union)

NICE Guidance MTG12

Functional electrical stimulation (FES) for foot drop

Criteria

With prior approval, NEL CCGs will fund initiation or continuation of treatment when one of the following criteria are met:

The patient will have objectively demonstrated that the use of FES is still clinically appropriate by:

Initiation

1. Foot drop which impedes gait and evidence that this is not satisfactorily controlled using ankle-foot orthosis

OR

Continuation

2. Gait improvement from its use

Ganglion excision

Criteria

Section 1: Wrist ganglia

With prior approval, NEL CCGs will fund wrist ganglia excision when 1 and 3 or 2 and 3 of the following criteria are met:

1. No treatment unless causing pain or tingling/numbness or concern (worried it is a cancer)

OR

2. Aspiration if causing pain, tingling/numbness or concern

AND

3. Surgical excision only considered if aspiration fails to resolve the pain or tingling/numbness and there is restricted hand function

Section 2: Seed ganglia that are painful

With prior approval, NEL CCGs will fund seed ganglia that are painful when one of the following criteria are met:

1. Puncture/aspirate the ganglion using a hypodermic needle

OR

2. Surgical excision only considered if ganglion persists or recurs after puncture/aspiration

Section 3: Mucous cysts

With prior approval, NEL CCGs will fund mucous cysts when one of the following criteria are met:

1. No surgery should be considered unless recurrent spontaneous discharge of fluid

OR

2. Significant nail deformity

Interventional treatments for back pain

Criteria

This policy relates to interventional treatments for back pain only as described in detail below and relates to people aged 18 and over

For many patients, consideration of such treatments only arises after conservative management in primary care or specialist musculoskeletal services.

The following exclusions apply:

- Children (aged under 18)
- Patients thought to have/have cancer (including metastatic spinal cord compression)
- Patients with neurological deficit (spinal cord compression or cauda equina symptoms), fracture or infection

In ordinary circumstances, funding for interventional treatments for back pain is available for patients who meet the following criteria.

Section 1: Epidurals

With prior approval, NEL CCGs will fund interventions for epidurals when criteria 1 and 2 and one of 3(a) or 3(b) are met:

1. The patient has radicular pain consistent with the level of spinal involvement

AND

2. The patient has moderate-severe symptoms that have persisted for 12 weeks or more

AND either one of the following:

3(a). The patient has severe pain and advice, reassurance, analgesia and manual therapy ideally part of community Musculoskeletal (MSK) service has been undertaken. (Evidence that disc prolapses get better on their own)

AND/OR

3(b). The MRI scan (unless contraindicated) shows pathology concordant with the clinical diagnosis.

A maximum of three epidural injections, within a 12 month period with objective with functional benefit demonstrable with each injection, will be funded

For patients with persisting symptoms after three injections, re-approval of treatment with epidural injections will be needed through the IFR panel. This may be older/frailer patients who derive medium term benefit but are unsuitable for or unwilling to have surgery.

Medial branch blocks, sacroiliac joint injections and subsequent medial branch radiofrequency lesioning (facet joint denervation) or sacroiliac joint radiofrequency denervation are only funded if performed in a Pain Service with a multidisciplinary team approach, only to be performed by doctors trained in Biopsychosocial Assessment.

Section 2: Spinal decompression

With prior approval, NEL CCGs will fund interventions for spinal decompression when all of the following criteria are met:

1. The patient has radicular/claudicant leg pain consistent with the level of spinal involvement

AND

2. The MRI scan (unless contraindicated) shows one or more areas of spinal stenosis whereby the pathology is concordant with the clinical diagnosis

AND

3. The patient has shown no sign of improvement despite conventional therapy for one year

Section 3: Discectomy

With prior approval, NEL CCGs will fund interventions for discectomy when both of the following criteria are met:

1. The patient has radicular pain consistent with the level of spinal involvement

AND

2. The patient has shown no sign of improvement despite conventional therapy for 12 weeks

Section 4: Epidurolysis (See also NICE IPG 333)

With prior approval, NEL CCGs will fund interventions for epidurolysis when all of the following criteria are met:

1. The patient has late onset radiculopathy post spinal surgery

AND

2. MRI Gadolinium-enhanced or dynamic epidurogram (unless contraindicated) findings are concordant to show adhesive radiculopathy

AND

3. Conservative management and epidural injections have failed

The specialist applying for funding must confirm that they are trained in the technique.

Subsequent epidurolysis treatments will require an IFR approval, including information about the nature and duration of benefit from initial treatment.

Spinal Fusion

Spinal fusion surgery is not routinely funded for non-radicular back pain

Lumbar Disc Replacement

Lumbar disc replacement surgery is not routinely funded

Acupuncture

Acupuncture for back pain is not routinely funded but can continue to be provided as part of existing physiotherapy packages of care.

Ozone Discectomy

Ozone discectomy is not routinely funded

Shoulder decompression

Criteria

With prior approval, NEL CCGs will fund arthroscopic subacromial decompression when:

1. The Arthroscopic subacromial decompression is for pure subacromial shoulder impingement

Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only offered in appropriate cases. To be clear, 'pure subacromial shoulder impingement' means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases.

For patients who have persistent or progressive symptoms, in spite of adequate non-operative treatment, surgery should be considered. The latest evidence for the potential benefits and risks of subacromial shoulder decompression surgery should be discussed with the patient and a shared decision reached between surgeon and patient as to whether to proceed with surgical intervention.

Surgical treatment of carpal tunnel syndrome

Criteria

Mild cases with intermittent symptoms causing little or no interference with sleep or activities require no treatment.

Cases with intermittent symptoms which interfere with activities or sleep should first be treated with:

- Corticosteroid injection(s) (medication injected into the wrist: good evidence for short (8-12 weeks) term effectiveness)

OR

- Night splints (a support which prevents the wrist from moving during the night: not as effective as steroid injections)

With prior approval, NEL CCGs will fund surgical treatment for carpal tunnel syndrome when one of the following criteria are met:

1. The symptoms significantly interfere with daily activities and sleep symptoms and have not settled to a manageable level with either one local corticosteroid injection and/or nocturnal splinting for a minimum of eight weeks

OR

2. A permanent (ever-present) reduction in sensation in the median nerve distribution

OR

3. Muscle wasting or weakness of thenar abduction (moving the thumb away from the hand)

Nerve Conduction Studies if available are suggested for consideration before surgery to predict positive surgical outcome or where the diagnosis is uncertain.

Sympathectomy for severe hyperhidrosis (palmar, plantar, axillary)

Criteria

With prior approval, NEL CCGs will fund sympathectomy when criteria 1(a) and 2 are met or 1(b) and 2 are met:

1(a). Significant focal hyperhidrosis and a one to two month trial of aluminium salts (under primary care supervision to ensure compliance) has been unsuccessful in controlling the condition

OR

1(b). Significant focal hyperhidrosis and intolerance of topical aluminium salts despite reduced frequency of application and use of topical 1% hydrocortisone

AND

2.All of the following conservative therapies have been tried and found to be unsuitable or unsuccessful:

- treatment of underlying anxiety if it is an exacerbating factor
- referral to a dermatologist for modified topical therapy
- prescription of oral anticholinergics (which block the effect of the nerves that stimulate the sweat glands)
- iontophoresis (for palmar or plantar hyperhidrosis) or botulinum toxin injections (for axillary hyperhidrosis)

Sympathectomy is an established intervention for this condition BUT should be considered only after all other non-invasive non-surgical treatment options have been tried and failed.

Additional Information
Compensatory sweating following sympathectomy is common and can be worse than the original problem. Patients should be made aware of this risk.

Trigger finger
Criteria
Mild cases which cause no loss of function require no treatment or avoidance of activities which precipitate triggering and may resolve spontaneously. Cases interfering with activities or causing pain should first be treated with: • one or two steroid injections which are typically successful (strong evidence), but the problem may recur, especially in diabetics **OR** • splinting of the affected finger for 3-12 weeks (weak evidence) **With prior approval, NEL CCGs will fund trigger finger surgery when one of the following criteria are met:** 1. The triggering persists or recurs after one of the above measures (particularly steroid injections) **OR** 2. The finger is permanently locked in the palm **OR** 3. The patient has previously had two other trigger digits unsuccessfully treated with appropriate nonoperative methods **OR** 4. Diabetics Surgery is usually effective and requires a small skin incision in the palm, but can be done with a needle through a puncture wound (percutaneous release). Treatment with steroid injections usually resolve troublesome trigger fingers within one week (strong evidence) but sometimes the triggering keeps recurring. Surgery is normally successful (strong evidence), provides better outcomes than a single steroid injection at one year and usually provides a permanent cure. Recovery after surgery takes two to four weeks. Problems sometimes occur after surgery, but these are rare (<3%).

Abdominal Surgery

Category 1 Procedures: Individual funding request (IFR)

Cholecystectomy for asymptomatic gall stones

Bariatric Surgery

Category 1 Procedures: Individual funding request (IFR)

Excess skin excision from buttocks, thighs and arms
Liposuction
Surgery to correct divarification (or diastasis) of the abdominal rectus muscle

Category 2 Procedures: Prior Approval (PA)

Bariatric Surgery
Criteria
With prior approval, NEL CCGs will fund bariatric surgery when all of the following criteria are met: • They have a BMI of 40 kg/m2 or more, **OR** between 35 kg/m2 and 40 kg/m2 and other significant diseases (type 2 diabetes or high blood pressure) that could be improved if they lost weight **AND** • All appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss **AND** • The person has been receiving or will receive intensive management in a tier 3 service **AND** • The person is generally fit for anaesthesia and surgery **AND** • The person commits to the need for long term follow up For further details see NICE clinical guidance CG189: https://www.nice.org.uk/guidance/cg189/chapter/1-recommendations

Gastroenterology

Category 1 Procedures: Individual funding request (IFR)

Double balloon enteroscopy for diagnostic purpose

Gynaecology/Urology

Category 1 Procedures: Individual funding request (IFR)

Cosmetic genital procedures (Labiaplasty – excluding Female Genital Mutilation (refer to circumcision category 2 prior approval policy)
Dilation & curettage (D&C) for heavy menstrual bleeding in women
MRI guided ultrasound (MRgFUS) for uterine fibroids
Non-medical circumcision
Reversal of female sterilisation and reversal of vasectomy
Sacral nerve stimulation for faecal and urinary incontinence
Varicocele

Category 2 Procedures: Prior Approval (PA)

Bartholin's cysts
Criteria
With prior approval, NEL CCGs will fund the surgical treatment of Bartholin's cysts which cause one of the following: 1. Significant pain **OR** 2. Have become infected requiring anti-biotic treatment on at least two separate occasions

Circumcision
Criteria
With prior approval, NEL CCGs will fund circumcision when one of the following criteria are met:

1. Phimosis seriously interfering with urine flow and/or associated with recurrent infection

OR

2. Paraphimosis

OR

3. Suspected cancer or balanitis obliterans

OR

4. Congenital urological abnormalities when skin is required for grafting and interference with sexual activity in adult males

OR

5. Recurrent, significantly troublesome episodes of infection beneath the foreskin

OR

6. To restore functional anatomy after female circumcision to facilitate childbirth where mutilation renders this hazardous

Female circumcision (Female Genital Mutilation) is prohibited under the Prohibition of Female Circumcision Act 1995.

Hysterectomy for menorrhagia (heavy menstrual bleeding)

Criteria

Based on NICE guidelines [Heavy menstrual bleeding: assessment and management [NG88] Published date: March 2018], hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding.

It is important that healthcare professionals understand what matters most to each woman and support her personal priorities and choices.

With prior approval, NEL CCGs will fund hysterectomy when criteria 1 and 3(a), 3(b) and 3(c) are met or 2 and 3(a), 3(b) and 3(c) are met:

Hysterectomy should be considered only when:

1. Where other treatment options have failed

OR

2. Where other treatment options are contradicted

OR

3a. there is a wish for amenorrhoea (no periods)

AND

3b. the woman (who has been fully informed) requests it

AND

3c. the woman no longer wishes to retain her uterus and fertility

NICE guideline NG88 1.5 Management of HMB: When agreeing treatment options for HMB with women, take into account: the woman's preferences, any comorbidities, the presence or absence of fibroids (including size, number and location), polyps, endometrial pathology or adenomyosis, other symptoms such as pressure and pain.

With prior approval, NEL CCGs will fund treatment for women with no identified pathology, fibroids less than 3 cm in diameter, or suspected or diagnosed adenomyosis when one of the following criteria are met:

1. Consider an LNG-IUS (levonorgestrel-releasing intrauterine system) as the first treatment for HMB in women with: no identified pathology or fibroids less than 3 cm in diameter, which are not causing distortion of the uterine cavity or suspected or diagnosed adenomyosis.

OR

2. If a woman with HMB declines an LNG-IUS or it is not suitable, consider the following pharmacological treatments: non-hormonal: tranexamic acid, NSAIDs (non-steroidal anti-inflammatory drugs), hormonal: combined hormonal contraception, cyclical oral progestogens.

Be aware that progestogen-only contraception may suppress menstruation, which could be beneficial to women with HMB.

OR

3. If treatment is unsuccessful, the woman declines pharmacological treatment, or symptoms are severe, consider referral to specialist care for: investigations to diagnose the cause of HMB, if needed, taking into account any investigations the woman has already had and alternative treatment choices, including: pharmacological options not already tried, surgical options: second-generation endometrial ablation, hysterectomy.

OR

4. For women with submucosal fibroids, consider hysteroscopic removal

Treatments for women with fibroids of 3 cm or more in diameter

Consider referring women to specialist care to undertake additional investigations and discuss treatment options for fibroids of 3 cm or more in diameter.

If pharmacological treatment is needed while investigations and definitive treatment are being organised, offer tranexamic acid and/or NSAIDs.

Advise women to continue using NSAIDs and/or tranexamic acid for as long as they are found to be beneficial.

For women with fibroids of 3cm or more in diameter, take into account the size, location and number of fibroids, and the severity of the symptoms and consider the following treatments: pharmacological: non-hormonal: tranexamic acid, NSAIDs, hormonal: LNG-IUS, combined hormonal contraception, cyclical oral progestogens, uterine artery embolization, surgical: myomectomy, hysterectomy.

Be aware that the effectiveness of pharmacological treatments for HMB may be limited in women with fibroids that are substantially greater than 3cm in diameter.

Prior to scheduling of uterine artery embolisation or myomectomy, the woman's uterus and fibroid(s) should be assessed by ultrasound. If further information about fibroid position, size, number and vascularity is needed, MRI should be considered. [2007]

Consider second-generation endometrial ablation as a treatment option for women with HMB and fibroids of 3cm or more in diameter who meet the criteria specified in the manufacturers' instructions.

If treatment is unsuccessful: consider further investigations to reassess the cause of HMB, taking into account the results of previous investigations and offer alternative treatment with a choice of the options described in recommendation.

Pretreatment with a gonadotrophin-releasing hormone analogue before hysterectomy and myomectomy should be considered if uterine fibroids are causing an enlarged or distorted uterus.

General Surgery

Category 1 Procedures: Individual funding request (IFR)

All treatments for vascular lesions

Category 2 Procedures: Prior Approval (PA)

Abdominal wall hernia management and repair
Criteria
With prior approval, NEL CCGs will fund abdominal wall hernia management and repair when one of the following hernias are diagnosed: 1. Symptomatic hernias (i.e. hernias causing pain) **OR** 2. Irreducible hernias **OR** 3. All femoral hernias **OR** 4. Spigelian hernias **OR** 5. Inguinal hernias extending to scrotum **OR** 6. Incisional hernias with small defects **OR** 7. Hernias at risk of strangulation - small neck **OR** 8. Symptomatic umbilical hernias

Abdominoplasty
Criteria
With prior approval, NEL CCGs will fund abdominoplasty following significant weight loss after bariatric surgery when criteria 1 is met or when criteria 2(a) and 2(b) are met: **Section 1: Following weight loss** 1. Following non bariatric surgery weight loss have a stable BMI of less than 27 Kg/m2 for at least 24 months **OR** 2(a). Following post bariatric surgery weight loss have a stable BMI of less than 27 Kg/m2 for at least 24 months **AND** 2(b).Had their surgery at least two years previously **With prior approval, NEL CCGs will fund abdominoplasty following significant weight loss after natural weight loss when one of criteria 3(a), 3(b) or 3(c) are met:** **Section 2** have severe functional problems from excessive abdominal skin folds as defined as: 3(a). Severe difficulties with daily living (i.e. walking, dressing, toileting) which have been formally assessed, and for which abdominoplasty will provide a clear resolution **OR** 3(b). Documented evidence of clinical pathology due to excess overlying skin e.g. recurrent infections or intertrigo which has led to ulceration requiring four or more courses of antibiotics in the 24 month period of stable weight **OR** 3(c). Where overhanging skin makes it impossible to maintain care of stoma bags

Haemorrhoidectomy
Criteria

Often haemorrhoids (especially early stage haemorrhoids) can be treated by simple measures such as eating more fibre or drinking more water. If these treatments are unsuccessful many patients will respond to outpatient treatment in the form of banding or perhaps injection.

With prior approval, NEL CCGs will fund haemorrhoidectomy when one of the following criteria are met:

1. Do not respond to the non-operative measures outlined above

OR if the haemorrhoids are more severe

2. Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding

OR

3. Irreducible and large external haemorrhoids

In cases where there is significant rectal bleeding the patient should be examined internally by a specialist.

Varicose veins

Criteria

Intervention in terms of, endovenous thermal (laser ablation, and radiofrequency ablation), ultrasound guided foam sclerotherapy, open surgery (ligation and stripping) are all cost effective treatments for managing symptomatic varicose veins compared to no treatment or the use of compression hosiery. For truncal ablation there is a treatment hierarchy based on the cost effectiveness and suitability, which is endothermal ablation then ultrasound guided foam, then conventional surgery.

With prior approval, NEL CCGs will fund varicose veins when one of the following criteria are met:

1. Symptomatic * primary or recurrent varicose veins

OR

2. Lower limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency

OR

3. Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence

OR

4. A venous leg ulcer (a break in the skin below the knee that has not healed within two weeks)

OR

5. A healed venous leg ulcer.

*Symptomatic: “Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching).” [NICE CG 168]

For patients whose veins are purely cosmetic and are not associated with any symptoms do not refer for NHS treatment.

Refer people with bleeding varicose veins to a vascular service immediately.

Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable.

Physiotherapy

Category 1 Procedures: Individual funding request (IFR)

Manual therapies (osteopathy – outside of an MSK integrated service)

Medicine

Category 1 Procedures: Individual funding request (IFR)

Ketogenic diet for epilepsy

Alternative therapy

Category 1 Procedures: Individual funding request (IFR)

Acupuncture
Herbal medicines
Homeopathy

Other

Category 2 Procedures: Prior Approval (PA)

Botulinum toxin (not cosmetic)
Criteria
NEL CCGs will not fund the use of Botulinum Toxin for cosmetic treatments. **<u>Botulinum Toxin applications in oculoplastics</u>** **With prior approval, NEL CCGs will fund the use Botulinum A by an oculoplastics specialist when one of the following criteria are met:** **<u>Section 1: Entropion</u>** **Botox will be commissioned by NEL CCGs for patients with INVOLUTIONAL entropion who meet one of the following criteria:** 1. Have a corneal ulcer/keratopathy secondary to entropion **OR** 2. Where surgery is contraindicated due to medical co-morbidities not warranting cessation of anticoagulation **OR** 3. Patient with advanced dementia, who is not fir for surgery under local, with or without sedation or general anaesthesia **<u>Section 2: Corneal Ulcer/lagophthalmos</u>** **With prior approval, NEL CCGs will fund corneal ulcer/lagophthalmos by an oculoplastics specialist when one of the following criteria are met:** Botox will be commissioned by NEL CCGs for patients with corneal ulcer/ lagophthalmos who: 1. Have a corneal ulcer due to facial palsy and lagophthalmos to induce a protective ptosis **OR** 2. Have a corneal ulcer due to lagopthalmos secondary to eyelid retraction, trauma or proptosis to induce a protective ptosis Botox treatment may need to be repeated after three to six months. Prior approval is not required for the following treatments:

Blepharospasm

Botulinum A toxin is routinely funded and does not require prior approval for the treatment of blepharospasm.

For palmar or plantar hyperhidrosis, other procedures such as iontophoresis appear to be more effective and have fewer side effects and should be considered as initial treatment.

Botulinum A toxin is routinely funded and does not require prior approval for:
1. spasticity, hand and wrist disability associated with stroke, hemofacial spasm, spasmodic torticollis
2. severe hyperhidrosis, overactive bladder syndrome

Botulinum B toxin is routinely funded and does not require prior approval for:
1. spasmodic torticollis
2. as alternative to Botulinum toxin A in presence of antibodies to Botulinum A.

Botulinum A will also be approved for treatment of migraine for patients who meet the criteria described in NICE TA 260 (https://www.nice.org.uk/guidance/ta260/chapter/1-Guidance) :

1.1 Botulinum toxin type A is recommended as an option for the prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine):
- that has not responded to at least three prior pharmacological prophylaxis therapies and
- whose condition is appropriately managed for medication overuse.

1.2 Treatment with botulinum toxin type A that is recommended according to 1.1 should be stopped in people whose condition:
- is not adequately responding to treatment (defined as less than a 30% reduction in headache days per month after two treatment cycles) or
- has changed to episodic migraine (defined as fewer than 15 headache days per month) for three consecutive months.

Open MRI

Criteria

Claustrophobic patients

Most patients with claustrophobia can be successfully scanned using a conventional MRI scanner. **With prior approval, NEL CCGs will fund open MRI when 1(a) and 2 or 1(b) and 2 of the following criteria are met:**

1(a). The patient has failed to tolerate a conventional scan using feet first

OR

1(b). Oral sedation approaches as appropriate

AND

2. Confirm that no other diagnostic tests are suitable. If more serious health problems preclude sedation, this will need to be detailed

Obese patients

Patients who are too large to fit within a conventional MRI scanner should be referred by a secondary care clinician to a bariatric MRI service.

Appendix A

This appendix provides more clinical guidance for treatments for category 1 procedures (IFR) through either the work of London Choosing Wisely or the National Evidence Based Interventions.

Category 1 Procedures: Individual funding request (IFR)

Injections for non-specific low back pain
Criteria
Spinal injections of local anaesthetic and steroid should not be offered for patients with non-specific low back pain. For people with non-specific low back pain the following injections should not be offered: • Facet joint injections • Therapeutic medial branch blocks • Intradiscal therapy • Prolotherapy • Trigger point injections with any agent, including botulinum toxin • Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis • Any other spinal injections not specifically covered above Radiofrequency denervation can be offered according to NICE guideline (NG59) if all non-surgical and alternative treatments have been tried and there is moderate to severe chronic pain that has improved in response to diagnostic medical branch block. Epidurals (local anaesthetic and steroid) should be considered in patients who have acute and severe lumbar radiculopathy at time of referral. Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic. Alternative options are suggested in line with the National Back Pain Pathway. For further information, please see: https://www.nice.org.uk/guidance/ng59

Dilation & curettage (D&C) for heavy menstrual bleeding in women
Criteria
D&C should not be used for diagnosis or treatment for heavy menstrual bleeding in women because it is clinically ineffective. UIltrasound scans and camera tests with sampling of the lining of the womb (hysteroscopy and biopsy) should be used to investigate heavy periods. Medication and intrauterine systems (IUS) should be used to treat heavy periods. NICE guidelines recommend that D&C is not offered as a treatment option for heavy menstrual bleeding. There is very little evidence to suggest that D&C works to treat heavy periods and the one study identified by NICE showed the effects were only temporary. D&C should not be used to investigate heavy menstrual bleeding as hysteroscopy and biopsy work better. Complications following D&C are rare but include uterine perforation, infection, adhesions (scar tissue) inside the uterus and damage to the cervix.

Knee arthroscopy for patients with osteoarthritis

Criteria

Arthroscopic knee washout (lavage and debridement) should not be used as a treatment for osteoarthritis because it is clinically ineffective.

Referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking.

More effective treatment includes exercise programmes (e.g. ESCAPE pain), losing weight (if necessary) and managing pain. Osteoarthritis is relatively common in older age groups. Where symptoms do not resolve after non operative treatment, referral for consideration of knee replacement, or joint preserving surgery such as osteotomy is appropriate.

Surgical interventions for snoring in the absence of obstructive sleep apnoea

Criteria

It is on the basis of limited clinical evidence of effectiveness, and the significant risks that patients could be exposed to, this procedure should no longer be routinely commissioned in the management of simple snoring.
Alternative Treatments

There are a number of alternatives to surgery that can improve the symptom of snoring. These include:

- Weight loss
- Stopping smoking
- Reducing alcohol intake
- Medical treatment of nasal congestion (rhinitis)
- Mouth splints (to move jaw forward when sleeping)

In two systematic reviews of 72 primary research studies there is no evidence that surgery to the palate to improve snoring provides any additional benefit compared to other treatments. While some studies demonstrate improvements in subjective loudness of snoring at 6-8 weeks after surgery; this is not longstanding (> 2years) and there is no long-term evidence of health benefit. This intervention has limited to no clinical effectiveness and surgery carries a 0-16% risk of severe complications (including bleeding, airway compromise and death). There is also evidence from systematic reviews that up to 58-59% of patients suffer persistent side effects (swallowing problems, voice change, globus, taste disturbance & nasal regurgitation). It is on this basis the interventions should no longer be routinely commissioned.